The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to https://regence.com or call 1 (866) 240-9580. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at healthcare.gov/sbc-glossary or call 1 (866) 240-9580 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$2,000 individual / $4,000 family per calendar year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Certain preventive care and those services listed below as "deductible does not apply" or as "No charge."	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network: $5,500 individual / $13,500 family per calendar year. Out-of-network: $5,000 individual per calendar year.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See https://regence.com/go/OR/Preferred or call 1 (866) 240-9580 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay / office visit, deductible does not apply; 20% coinsurance for all other services	40% coinsurance	Coverage includes primary care visits at a retail clinic. Copayment applies to each in-network office and retail clinic visit only. All other services are covered at the coinsurance specified, after deductible. In-network acupuncture services are subject to $25 copayment / visit, deductible does not apply; out-of-network subject to the coinsurance specified, after deductible. 15 acupuncture visits / year In-network spinal manipulations are subject to $25 copayment / visit, deductible does not apply; out-of-network subject to the coinsurance specified, after deductible. 30 spinal manipulation visits / year
	Specialist visit	$25 copay / office visit, deductible does not apply; 20% coinsurance for all other services	40% coinsurance	
	Preventive care/screening/ immunization	No charge	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance, deductible does not apply for outpatient services	40% coinsurance	Preauthorization may be required.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://regence.com/go/2022/OR/4tier	Generic drugs	$10 copay / retail prescription $10 copay / mail order prescription $10 copay / self-administrable cancer chemotherapy prescription		Prescription drugs not on the Drug List are not covered, unless an exception is approved. Deductible does not apply. 30-day supply / retail prescription 90-day supply / mail order prescription 30-day supply / specialty drug retail prescription Specialty drugs are not available through mail order. Coverage includes compound medications at 50% coinsurance, refer to your plan for further information.
	Preferred brand drugs	$30 copay / retail prescription $60 copay / mail order prescription $50 copay / self-administrable cancer chemotherapy prescription		

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Brand drugs	$50 copay / retail prescription $100 copay / mail order prescription $100 copay / self-administrable cancer chemotherapy prescription		Cost shares for insulin will not exceed $75 / 30-day supply retail prescription or $225 / 90-day supply mail order prescription. No charge for certain preventive drugs, women's contraceptives and immunizations at a participating pharmacy. You are responsible for the difference in cost between a dispensed brand drug and the equivalent generic drug, in addition to the copayment and/or coinsurance, unless your provider specifies "dispense as written." The first fill of specialty drugs may be provided by a retail pharmacy; additional refills must be provided by a specialty pharmacy.
	Specialty drugs	30% up to $200 maximum / retail prescription		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	$250 copay / visit, deductible does not apply	$250 copay / visit, deductible does not apply	Copayment applies to facility charge for each visit (waived if admitted).
	Emergency medical transportation	Ground: 20% coinsurance; Air: 50% coinsurance	Ground: 20% coinsurance; Air: 50% coinsurance	Limited to nearest facility able to treat condition. Air covered if ground medically or physically inappropriate. Out-of-network air covered up to 200% of the Medicare allowance.
	Urgent care	Covered the same as **If you visit a health care provider's office or clinic** (Primary care visit or Specialist visit) or **If you have a test** above.		None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization required for some inpatient services.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay / office visit, deductible does not apply; 20% coinsurance for all other services	40% coinsurance	Copayment applies to each in-network office/psychotherapy visit only. All other services are covered at the coinsurance specified, after deductible.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Inpatient services	20% coinsurance	40% coinsurance	Preauthorization required for some inpatient services.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	$200 copay for services billed under the professional global fee, deductible does not apply; 20% coinsurance for all other services	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	130 visits / year Preauthorization required.
	Rehabilitation services	20% coinsurance, deductible does not apply for outpatient services	40% coinsurance	30 inpatient days / year 60 inpatient days for each head or spinal cord injury 30 outpatient visits / year Includes physical therapy, occupational therapy and speech therapy. Preauthorization required for inpatient services.
	Habilitation services	20% coinsurance, deductible does not apply	40% coinsurance	30 neurodevelopmental visits / year Neurodevelopmental therapy limited to individuals under age 18. Includes physical therapy, occupational therapy and speech therapy. Preauthorization required for inpatient services.
	Skilled nursing care	20% coinsurance	40% coinsurance	60 inpatient days / year Preauthorization required.
	Durable medical equipment	20% coinsurance	40% coinsurance	1 wig / year after chemotherapy or radiation therapy Preauthorization may be required.
	Hospice services	20% coinsurance	40% coinsurance	30 respite inpatient or outpatient days / lifetime Preauthorization required.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Bariatric surgery
- Cosmetic surgery, except congenital anomalies
- Custodial Care
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Recreation therapy
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Abortion
- Acupuncture
- Chiropractic care, spinal manipulations only
- Hearing aids
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1 (877) 267-2323 ext. 61565 or cciio.cms.gov or your state insurance department. You may also contact the plan at 1 (866) 240-9580. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit HealthCare.gov or call 1 (800) 318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the plan at 1 (866) 240-9580 or visit regence.com or the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or dol.gov/ebsa/healthreform. You may also contact the Oregon Division of Financial Regulation by calling 1 (503) 947-7984 or the toll-free message line at 1 (888) 877-4894; by writing to the Oregon Division of Financial Regulation, Consumer Advocacy Unit, P.O. Box 14480, Salem, OR 97309-0405; through the Internet at: dfr.oregon.gov/help/complaints-licenses/Pages/file-complaint.aspx; or by E-mail at: DFRInsuranceHelp@oregon.gov.

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1 (866) 240-9580.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$2,000**
Specialist copayment	**$25**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$211
Coinsurance	$1,521
What isn't covered	
Limits or exclusions	$61
The total Peg would pay is	**$3,793**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$2,000**
Specialist copayment	**$25**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$790
Copayments	$674
Coinsurance	$17
What isn't covered	
Limits or exclusions	$178
The total Joe would pay is	**$1,659**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$2,000**
Specialist copayment	**$25**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$330
Coinsurance	$19
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,349**

The plan would be responsible for the other costs of these EXAMPLE covered services.