

 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 [regence.com/go/2019/policy/OR/StandardSilverPlanEPOOHSU](https://regence.com/go/2019/policy/OR/StandardSilverPlanEPOOHSU) or call 1 (888) 675-6570. 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](https://healthcare.gov/sbc-glossary) or call 1 (888) 675-6570 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: \$2,850 individual / \$5,700 family per calendar year. Out-of-network: Not applicable	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. Prescription drugs and the following in-network services: preventive care, office and urgent care visits, outpatient mental health and substance use disorder office/psychotherapy visits, outpatient rehabilitation/habilitation visits or pediatric vision.	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 <a href="https://healthcare.gov/coverage/preventive-care-benefits/">healthcare.gov/coverage/preventive-care-benefits/</a> .
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: \$7,900 individual / \$15,800 family per calendar year. Out-of-network: Not applicable	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-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. See <a href="https://regence.com/go/OHSUPlus">regence.com/go/OHSUPlus</a> or call 1 (888) 675-6570 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 <u>provider's office or clinic</u>	Primary care visit to treat an injury or illness	\$40 <u>copay</u> / visit, <u>deductible</u> does not apply; all other services 30% <u>coinsurance</u>	Not covered	<u>Copayment</u> applies to each in- <u>network</u> office visit only. All other services that are not billed as an office visit are covered at the <u>coinsurance</u> specified, after <u>deductible</u> .
	<u>Specialist</u> visit	\$80 <u>copay</u> / visit, <u>deductible</u> does not apply; all other services 30% <u>coinsurance</u>	Not covered	
	<u>Preventive care/screening/immunization</u>	No charge	Not covered	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)	30% <u>coinsurance</u>	Not covered	None
	Imaging (CT/PET scans, MRIs)	30% <u>coinsurance</u>	Not covered	

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)	
<b>If you need drugs to treat your illness or condition</b> More information about <u>prescription drug coverage</u> is available at <a href="http://regence.com/go/druglist/2019/6tier">regence.com/go/druglist/2019/6tier</a> .	Preferred generic drugs & generic drugs	\$15 <u>copay</u> * / preferred retail prescription \$30 <u>copay</u> / preferred mail order prescription 25% <u>coinsurance</u> * / retail prescription 20% <u>coinsurance</u> / mail order prescription		No coverage for <u>prescription drugs</u> not on the Drug List. No coverage for <u>prescription drugs</u> from an out-of- <u>network</u> pharmacy. Limited to a 90-day supply retail (1 <u>copayment</u> per 30-day supply), 90-day supply mail order or 30-day supply self-administrable cancer chemotherapy and <u>specialty drugs</u> (including preferred). No charge for FDA-approved women's contraceptives and certain preventive drugs and immunizations at a participating pharmacy. <u>Deductible</u> waived for all <u>prescription drugs</u> . The first fill for designated <u>specialty drugs</u> (including preferred) may be provided at a retail pharmacy, additional refills and any fills for other non-designated <u>specialty drugs</u> (including preferred) must be provided at a specialty pharmacy. Coverage for self-administrable cancer chemotherapy drugs is 30% <u>coinsurance</u> . *Discount of \$5 off <u>copayment</u> or 5% off <u>coinsurance</u> when filled at a preferred retail pharmacy
	Preferred brand drugs	\$60 <u>copay</u> * / retail prescription \$120 <u>copay</u> / mail order prescription		
	Brand drugs	50% <u>coinsurance</u> * / retail prescription 45% <u>coinsurance</u> / mail order prescription		
	<u>Preferred specialty drugs &amp; specialty drugs</u>	40% <u>coinsurance</u> / preferred retail prescription 50% <u>coinsurance</u> / retail prescription		
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	30% <u>coinsurance</u>	Not covered	None
	Physician/surgeon fees	30% <u>coinsurance</u>	Not covered	None
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	In- <u>network</u> <u>deductible</u> applies to in- <u>network</u> and out-of- <u>network</u> services.
	<u>Emergency medical transportation</u>	30% <u>coinsurance</u>	30% <u>coinsurance</u>	In- <u>network</u> <u>deductible</u> applies to in- <u>network</u> and out-of- <u>network</u> services.
	<u>Urgent care</u>	\$70 <u>copay</u> / visit, <u>deductible</u> does not apply; all other services 30% <u>coinsurance</u>	Not covered	<u>Copayment</u> applies to each in- <u>network</u> office visit only. All other services that are not billed as an office visit are covered at the <u>coinsurance</u> specified, after <u>deductible</u> .

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 have a hospital stay	Facility fee (e.g., hospital room)	30% <u>coinsurance</u>	Not covered	None
	Physician/surgeon fees	30% <u>coinsurance</u>	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$40 <u>copay</u> / visit, <u>deductible</u> does not apply; all other services 30% <u>coinsurance</u>	Not covered	<u>Copayment</u> applies to each in- <u>network</u> outpatient office/psychotherapy visit only. All other outpatient services are covered at the <u>coinsurance</u> specified, after <u>deductible</u> .
	Inpatient services	30% <u>coinsurance</u>	Not covered	None
If you are pregnant	Office visits	30% <u>coinsurance</u>	Not covered	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, a <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 professional services	30% <u>coinsurance</u>	Not covered	
	Childbirth/delivery facility services	30% <u>coinsurance</u>	Not covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	30% <u>coinsurance</u>	Not covered	None
	<u>Rehabilitation services</u>	30% <u>coinsurance</u> / inpatient services; \$40 <u>copay</u> / outpatient visit, <u>deductible</u> does not apply	Not covered	Limited to 30 inpatient days (up to 60 days for head or spinal cord injury) and 30 outpatient visits each for rehabilitation and <u>habilitation services</u> / year. Includes physical therapy, speech therapy, and occupational therapy. <u>Copayment</u> applies to each in- <u>network</u> outpatient therapy visit only.
	<u>Habilitation services</u>	30% <u>coinsurance</u> / inpatient services; \$40 <u>copay</u> / outpatient visit, <u>deductible</u> does not apply	Not covered	
	<u>Skilled nursing care</u>	30% <u>coinsurance</u>	Not covered	Limited to 60 inpatient days / year.
	<u>Durable medical equipment</u>	30% <u>coinsurance</u>	Not covered	Limited to 1 synthetic wig / year and 1 pair of glasses or contacts / year due to severe medical or surgical problem other than refractive procedures.
	<u>Hospice services</u>	30% <u>coinsurance</u>	Not covered	Limited to 30 inpatient or outpatient respite days / lifetime (limited to a maximum of 5 consecutive respite days at a time).

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)	
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge	Not covered	Limited to 1 routine exam / year for individuals under age 19.
	Children's glasses	No charge	Not covered	Limited to 1 pair of lenses (2 lenses) and 1 frame / year for individuals under age 19. Frames from a VSP Doctor are limited to the Otis & Piper Eyewear Collection.
	Children's dental check-up	Not covered	Not covered	Pediatric dental is excluded.

### Excluded Services & Other Covered Services:

Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Bariatric surgery</li> <li>Chiropractic care</li> <li>Cosmetic surgery, except for certain situations</li> </ul>	<ul style="list-style-type: none"> <li>Dental care (Adult and Pediatric)</li> <li>Infertility treatment</li> <li>Long-term care</li> <li>Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>Private-duty nursing</li> <li>Routine eye care, including vision hardware (Adult)</li> <li>Routine foot care, except for diabetic patients</li> <li>Weight loss programs, unless required by law</li> </ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"> <li>Abortion</li> </ul>	<ul style="list-style-type: none"> <li>Hearing aids</li> </ul>	

**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](http://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 x61565 or [cciio.cms.gov](http://cciio.cms.gov) or your state insurance department. You may also contact the plan at 1 (888) 675-6570. 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](http://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 (888) 675-6570 or visit [regence.com](http://regence.com) or the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or [dol.gov/ebsa/healthreform](http://dol.gov/ebsa/healthreform). You may also contact the Oregon Division of Financial Regulation by calling (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/gethelp/Pages/file-a-complaint.aspx](http://dfr.oregon.gov/gethelp/Pages/file-a-complaint.aspx); or by E-mail at:

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

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**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 (888) 675-6570.

\_\_\_\_\_ *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 <u>plan's</u> overall <u>deductible</u>	\$2,850
■ <u>Specialist copayment</u>	\$80
■ Hospital (facility) <u>coinsurance</u>	30%
■ Other <u>coinsurance</u>	30%

**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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$2,850
Copayments	\$36
Coinsurance	\$2,809

<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$5,755</b>

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

■ The <u>plan's</u> overall <u>deductible</u>	\$2,850
■ <u>Specialist copayment</u>	\$80
■ Hospital (facility) <u>coinsurance</u>	30%
■ Other <u>coinsurance</u>	30%

**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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$102
Copayments	\$2,695
Coinsurance	\$0

<i>What isn't covered</i>	
Limits or exclusions	\$255
<b>The total Joe would pay is</b>	<b>\$3,052</b>

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

■ The <u>plan's</u> overall <u>deductible</u>	\$2,850
■ <u>Specialist copayment</u>	\$80
■ Hospital (facility) <u>coinsurance</u>	30%
■ Other <u>coinsurance</u>	30%

**This EXAMPLE event includes services like:**

Emergency room care  
(*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,925</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$1,636
Copayments	\$289
Coinsurance	\$0

<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,925</b>

## 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:

### **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, koji' 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 ដោយមិនគិតល្អិត គឺអាចមានសំរាប់អ្នក។ 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)::

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

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-888-344-6347 (टिक्टाइप: 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)

ប្រៃសណីយ៍: ថ្នាំថា វាមានជាភាសា ខ្មែរ, ការបំរើការងារឆ្លើយតបភាសា, ដោយឥតគិតថ្លៃ, យើងនឹងជួយអ្នកបំរើការងារ។ 1-888-344-6347 (TTY: 711)

Afaan dubbattan Oroomiffaa tiif, tajaajila gargaarsa afaanii tola ni jira. 1-888-344-6347 (TTY: 711) tiin bilbilaa.

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-344-6347 (TTY: 711) تماس بگیرید.

ملحوظة: إذا كنت تتحدث فاذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-344-6347 (رقم هاتف الصم والبكم 711 TTY)