



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.Regence.com or by calling 1 (888) 370-6159.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$200 claimant / \$600 family per calendar year. Doesn't apply to certain preventive care. <u>Copayments</u> or amounts in excess of the <u>allowed amount</u> do not count toward the <u>deductible</u> .	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	Yes. \$100 per claimant for <u>prescription drug coverage</u> . There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. <u>Preferred</u> & Participating: \$2,200 claimant / \$4,600 family per calendar year. Non-Participating: \$4,200 claimant / \$8,600 family per calendar year.	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Coinsurance</u> for alternative care, <u>premiums</u> , prescription drugs <u>out-of-pocket limit</u> , balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Does this plan use a <u>network of providers</u> ?	Yes. See www.Regence.com or call 1 (888) 370-6159 for lists of <u>preferred</u> or participating <u>providers</u> .	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	No. You don't need a referral to see a <u>specialist</u> .	You can see the <u>specialist</u> you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about <u>excluded services</u> .

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Claims Administrator: Regence BlueCross BlueShield of Oregon



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **preferred** and participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	40% coinsurance	_____none_____
	Specialist visit	20% coinsurance	40% coinsurance	40% coinsurance	
	Other practitioner office visit	20% coinsurance for spinal manipulations	20% coinsurance for spinal manipulations	20% coinsurance for spinal manipulations	Coverage is limited to 12 spinal manipulations / year.
	Preventive care/ screening/immunization	No charge	No charge	40% coinsurance	No charge for childhood immunizations from non-participating providers .
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	40% coinsurance	_____none_____
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is	Generic drugs	\$5 copay / retail prescription \$10 copay / mail order prescription			Out-of-pocket limit \$2,600 / claimant / year Coverage is limited to a 34-day supply retail or 90-day supply mail order. Coverage is limited to a 34-day supply for self-injectable medications or 90-day supply for specialty drugs retail or mail order.
	Preferred brand drugs	30% copay / retail prescription 30% copay / mail order prescription			
	Non-preferred brand drugs	40% copay / retail prescription 40% copay / mail order prescription			

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
available at www.Regence.com .	Specialty drugs	Refer to generic, preferred brand and non-preferred brand drugs above, for specialty medication or self-administrable cancer chemotherapy drug coverage.			You are responsible for the difference in cost between a dispensed brand-name drug and the equivalent generic drug, in addition to the copayment and/or coinsurance , unless your provider specifies “dispense as written.” The first fill for specialty drugs may be provided at a retail pharmacy. Additional fills and any fills for self-administrable cancer chemotherapy drugs must be provided at a specialty pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	40% coinsurance	—————none—————
	Physician/surgeon fees	20% coinsurance	40% coinsurance	40% coinsurance	—————none—————
If you need immediate medical attention	Emergency room services	20% coinsurance after \$100 copay / visit	20% coinsurance after \$100 copay / visit	20% coinsurance after \$100 copay / visit	Copayment applies to the facility charge for each visit (waived if admitted), whether or not the deductible has been met.
	Emergency medical transportation	20% coinsurance	20% coinsurance	20% coinsurance	—————none—————
	Urgent care	Covered the same as the If you visit a health care provider’s office or clinic or If you have a test Common Medical Events.			—————none—————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	40% coinsurance	—————none—————
	Physician/surgeon fee	20% coinsurance	40% coinsurance	40% coinsurance	—————none—————

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% coinsurance	20% coinsurance	40% coinsurance	—————none—————
	Mental/Behavioral health inpatient services	20% coinsurance	20% coinsurance	40% coinsurance	
	Substance use disorder outpatient services	20% coinsurance	20% coinsurance	40% coinsurance	
	Substance use disorder inpatient services	20% coinsurance	20% coinsurance	40% coinsurance	
If you are pregnant	Prenatal and postnatal care	20% coinsurance	40% coinsurance	40% coinsurance	—————none—————
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	20% coinsurance	Coverage is limited to 180 visits / year.
	Rehabilitation services	20% coinsurance	20% coinsurance for outpatient 40% coinsurance for inpatient	20% coinsurance for outpatient 40% coinsurance for inpatient	Coverage is limited to 77 outpatient visits for all rehabilitation and habilitation services, including neurodevelopmental services / year.
	Habilitation services	20% coinsurance	20% coinsurance for outpatient 40% coinsurance for inpatient	20% coinsurance for outpatient 40% coinsurance for inpatient	Coverage for neurodevelopmental therapy is limited to services for claimants through age 17.
	Skilled nursing care	20% coinsurance	40% coinsurance	40% coinsurance	Coverage is limited to 120 inpatient days / year.
	Durable medical equipment	20% coinsurance	40% coinsurance	40% coinsurance	—————none—————
	Hospice service	No charge	No charge	No charge	Coverage is limited to 14 respite days / lifetime.
If your child needs dental or eye care	Eye exam	Not covered	Not covered	Not covered	—————none—————
	Glasses	Not covered	Not covered	Not covered	—————none—————
	Dental check-up	Not covered	Not covered	Not covered	—————none—————

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery, except congenital anomalies
- Dental care (Adult or child)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Vision hardware
- Weight loss programs, except for nutritional counseling

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care, including spinal manipulations
- Hearing aids for claimants 18 or younger or for enrolled children 19 years of age or older and enrolled in a secondary school or an accredited educational institution
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1 (888) 370-6159. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1 (877) 267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the plan at 1 (888) 370-6159 or visit www.Regence.com. You may also contact the Oregon Insurance Division by calling (503) 947-7984 or the toll free message line at 1 (888) 877-4894; by writing to the Oregon Insurance Division, Consumer Advocacy Unit, P.O. Box 14480, Salem, OR 97309-0405; through the Internet at: www.oregon.gov/DCBS/insurance/gethelp/Pages/fileacomplaint.aspx; or by E-mail at: cp.ins@state.or.us or the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for covered services. This is called the “minimum value standard.” **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1 (888) 370-6159.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays: \$5,770
- Patient pays: \$1,770

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$200
Copays	\$10
Coinsurance	\$1,410
Limits or exclusions	\$150
Total	\$1,770

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays: \$3,940
- Patient pays: \$1,460

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$200
Copays	\$130
Coinsurance	\$1,090
Limits or exclusions	\$40
Total	\$1,460

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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PLAN I – PRESCRIPTION & VALUE ADDED SERVICES

Common Medical Event	Services You May Need	Your Cost if You Use a Preferred Provider	Your Cost if You Use a Participating Provider	Your Cost if You Use a Non-Participating Provider	Limitations & Exceptions
If you need an alternative care provider	Chiropractor	20% coinsurance	20% coinsurance	20% coinsurance	Applied to annual deductible & out-of-pocket limit. Maximum 12 visits per calendar year per person.
If your child needs a hearing specialist	Hearing Aid	20% coinsurance	40% coinsurance	40% coinsurance	Applied to deductible & out-of-pocket limit. For claimants 18 years of age and younger, or enrolled children 19 years of age or older and enrolled in a secondary school or an accredited educational institution.
If you have nutritional needs	Counseling	0%	0%	0%	Limited to 4 visits per calendar year. (Diabetic education and counseling is not subject to the 4 visit limitation per calendar year.)
If you need assistance losing weight	Weight management & obesity treatment	0%	0%	0%	Includes integrated care coordination, nutritional counseling (up to 4 visits per calendar year), physician visit (up to 4 visits per calendar year) and coordination of care.
	Bariatric surgery to treat morbid obesity	\$1,000 copay, then 20% coinsurance	\$1,000 copay, then 40% coinsurance	\$1,000 copay, then 40% coinsurance	Deductible applied. Not applied to out-of-pocket limit. This may be a covered service if you have participated, successfully, in at least six consecutive months of Turning Point. To learn more about our Bariatric Program call (888) 370-6159 . Surgery must be authorized to be covered.
Additional Prescription Benefits					
Brand-Name Prescription Medication Instead of Generic	If an equivalent generic medication is available and a brand-name medication is chosen, the member is responsible for paying the applicable brand-name co-payment plus the difference in price between the equivalent generic medication and the brand-name medication, not to exceed total retail cost. The exception is when the prescribing provider specifies that the brand-name medication must be dispensed, in which case the member will not be responsible for payment of the difference in cost.				
Value-Based Medications	You do not need to pay the copay when you fill prescriptions for those generic medications or formulary brand-name medications that we specifically designate as preventative for asthma, diabetes, high blood pressure, high cholesterol or tobacco addiction. You can find a list of such medications at the Claims Administrator's website, www.regence.com . (From there click on Regence Rx Pharmacy Benefit)				

Value Added Services Offered by Regence BCBS of Oregon and CIS

Case Management	Receive one-on-one help and support in the event you have a serious or sudden illness or injury. An experienced, compassionate case manager will serve as your personal advocate during a time when you need it most. Your case manager is a licensed healthcare professional who will help you understand your treatment options, show you how to get the most of our available Plan benefits and work with your physician to support your treatment plan. To learn more or to make a referral to case management, please call (866) 543-5765 .
Disease Management	Regence Disease Management is a support and education program for people with chronic conditions such as diabetes, heart disease, asthma and/or depression. The Claim's Administrator's nurses and behavioral health care coordinators provide tailored educational materials, tools and other services to help you get on track with your care and stay there. They can help you understand the care plan you developed with your physician, and make smarter choices for better health. To learn more, please call (866) 543-5765 .
Special Beginnings Program	<p>Pregnancy is a time of planning and excitement, but it can also be a time of confusion and questions. Special Beginnings can provide answers and assistance so that you can relax and enjoy those nine life-changing months.</p> <p>This program offers expectant mothers access to a nurse 24 hours a day, 7 days a week, an informative maternity book or DVD and educational materials tailored to their needs. To learn more call (888) JOY-BABY (569-2229).</p>
Regence Advice 24 (Nurse Advice Line)	Registered nurses are available 24/7 to answer your health-related questions and help you make informed decisions about when, where, and if you should seek care. If you're not sure whether to visit the emergency room, see your doctor or treat your condition at home, the nurses are there, day or night. Call the Nurse Advice Line any time 24 hours a day seven days a week, at (800) 267-6729 .
BlueCard® Program (Out of Area Service)	The BlueCard Program is a unique program that enables you to access hospitals and physicians when outside the four-state area Regence services (Idaho, Oregon, Utah and Washington), as well as receive care in 200 countries around the world. Find a provider near you at www.bcbs.com or call (800) 810-BLUE (2583) .
Quit for Life® Tobacco Cessation Program	A tobacco cessation program offered through CIS for all eligible Regence covered members. For program eligibility and details go to www.cisbenefits.org >> Healthy Benefits & Wellness or call 24-hours a day, 7 days a week at (866) 784-8454 .