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, call 1-877-396-4612. 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 https://www.healthcare.gov/sbc-glossary or call 1-877-396-4612 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$150 individual/$450 family	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, hospice services and ACA-mandated preventative care are covered before you meet your deductibles.	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 https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	There are no other specific deductibles.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$1,150 annually per Family for medical and $750 annually per Family for prescription drugs.	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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed 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. For a list of preferred providers, see www.regence.com or call (503) 220-6100 or 1-800-452-8812.	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
		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	10% coinsurance	20% coinsurance	None
	Specialist visit	10% coinsurance	20% coinsurance	Chiropractic benefits limited to treatment of musculoskeletal disorders. Plan provides up to 52 visits per calendar year. Deductible is waived. Diagnostic services performed in support of chiropractic care are covered under the Plan's Diagnostic Laboratory and Imaging benefit.
	Preventive care/screening/ immunization	No Charge	20% coinsurance	None
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	20% coinsurance	Some services require preauthorization
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.express-scripts.com	Generic drugs	10% coinsurance	Not Covered	31 day supply $5 minimum and $50 maximum for retail; $10 minimum and $100 maximum for 32-60 day supply; $15 minimum and $150 maximum for 61-90 day supply. $12.50 minimum and $125 maximum for mail. $750 maximum copay per family.
	Preferred brand drugs	15% coinsurance	Not Covered	31 day supply $15 minimum and $100 maximum for retail; $30 minimum and $200 maximum for 32-60 day supply; $45 minimum and $300 maximum for 61-90 day supply. $37.50 minimum and $250 maximum for mail. $750 maximum copay per family.
	Non-preferred brand drugs	25% coinsurance	Not Covered	31 day supply $25 minimum and $100 maximum for retail; $50 minimum and $200 maximum for 32-60 day supply; $75 minimum and $300 maximum for 61-90 day supply. $62.50 minimum and $250 maximum for mail. $750 maximum copay per family.

	Specialty drugs	100% coinsurance up to $100 maximum	Not Covered	Requires preauthorization. Limited to 30 day supply. $100 copay or 100% of the cost if less.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	20% coinsurance	None
	Physician/surgeon fees	10% coinsurance	20% coinsurance	None
If you need immediate medical attention	Emergency room care	10% coinsurance and $150 copay	10% coinsurance and $150 copay	$150 copay waived if admitted to hospital
	Emergency medical transportation	15% coinsurance	15% coinsurance	None
	Urgent care	10% coinsurance	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	20% coinsurance	$3,500 copay or the Plan's out-of-pocket maximum for Bariatric Surgery
	Physician/surgeon fees	10% coinsurance	20% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	20% coinsurance	None
	Inpatient services	10% coinsurance	20% coinsurance	None
If you are pregnant	Office visits	10% coinsurance	20% coinsurance	None
	Childbirth/delivery professional services	10% coinsurance	20% coinsurance	None
	Childbirth/delivery facility services	10% coinsurance	20% coinsurance	None
If you need help recovering or have other special health needs	Home health care	10% coinsurance	20% coinsurance	Limited to 180 visits annually; limited to 2 visits/day for nurses and 1 visit/day for other Home Health Care providers
	Rehabilitation services	10% coinsurance	20% coinsurance	Limited to 1 session of a given type per day and 30 visits annually (60 visits annually for head and spinal injury)
	Habilitation services	10% coinsurance	20% coinsurance	
	Skilled nursing care	10% coinsurance	20% coinsurance	Limited to 90 days annually
	Durable medical equipment	10% coinsurance	20% coinsurance	None
	Hospice services	10% coinsurance	20% coinsurance	Deductible waived. Limited to 6 months. May apply for extension.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Covered under separate vision plan
	Children's glasses	Not Covered	Not Covered	Covered under separate vision plan
	Children's dental check-up	Not Covered	Not Covered	Covered under separate dental benefit

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.)

- Cosmetic surgery
- Hearing aids (covered for Dependent children)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside of the U.S.
- Private-duty nursing
- Routine eye care
- Routine foot care

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

- Acupuncture
- Bariatric surgery
- Chiropractic spinal manipulation
- Dental care (Separate Plan)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the Administrative Office at 1-877-396-4612. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 www.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 Administrative Office at 1-877-396-4612 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.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 1-877-396-4612.
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-396-4612.
[Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-877-396-4612.
[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-396-4612.

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	$150
Specialist *coinsurance*	10%
Hospital (facility) *coinsurance*	10%
Other *coinsurance*	10%

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	$150
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,210**

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

The plan's overall deductible	$150
Specialist *coinsurance*	10%
Hospital (facility) *coinsurance*	10%
Other *coinsurance*	10%

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	$150
Copayments	$0
Coinsurance	$700
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$870**

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

The plan's overall deductible	$150
Specialist *coinsurance*	10%
Hospital (facility) *coinsurance*	10%
Other *coinsurance*	10%

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	$150
Copayments	$150
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$600**

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