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/go/2023/booklet/OR/Gold1500Preferred or call 1 (888) 367-2116. 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 (888) 367-2116 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $1,500 individual / $3,000 family per calendar year. Out-of-network: $5,000 individual / $10,000 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: $8,550 individual / $17,100 family per calendar year. Out-of-network: $10,000 individual / $20,000 family 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?	Pediatric vision services, 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 (888) 367-2116 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	$30 copay / office visit, deductible does not apply; 30% coinsurance for all other services	50% coinsurance	Copayment applies to each in-network office visit only. All other services are covered at the coinsurance specified, after deductible. In-network acupuncture services are subject to $30 copayment / visit, deductible does not apply; out-of-network subject to the coinsurance specified, after deductible. 12 acupuncture visits / year In-network spinal manipulations are subject to $30 copayment / visit, deductible does not apply; out-of-network subject to the coinsurance specified, after deductible. 20 spinal manipulation visits / year
	Specialist visit	$50 copay / office visit, deductible does not apply; 30% coinsurance for all other services	50% coinsurance	
	Preventive care/screening/ immunization	No charge	50% 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)	30% coinsurance, deductible does not apply for outpatient services	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://regence.com/go/2023/OR/6tier	Preferred generic drugs & generic drugs	$10 copay / preferred retail prescription $30 copay / preferred home delivery prescription $35 copay / retail prescription $105 copay / home delivery prescription		Prescription drugs not on the Drug List are not covered, unless an exception is approved. No coverage for prescription drugs provided by an out-of-network pharmacy. Deductible does not apply. 90-day supply / retail prescription (your cost share is per 30-day supply) 90-day supply / home delivery (mail order) prescription 30-day supply / specialty drug prescription Specialty drugs are not available through home delivery (mail order). Cost shares for insulin will not exceed $80 / 30-day
	Preferred brand drugs	$50 copay / retail prescription $150 copay / home delivery prescription		
	Brand drugs	50% coinsurance / retail prescription 50% coinsurance / home delivery prescription		
	Preferred specialty drugs & specialty drugs	20% coinsurance / preferred specialty drug 50% coinsurance / specialty drug		

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)	
				supply retail prescription or $240 / 90-day supply home delivery (mail order) prescription. No charge for certain preventive drugs, contraceptives and immunizations at a participating pharmacy. If you fill a brand drug or specialty drug when there is an equivalent generic drug or specialty biosimilar drug available, you pay the difference in cost in addition to the copayment and/or coinsurance. The first fill of specialty drugs may be provided by a retail pharmacy; additional refills must be provided by a specialty pharmacy. Coverage for self-administrable cancer chemotherapy drugs is 30% coinsurance.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance for ambulatory surgery centers; 30% coinsurance for all other facilities	50% coinsurance	None
	Physician/surgeon fees	20% coinsurance for ambulatory surgery center physicians; 30% coinsurance for all other physicians	50% coinsurance	None
If you need immediate medical attention	Emergency room care	$300 copay / visit	$300 copay / visit	Copayment applies to facility charge for each visit (waived if admitted), whether or not the deductible has been met.
	Emergency medical transportation	30% coinsurance	30% coinsurance	In-network deductible applies to in-network and out-of-network services.
	Urgent care	$50 copay / office visit, deductible does not apply; 30% coinsurance for all other services	50% coinsurance	Copayment applies to each in-network office 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)	
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	$3,500 / day for inpatient non-emergency admission in non-participating facilities
	Physician/surgeon fees	30% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay / office visit, deductible does not apply; 30% coinsurance for all other services	50% coinsurance	Copayment applies to each in-network office/psychotherapy visit only. All other services are covered at the coinsurance specified, after deductible.
	Inpatient services	30% coinsurance	50% coinsurance	$3,500 / day for inpatient non-emergency admission in non-participating facilities
If you are pregnant	Office visits	30% coinsurance	50% 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). $3,500 / day for inpatient non-emergency admission in non-participating facilities
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	None
	Rehabilitation services	$30 copay / outpatient visit, deductible does not apply; 30% coinsurance for inpatient services	50% coinsurance	30 inpatient days (up to 60 days for head or spinal cord injury) each for rehabilitation and habilitation services / year 30 outpatient visits each for rehabilitation and habilitation services / year Copayment applies to each in-network outpatient visit only. All inpatient services are covered at the coinsurance specified, after deductible. Includes physical therapy, occupational therapy and speech therapy. $3,500 / day for inpatient non-emergency admission in non-participating facilities
	Habilitation services	$30 copay / outpatient visit, deductible does not apply; 30% coinsurance for inpatient services	50% coinsurance	
	Skilled nursing care	30% coinsurance	50% coinsurance	60 inpatient days / year
	Durable medical equipment	30% coinsurance	50% coinsurance	1 synthetic wig / year 1 pair of glasses or contacts / year for individuals with severe medical or surgical problems other than

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)	
				refractive procedures
	Hospice services	30% coinsurance	50% coinsurance	30 respite inpatient or outpatient days / lifetime Respite limited to 5 consecutive days at a time.
If your child needs dental or eye care	Children's eye exam	No charge	50% coinsurance, deductible does not apply	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 / year for individuals under age 19 VSP doctors are the only in-network providers.
	Children's glasses	No charge	50% coinsurance, deductible does not apply	For services provided by an out-of-network provider, you pay all charges up front then submit a claim for reimbursement. 1 pair of lenses / year 1 set of frames / year Glasses limited to individuals under age 19. Frames from VSP doctors are limited to Otis & Piper Eyewear Collection. VSP doctors are the only in-network providers.
	Children's dental check-up	No charge	No charge	2 cleanings* / year 2 preventive oral examinations / year Coverage limited to individuals under age 19. *Coverage may include another cleaning, refer to your plan for further information. Coverage includes basic and major dental services for individuals under age 19, refer to your plan for further information.

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 (Adult)
• Cosmetic surgery, except congenital anomalies	• Long-term care	• Routine foot care, except for diabetic patients
• Dental care (Adult)	• 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, spinal manipulations only	• Non-emergency care when traveling outside the U.S.
• Acupuncture	• 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 cciio.cms.gov or your state insurance department. You may also contact the plan at 1 (888) 367-2116. 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 (888) 367-2116 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: DFR.InsuranceHelp@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 (888) 367-2116.

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	$1,500
Specialist copayment	$50
Hospital (facility) coinsurance	30%
Other coinsurance	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)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$11
Coinsurance	$3,215
What isn't covered	
Limits or exclusions	$61
The total Peg would pay is	**$4,787**

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

The plan's overall deductible	$1,500
Specialist copayment	$50
Hospital (facility) coinsurance	30%
Other coinsurance	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)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$790
Copayments	$1,004
Coinsurance	$26
What isn't covered	
Limits or exclusions	$178
The total Joe would pay is	**$1,998**

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

The plan's overall deductible	$1,500
Specialist copayment	$50
Hospital (facility) coinsurance	30%
Other coinsurance	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)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$575
Coinsurance	$87
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,162**

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

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 https://regence.com. For provider or benefit questions call VSP at 1 (844) 299-3041. For membership questions call Regence at 1 (888) 367-2116. 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 (888) 367-2116 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 plan 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 plan covers.
Are there other deductibles for specific services?	No.	See the Common Vision Event chart below for your costs for services this plan covers.
What is the out-of-pocket limit for this plan?	Not applicable.	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Not applicable.	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Yes. See https://regence.com/go/OR/VSPNetwork or call 1 (844) 299-3041 for a list of VSP doctors.	This plan uses a vision provider network (Vision Service Plan). You will pay less if you use a vision provider in the plan's network. You will pay the most if you use an out-of-network vision provider, and you might receive a bill from a vision provider for the difference between the provider's charge and what your plan pays (balance billing).
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

Common Vision Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		VSP Doctor (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a vision care provider's office or clinic	Routine vision examination	No charge	No charge up to the out-of-network provider 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 / year Routine eye examination limited to $45 for out-of-network providers.
	Vision hardware	No charge up to the VSP doctor limit	No charge up to the out-of-network provider limit	For services provided by an out-of-network provider, you pay all charges up front then submit a claim for reimbursement. 1 pair of frames / year Frames limited to $200 for VSP doctors. Frames limited to $110 for VSP approved wholesale/retail vendors. Frames limited to $70 for out-of-network providers. 1 pair of standard glass or plastic lenses / year for either: Single vision lenses; Lined bifocal (or standard progressive) lenses; Lined trifocal lenses; Lenticular lenses; or Contact lenses*. Elective contact lenses* limited up to $200 for VSP doctors. Necessary contact lenses* limited to a calendar year supply for VSP doctors. Single vision lenses limited to $30 for out-of-network providers. Lined bifocal (or standard progressive) lenses limited to $50 for out-of-network providers. Lined trifocal lenses limited to $65 for out-of-network

Common Vision Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		VSP Doctor (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				providers. Lenticular lenses limited to $100 for out-of-network providers. Elective contact lenses* (including fitting/evaluation services) limited to $105 once / calendar year for out-of-network providers. Necessary contact lenses* (including fitting/evaluation services) limited to a calendar year supply up to $210 for out-of-network providers. *Contact lenses are in lieu of all other frame and lens benefits. When you receive contact lenses, you will not be eligible for any frames or other types of lenses until the next calendar year.
	Contact lens evaluation and fitting examination	$60 copay	No charge up to the out-of-network provider limit	For services provided by an out-of-network provider, you pay all charges up front then submit a claim for reimbursement. 1 contact lens evaluation and fitting examination / year Elective contact lens evaluation and fitting examination (including elective contact lenses) limited to $105 for out-of-network providers. Necessary contact lens evaluation and fitting examination (including necessary contact lenses) limited to $210 for out-of-network providers.
	Low vision supplemental examinations (testing)	No charge	No charge up to the out-of-network provider limit	For services provided by an out-of-network provider, you pay all charges up front then submit a claim for reimbursement. $1,000 low vision maximum / 2 years, including supplemental examinations (testing) and care aids 2 supplemental examinations / 2 years Supplemental examinations limited to $125 for out-of-network providers.
	Low vision supplemental care aids	25% coinsurance	25% coinsurance	

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 and interest • Medical or surgical treatment of the eyes • Non-direct patient care	• Orthoptics or vision training • Pediatric vision (under age 19) • Plano lenses • Two pair of glasses in lieu of bifocals