Regence BlueCross BlueShield of Oregon: Preferred Plan B 3,500

Coverage Period: 01/01/2016 – 12/31/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual & Eligible Family | **Plan Type:** PPO

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) 367-2116.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$3,500** member / **$7,000** family per calendar year. Doesn't apply to certain preventive care, upfront outpatient diagnostic x-ray / laboratory / imaging services or outpatient mental health and substance abuse or routine newborn care. **Copayments** or amounts in excess of the **allowed amount** do not count toward the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** 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 **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$6,350** member / **$12,700** family per calendar year.	The **out–of–pocket limit** 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 out–of–pocket limit?	**Coinsurance** for complementary care, **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**.
Does this plan use a network of providers?	Yes. See www.Regence.com or call 1 (888) 367-2116 for lists of **preferred** or participating **providers**.	If you use an in–network doctor or other health care **provider**, 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 **provider** for some services. Plans use the term in–network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a **specialist**.	You can see the **specialist** 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 **excluded services**.

Questions: Call 1 (888) 367-2116 or visit us at www.Regence.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary.
You can view the Glossary at www.cciio.cms.gov or call 1 (888) 367-2116 to request a copy.

- **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	$25 copay / visit, other services 30% coinsurance	$25 copay / visit, other services 50% coinsurance	50% coinsurance	**Copayment** applies to each **preferred** and participating office visit only, **deductible** waived. All other services are covered at the **coinsurance** specified, after **deductible**.
	Specialist visit	$25 copay / visit, other services 30% coinsurance	$25 copay / visit, other services 50% coinsurance	50% coinsurance	
	Other practitioner office visit	20% coinsurance for complementary care – acupuncture and spinal manipulations	20% coinsurance for complementary care – acupuncture and spinal manipulations	20% coinsurance for complementary care – acupuncture and spinal manipulations	Coverage is limited to 24 complementary care visits / year. **Deductible** waived. **Coinsurance** does not apply to the **out–of–pocket limit**.
	Preventive care/ screening/immunization	No charge	No charge	No charge	————————none————————
If you have a test	Diagnostic test (x–ray, blood work)	No charge for the first $500 / year, then 30% coinsurance	No charge for the first $500 / year, then 50% coinsurance	No charge for the first $500 / year, then 50% coinsurance	No charge for the first $500 per year for upfront outpatient laboratory and radiology services, **deductible** waived. Once the limit has been met and for all inpatient services, services are covered at the **coinsurance** specified, after **deductible**.
	Imaging (CT/PET scans, MRIs)	No charge for the first $500 / year, then 30% coinsurance	No charge for the first $500 / year, then 50% coinsurance	No charge for the first $500 / year, then 50% coinsurance	

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.Regence.com.	Generic drugs	$15 copay / retail prescription $30 copay / mail order prescription $10 copay for self–administrable cancer chemotherapy prescription			Coverage is limited to a 90–day supply retail (1 copay per 30-day supply), 90–day supply mail order or 30-day supply injectable and specialty drugs. No charge for generic or preferred brand drugs specifically designated as preventive for treatment of chronic diseases that are on the Optimum Value Medication List. 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**. The first fill for specialty drugs may be provided at a retail pharmacy, additional fills must be provided at a specialty pharmacy.
	Preferred brand drugs	$35 copay / retail prescription $70 copay / mail order prescription $50 copay for self–administrable cancer chemotherapy prescription			
	Non–preferred brand drugs	$75 copay / retail prescription $150 copay / mail order prescription $100 copay for self–administrable cancer chemotherapy prescription			
	Specialty drugs	Refer to generic, preferred brand and non–preferred brand drugs above.			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	50% coinsurance	——————none——————
	Physician/surgeon fees	30% coinsurance	50% coinsurance	50% coinsurance	——————none——————
If you need immediate medical attention	Emergency room services	30% coinsurance after $100 copay / visit	30% coinsurance after $100 copay / visit	30% 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	30% coinsurance	30% coinsurance	30% 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)	30% coinsurance	50% coinsurance	50% coinsurance	——————none——————
	Physician/surgeon fee	30% coinsurance	50% coinsurance	50% 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	$25 copay / visit	$25 copay / visit	50% coinsurance	**Deductible** waived for outpatient services. **Copayment** applies to each **preferred** or participating outpatient therapy visit only.
	Mental/Behavioral health inpatient services	30% coinsurance	30% coinsurance	50% coinsurance	
	Substance use disorder outpatient services	$25 copay / visit	$25 copay / visit	50% coinsurance	
	Substance use disorder inpatient services	30% coinsurance	30% coinsurance	50% coinsurance	
If you are pregnant	Prenatal and postnatal care	30% coinsurance	50% coinsurance	50% coinsurance	**Deductible** waived for routine newborn care.
	Delivery and all inpatient services	30% coinsurance	50% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	50% coinsurance	Coverage is limited to 130 visits / year.
	Rehabilitation services	30% coinsurance	50% coinsurance	50% coinsurance	Coverage is limited to 30 inpatient days / year. Coverage is limited to 25 outpatient visits / year.
	Habilitation services	30% coinsurance	50% coinsurance	50% coinsurance	Coverage for neurodevelopmental therapy is limited to 25 outpatient visits / year. Coverage for neurodevelopmental therapy is limited to services for members through age 17.
	Skilled nursing care	30% coinsurance	50% coinsurance	50% coinsurance	Coverage is limited to 60 inpatient days / year.
	Durable medical equipment	30% coinsurance	50% coinsurance	50% coinsurance	————————none————————
	Hospice service	30% coinsurance	50% coinsurance	50% coinsurance	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.)**

- Bariatric surgery
- Cosmetic surgery, except congenital anomalies
- Dental care (Adult)
- 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.)**

- Acupuncture
- Chiropractic care
- Hearing aids for members 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) 367-2116. 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) 367-2116 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) 367-2116.

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:** $2,740
- **Patient pays:** $4,800

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	$3,500
Copays	$20
Coinsurance	$1,130
Limits or exclusions	$150
Total	**$4,800**

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

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,340
- **Patient pays:** $2,060

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	$420
Copays	$1,600
Coinsurance	$0
Limits or exclusions	$40
Total	**$2,060**

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.

Regence BlueCross BlueShield of Oregon: Regence Vision Plan

Coverage Period: 01/01/2016 - 12/31/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual & Eligible Family | **Plan Type:** PPO

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) 367-2116.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	This plan has no **deductible**.	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	No.	There's no limit on how much you could pay during a coverage period for your share of the cost of covered services.
What is not included in the out–of–pocket limit?	This plan has no **out-of-pocket limit**.	Not applicable because there's no **out-of-pocket limit** on your expenses.
Does this plan use a network of providers?	Yes. See www.Regence.com or call 1 (888) 367-2116 for lists of in-network or out-of-network **providers**.	If you use an in-network **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network **provider** may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a **specialist**.	You can see the **specialist** 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 3. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered vision 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 a vision examination is $50, your **coinsurance** payment of 30% would be $10. 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 **provider** charges $150 for a vision examination and the **allowed amount** is $50, you may have to pay the $100 difference. (This is called **balance billing**.)

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 an eye care provider's office or clinic	Routine vision examination	No Charge	No Charge	No Charge	Coverage is limited to 1 routine eye exam / year. Coverage is limited to $200 for covered vision hardware / year and you pay any balance.
	Vision hardware	No charge up to $200 hardware maximum	No charge up to $200 hardware maximum	No charge up to $200 hardware maximum	

Excluded Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Contact fittings	• Medical services	• Prescription medication
• Cosmetic services and supplies	• Non-direct patient care	• Vision therapy and surgery
• Fees, taxes, interest	• Personal comfort items	