




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 (855) 877-0047. 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 (855) 877-0047 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	\$250 individual / \$500 family per calendar year.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u>?	Yes. Certain preventive care and those services listed below as " <u>deductible</u> does not apply" or as "No charge."	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain preventive services without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered preventive services at healthcare.gov/coverage/preventive-care-benefits .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	\$1,500 individual / \$3,000 family per calendar year.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See https://regence.com/go/WW/Preferred or call 1 (855) 877-0047 for a list of <u>network providers</u> .	You pay the least if you use a <u>provider</u> in the preferred <u>network</u> . You pay more if you use a <u>provider</u> in the participating <u>network</u> . You will pay the most if you use a <u>nonparticipating provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use a <u>nonparticipating provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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
		Preferred Network Provider (You pay the least)	Participating Network Provider (You pay more)	Nonparticipating Provider (You pay the most)	
If you visit a health care <u>provider's office</u> or clinic	Primary care visit to treat an injury or illness	\$20 <u>copay</u> / visit, <u>deductible</u> does not apply; other services 0% <u>coinsurance</u>	40% <u>coinsurance</u> after \$20 <u>copay</u> / visit, <u>deductible</u> does not apply; other services 40% <u>coinsurance</u>	Not covered	<p><u>Copayment</u> applies to each preferred or participating office and retail clinic visit only. All other services are covered at the <u>coinsurance</u> specified, after <u>deductible</u>. Acupuncture services are limited to 12 visits / year, subject to <u>coinsurance</u>, after <u>deductible</u>.</p> <p>Spinal manipulations are limited to 15 / year, subject to \$20 <u>copay</u> / visit for preferred or participating <u>providers</u> after <u>deductible</u>.</p> <p>You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.</p>
	<u>Specialist</u> visit	\$20 <u>copay</u> / visit, <u>deductible</u> does not apply; other services 0% <u>coinsurance</u>	40% <u>coinsurance</u> after \$20 <u>copay</u> / visit, <u>deductible</u> does not apply; other services 40% <u>coinsurance</u>	Not covered	
	<u>Preventive care/screening/immunization</u>	No charge	No charge	Not covered	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	0% <u>coinsurance</u>	40% <u>coinsurance</u>	Not covered	None
	Imaging (CT/PET scans, MRIs)	0% <u>coinsurance</u>	40% <u>coinsurance</u>	Not covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You pay the least)	Participating Network Provider (You pay more)	Nonparticipating Provider (You pay the most)	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at https://regence.com/go/2021/WW/6tierLG .	Preferred generic drugs & generic drugs	\$5 <u>copay</u> / preferred generic retail prescription \$10 <u>copay</u> / preferred generic mail order prescription \$5 <u>copay</u> / generic retail prescription \$10 <u>copay</u> / generic mail order prescription			<u>Deductible</u> does not apply. 90-day supply / retail prescription (your <u>cost share</u> is per 30-day supply) 90-day supply / mail order 30-day supply / <u>specialty drug</u> retail prescription. <u>Specialty drugs</u> are not available through mail order. Coverage includes compound medications, refer to your plan for further information. The first fill of <u>specialty drugs</u> may be provided by a retail pharmacy; additional refills must be provided by a specialty pharmacy.
	Preferred brand drugs	\$35 <u>copay</u> / retail prescription \$70 <u>copay</u> / mail order prescription			
	Brand drugs	\$60 <u>copay</u> / retail prescription \$120 <u>copay</u> / mail order prescription			
	Preferred <u>specialty drugs</u> & <u>specialty drugs</u>	\$75 <u>copay</u> / preferred <u>specialty drugs</u> \$150 <u>copay</u> / <u>specialty drugs</u>			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% <u>coinsurance</u>	40% <u>coinsurance</u>	Not covered	None
	Physician/surgeon fees	0% <u>coinsurance</u>	40% <u>coinsurance</u>	Not covered	None
If you need immediate medical attention	Emergency room care	10% <u>coinsurance</u> after \$150 <u>copay</u> for facility, 0% <u>coinsurance</u> for professional services	10% <u>coinsurance</u> after \$150 <u>copay</u> for facility, 0% <u>coinsurance</u> for professional services	10% <u>coinsurance</u> after \$150 <u>copay</u> for facility, 0% <u>coinsurance</u> for professional services	<u>Copayment</u> applies to facility charge for each visit (waived if admitted), whether or not the <u>deductible</u> has been met.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Urgent care</u>	Covered the same as If you visit a health care provider's office or clinic (Primary care visit or <u>Specialist</u> visit) or If you have a test above.			None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You pay the least)	Participating Network Provider (You pay more)	Nonparticipating Provider (You pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Not covered	None
	Physician/surgeon fees	0% <u>coinsurance</u>	40% <u>coinsurance</u>	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% <u>coinsurance</u> for facility; 0% for professional services	10% <u>coinsurance</u> for facility; 0% for professional services	Not covered	None
	Inpatient services	10% <u>coinsurance</u> for facility; 0% for professional services	10% <u>coinsurance</u> for facility; 0% for professional services	Not covered	None
If you are pregnant	Office visits	0% <u>coinsurance</u>	40% <u>coinsurance</u>	Not covered	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Childbirth/delivery services for children are not covered.
	Childbirth/delivery professional services	0% <u>coinsurance</u>	40% <u>coinsurance</u>	Not covered	
	Childbirth/delivery facility services	10% <u>coinsurance</u>	40% <u>coinsurance</u>	Not covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You pay the least)	Participating Network Provider (You pay more)	Nonparticipating Provider (You pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	0% <u>coinsurance</u>	40% <u>coinsurance</u>	Not covered	130 visits / year.
	<u>Rehabilitation services</u>	Inpatient: 10% <u>coinsurance</u> for facility; 0% <u>coinsurance</u> for professional services Outpatient: 20% <u>coinsurance</u>	40% <u>coinsurance</u>	Not covered	40 inpatient days / year. 99 outpatient visits / year. Includes physical therapy, occupational therapy and speech therapy services.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Not covered	Includes physical therapy, occupational therapy and speech therapy services.
	<u>Skilled nursing care</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	Not covered	100 inpatient days / year.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Not covered	None
	<u>Hospice services</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	Not covered	14 respite inpatient or outpatient days / lifetime.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	Not covered	None
	Children's dental check-up	Not covered	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
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care, except for diabetic patients
- Weight loss programs, except as covered under preventive care

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

- Abortion
- Acupuncture
- Chiropractic care
- 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 (855) 877-0047. 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 (855) 877-0047. You may also contact your state insurance department at 1 (800) 562-6900 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.

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 (855) 877-0047.

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 **\$250**
- Specialist copayment **\$20**
- Hospital (facility) coinsurance **10%**
- Other coinsurance **0%**

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$9
Coinsurance	\$706
<i>What isn't covered</i>	
Limits or exclusions	\$61
The total Peg would pay is	\$1,026

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

- The plan's overall deductible **\$250**
- Specialist copayment **\$20**
- Hospital (facility) coinsurance **10%**
- Other coinsurance **0%**

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$686
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$178
The total Joe would pay is	\$1,114

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

- The plan's overall deductible **\$250**
- Specialist copayment **\$20**
- Hospital (facility) coinsurance **10%**
- Other coinsurance **0%**

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$215
Coinsurance	\$50
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$515



The Summary of Benefits and Coverage (SBC) document will help you choose a vision plan. The SBC shows you how you and the plan would share the cost for covered vision 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 regence.com. For provider or benefit questions call VSP at 1 (844) 299-3041. For membership questions, call Regence at 1 (855) 877-0047. 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 (855) 877-0047 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$0	See the Common Vision Event chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your deductible?	Not applicable.	See the Common Vision Event chart below for your costs for services this <u>plan</u> covers.
Are there other deductibles for specific services?	No.	See the Common Vision Event chart below for your costs for services this <u>plan</u> covers.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	Not applicable.	This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.
What is not included in the <u>out-of-pocket limit</u>?	Not applicable.	This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.
Will you pay less if you use a <u>network provider</u>?	Yes. See https://regence.com/go/VSPNetwork or call 1 (844) 299-3041 for a list of VSP doctors.	This <u>plan</u> uses a vision <u>provider network</u> (Vision Service Plan). You will pay less if you use a vision <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network</u> vision <u>provider</u> , and you might receive a bill from a vision <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>).
Do you need a referral to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

Common Vision Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		VSP Doctor	Out-of-Network Provider	
If you visit a vision care <u>provider's office</u> or clinic	Routine vision examination	No charge	No charge up to the <u>out-of-network provider</u> limit	For services provided by an out-of-network provider, you pay all charges up front then submit a claim for reimbursement. 1 routine eye examination / calendar year. Routine eye examination limited to \$45 for <u>out-of-network providers</u> .
	Vision hardware	Not covered	Not covered	None

Excluded 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.)

- Corrective vision treatment of an experimental nature
- Cosmetic services and supplies
- Fees, taxes, interest
- Medical or surgical treatment of the eyes
- Non-direct patient care
- Orthoptics or vision training
- Plano lenses
- Two pair of glasses in lieu of bifocals
- Vision hardware

NONDISCRIMINATION NOTICE

Regence complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Regence does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Regence:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, and accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services listed above, please contact:

Medicare Customer Service

1-800-541-8981 (TTY: 711)

Customer Service for all other plans

1-888-344-6347 (TTY: 711)

If you believe that Regence has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our civil rights coordinator below.

For VSP vision services, contact: **VSP**
1-844-299-3041 (TTY: 1-800-428-4833)

VSP provides administration for your Regence vision plan. Regence complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Regence does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Medicare Customer Service

Civil Rights Coordinator

MS: B32AG, PO Box 1827

Medford, OR 97501

1-866-749-0355, (TTY: 711)

Fax: 1-888-309-8784

medicareappeals@regence.com

Customer Service for all other plans

Civil Rights Coordinator

MS CS B32B, P.O. Box 1271

Portland, OR 97207-1271

1-888-344-6347, (TTY: 711)

CS@regence.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW,
Room 509F HHH Building
Washington, DC 20201

1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at
<http://www.hhs.gov/ocr/office/file/index.html>.

Language assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-344-6347 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-344-6347 (TTY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-344-6347 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-344-6347 (TTY: 711) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-344-6347 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-344-6347 (телетайп: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-344-6347 (ATS : 711)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-344-6347 (TTY:711) まで、お電話にてご連絡ください。

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, kojí' hódíílnih 1-888-344-6347 (TTY: 711.)

FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea te ke lava 'o ma'u ia. ha'o telefonimai mai ki he fika 1-888-344-6347 (TTY: 711)

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-344-6347 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតល្អល គឺអាចមានសរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-888-344-6347 (TTY: 711)។

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-344-6347 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachdienstleistungen zur Verfügung. Rufnummer: 1-888-344-6347 (TTY: 711)

ማስታወሻ:- የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገዝዎት ተዘጋጅተዋል፤ በሚከተለው ቁጥር ይደውሉ 1-888-344-6347 (መስማት ለተሳናቸው:- 711)::

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