



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:
<u>What is the overall 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> .
<u>Are there services covered before you meet your deductible?</u>	Yes. Certain <u>preventive care</u> , <u>prescription drug coverage</u> and those services listed below as " <u>deductible</u> does not apply." "No charge" means \$0 <u>copayment</u> or 0% <u>coinsurance</u> , regardless of <u>deductible</u> applicability.	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 <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at healthcare.gov/coverage/preventive-care-benefits/ .
<u>Are there other deductibles for specific services?</u>	No.	You don't have to meet <u>deductibles</u> for specific services.
<u>What is the out-of-pocket limit for this plan?</u>	Preferred <u>provider</u> : \$2,000 individual / \$4,000 family per calendar year. <u>Participating provider</u> & <u>non-participating provider</u> : \$4,000 individual / \$8,000 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.
<u>What is not included in the out-of-pocket limit?</u>	<u>Premiums</u> , <u>deductible</u> , <u>copayments</u> , <u>prescription drug out-of-pocket limit</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> .
<u>Will you pay less if you use a network provider?</u>	Yes. See https://regence.com/go/OR/Preferred or call 1-866-240-9580 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>non-participating 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>non-participating provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<u>Do you need a referral to see a 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	Preferred Provider (You pay the least)	What You Will Pay		Limitations, Exceptions, & Other Important Information
			Participating Provider (You pay more)	Non-participating Provider (You pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Specialist</u> visit	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	
	<u>Preventive care/screening/immunization</u>	No charge, <u>deductible</u> does not apply	No charge, <u>deductible</u> does not apply	40% <u>coinsurance</u>	No charge, <u>deductible</u> does not apply for childhood immunizations from <u>non-participating providers</u> . 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.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	
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/2026/OR/3tierStd	Tier 1 (Typically, generic drugs with highest overall value)	Not applicable, refer to <u>participating provider</u> and <u>non-participating provider</u> columns.	20% <u>coinsurance</u> , <u>deductible</u> does not apply / retail prescription; 20% <u>coinsurance</u> , <u>deductible</u> does not apply / home delivery prescription	20% <u>coinsurance</u> , <u>deductible</u> does not apply / retail prescription; 20% <u>coinsurance</u> , <u>deductible</u> does not apply / home delivery prescription	<u>Prescription drugs</u> not on the Drug List are not covered, unless an exception is approved. <u>Out-of-pocket limit</u> : \$700 individual / year. 90-day supply / retail prescription 90-day supply / home delivery prescription 30-day supply / <u>specialty drug</u> prescription <u>Specialty drugs</u> are not available through home delivery. Coverage includes compound medications at 50% <u>coinsurance</u> , <u>deductible</u> does not apply. <u>Cost shares</u> for PPI drugs will not exceed \$20 / 30-day supply. <u>Cost shares</u> for cholesterol lowering drugs will not exceed \$25 / 30-day supply. <u>Cost shares</u> for insulin will not exceed \$35 / 30-day supply or \$105 / 90-day supply.
	Tier 2 (Typically, brand drugs with moderate overall value)	Not applicable, refer to <u>participating provider</u> and <u>non-participating provider</u> columns.	20% <u>coinsurance</u> , <u>deductible</u> does not apply / retail prescription; 20% <u>coinsurance</u> , <u>deductible</u> does not apply / home delivery prescription	20% <u>coinsurance</u> , <u>deductible</u> does not apply / retail prescription; 20% <u>coinsurance</u> , <u>deductible</u> does not apply / home delivery prescription	

Common Medical Event	Services You May Need	Preferred Provider (You pay the least)	What You Will Pay Participating Provider (You pay more)	Non-participating Provider (You pay the most)	Limitations, Exceptions, & Other Important Information
	Tier 3 (Typically, brand drugs with lower overall value)	Not applicable, refer to <u>participating provider</u> and <u>non-participating provider</u> columns.	20% <u>coinsurance</u> , <u>deductible</u> does not apply / retail prescription; 20% <u>coinsurance</u> , <u>deductible</u> does not apply / home delivery prescription	20% <u>coinsurance</u> , <u>deductible</u> does not apply / retail prescription; 20% <u>coinsurance</u> , <u>deductible</u> does not apply / home delivery prescription	No charge, <u>deductible</u> does not apply for certain preventive drugs, contraceptives and immunizations at a participating pharmacy. If you fill a brand drug or <u>specialty drug</u> when there is an equivalent generic drug or specialty biosimilar drug available, you pay the difference in cost in addition to the <u>copayment</u> and/or <u>coinsurance</u> . The first fill of <u>specialty drugs</u> may be provided by a retail pharmacy; additional refills must be provided by a specialty pharmacy.
	<u>Specialty drugs</u>	Not applicable, refer to <u>participating provider</u> and <u>non-participating provider</u> columns.	Refer to tier 1, 2 and 3 drugs above.	Refer to tier 1, 2 and 3 drugs above.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u> after \$100 <u>copay</u> / visit	20% <u>coinsurance</u> after \$100 <u>copay</u> / visit	20% <u>coinsurance</u> after \$100 <u>copay</u> / visit	<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>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need mental health, behavioral	Outpatient services	20% <u>coinsurance</u> , <u>deductible</u> does not apply	20% <u>coinsurance</u> , <u>deductible</u> does not apply	40% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	Preferred Provider (You pay the least)	What You Will Pay		Limitations, Exceptions, & Other Important Information
Participating Provider (You pay more)		Non-participating Provider (You pay the most)			
health, or substance abuse services	Inpatient services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you are pregnant	Office visits	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	Deductible does not apply for newborn nursery care.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	<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). For example, an ultrasound billed separately is covered under the If you have a test above.
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need help recovering or have other special health needs	Home health care	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	180 visits / year
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	30 inpatient days / year 30 outpatient visits / year Includes physical therapy, occupational therapy, massage therapy when provided as therapeutic intervention and speech therapy.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	30 neurodevelopmental visits / year Includes physical therapy, occupational therapy, massage therapy when provided as therapeutic intervention and speech therapy.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	100 inpatient days / year
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	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	
	Children's dental check-up	Not covered	Not covered	Not covered	

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	• Infertility treatment	• Routine eye care
• Cosmetic surgery, except congenital anomalies	• Long-term care	• Routine foot care, except for diabetic patients
• Dental care	• Private-duty nursing	• Weight loss programs

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

• Abortion	• Chiropractic care, \$600 / year (combined with acupuncture services)	• Non-emergency care when traveling outside the U.S.
• Acupuncture, \$600 / year (combined with chiropractic care services)	• Hearing aids	

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 ccio.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.

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 preferred provider pre-natal care and a hospital delivery)

■ The <u>plan's overall deductible</u>	\$250
■ <u>Specialist coinsurance</u>	20%
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$250
Copayments	\$0
Coinsurance	\$1,800

What isn't covered

Limits or exclusions	\$60
The total Peg would pay is	\$2,060

Managing Joe's Type 2 Diabetes

(a year of routine preferred provider care of a well-controlled condition)

■ The <u>plan's overall deductible</u>	\$250
■ <u>Specialist coinsurance</u>	20%
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$250
Copayments	\$0
Coinsurance	\$1,000

What isn't covered

Limits or exclusions	\$200
The total Joe would pay is	\$1,450

Mia's Simple Fracture

(preferred provider emergency room visit and follow up care)

■ The <u>plan's overall deductible</u>	\$250
■ <u>Specialist coinsurance</u>	20%
■ <u>Hospital (facility) coinsurance</u>	20%
■ <u>Other coinsurance</u>	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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$250
Copayments	\$100
Coinsurance	\$500

What isn't covered

Limits or exclusions	\$0
The total Mia would pay is	\$850

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

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 less favorably because of race, color, national origin, age, disability, or sex.

Regence:

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

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

Provides free language assistance services to people whose primary language is not English, which may include:

- Qualified interpreters
- Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact the Civil Rights Coordinator.

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. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

Customer Service

Civil Rights Coordinator
PO Box 1106
Lewiston, ID 83501-1106
Phone: 1-888-344-6347, (TTY: 711)
Fax: 1-888-309-8784
Email: CS@regence.com

Medicare Customer Service

Phone: 1-800-541-8981 (TTY: 711)
Email: medicareappeals@regence.com

VSP Customer Service

Phone: 1-844-299-3041
TTY: 1-800-428-4833

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, available 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, D.C. 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 (телефон: 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 yánílti'go **Diné Bizaad**, saad bee áká'ánida'áwo'déé', t'áá jiik'eh, éí ná hóló, kojj' 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 slušom; 711)

ប្រយោជន៍ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ,
សេវាដំឡើងយោងទៅភាសា ដោយមិនគិតគូល
គឺអាជមានសំរាប់រឿងគ្រី ចូរ ទូរសព្ទ 1-888-344-
6347 (TTY: 711)⁴

ਪਿਆਨ 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:- የሚገኘት ቅኝ አማርኛ ከሆነ የተጠየቀ እርዳታ
ድርጅቶች፣ በንግድ ማስተካከል ተከራክሩ ተቋል፣ በማከተለው ቁጥር
ይደውሉ 1-888-344-6347 (መስማት ለተሳናቸው፡- 711)::

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мової підтримки. Телефонуйте за номером 1-888-344-6347 (телефон: 711)

ध्यान दिनुहोसः तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निमिति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस 1-888-344-6347 (टिटिवाइ: 711

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-344-6347 (TTY: 711)

MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-888-344-6347 (TTY: 711)

โปรดทราบ: ถ้าคุณพูดภาษาไทย

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

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