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/policy/OR/BronzeEssential8000With4CopayNoDeductibleOfficeVisits+300LegacyLHPEx 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 or call 1 (888) 675-6570 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0 at an Indian Health Care Provider (IHCP) or with IHCP referral to a non-IHCP; or $8,000 individual / $16,000 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?	$9,100 individual / $18,200 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/LegacyLHP 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?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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
		Indian Health Care Provider (IHCP) (You pay the least)	Non-IHCP In-Network Provider (You pay more)	Non-IHCP Out-of-Network 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	No charge	$60 copay / office visit, deductible does not apply; 10% coinsurance for all other services	Not covered	4 upfront office visits combined for in-network primary care, in-network specialist and in-network or out-of-network urgent care / year Cost sharing waived at a non-IHCP with an IHCP referral. Copayment applies to each in-network upfront office visit only. All other services and after the upfront visit limit is met, services are covered at the coinsurance specified, after deductible. Acupuncture services are covered at the coinsurance specified, after deductible. 12 acupuncture visits / year Spinal manipulations are covered at the coinsurance specified, after deductible. 20 spinal manipulation visits / year
	Specialist visit	No charge	$60 copay / office visit, deductible does not apply; 10% coinsurance for all other services	Not covered	
	Preventive care/screening/ immunization	No charge	No charge	Not covered	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)	No charge	10% coinsurance	Not covered	Cost sharing waived at a non-IHCP with an IHCP referral.
	Imaging (CT/PET scans, MRIs)	No charge	10% coinsurance	Not covered	
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	No charge	$15 copay / preferred retail prescription $45 copay / preferred home delivery prescription 10% coinsurance / retail prescription 10% coinsurance /	Not covered	Prescription drugs not on the Drug List are not covered, unless an exception is approved. Cost sharing waived at a non-IHCP with an IHCP referral. Deductible does not apply for insulin, preferred generic drugs, generic drugs and drugs specifically designated as preventive for treatment of chronic diseases that are on the Optimum Value Medication List.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You pay the least)	Non-IHCP In-Network Provider (You pay more)	Non-IHCP Out-of-Network Provider (You pay the most)	
			home delivery prescription		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 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 10% coinsurance.
	Preferred brand drugs	No charge	20% coinsurance / retail prescription 20% coinsurance / home delivery prescription	Not covered	
	Brand drugs	No charge	50% coinsurance / retail prescription 50% coinsurance / home delivery prescription	Not covered	
	Preferred specialty drugs & specialty drugs	No charge	40% coinsurance / preferred specialty drug 50% coinsurance / specialty drug	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	10% coinsurance	Not covered	Cost sharing waived at a non-IHCP with an IHCP referral.
	Physician/surgeon fees	No charge	10% coinsurance	Not covered	
If you need immediate medical attention	Emergency room care	No charge	10% coinsurance	10% coinsurance	Cost sharing waived at a non-IHCP with an IHCP referral.
	Emergency medical transportation	No charge	10% coinsurance	10% coinsurance	
	Urgent care	No charge	$60 copay / office	$60 copay / office	4 upfront office visits combined for in-network

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You pay the least)	Non-IHCP In-Network Provider (You pay more)	Non-IHCP Out-of-Network Provider (You pay the most)	
			visit, deductible does not apply; 10% coinsurance for all other services	visit, deductible does not apply; 10% coinsurance for all other services	primary care, in-network specialist and in-network or out-of-network urgent care / year Cost sharing waived at a non-IHCP with an IHCP referral. Copayment applies to each in-network or out-of-network upfront office visit only. All other services and after the upfront visit limit is met, services are covered at the coinsurance specified, after deductible.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	10% coinsurance	Not covered	Cost sharing waived at a non-IHCP with an IHCP referral.
	Physician/surgeon fees	No charge	10% coinsurance	Not covered	Cost sharing waived at a non-IHCP with an IHCP referral.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	10% coinsurance	Not covered	Cost sharing waived at a non-IHCP with an IHCP referral.
	Inpatient services	No charge	10% coinsurance	Not covered	Cost sharing waived at a non-IHCP with an IHCP referral.
If you are pregnant	Office visits	No charge	10% coinsurance	Not covered	Cost sharing waived at a non-IHCP with an IHCP referral. 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).
	Childbirth/delivery professional services	No charge	10% coinsurance	Not covered	
	Childbirth/delivery facility services	No charge	10% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge	10% coinsurance	Not covered	Cost sharing waived at a non-IHCP with an IHCP referral.
	Rehabilitation services	No charge	10% coinsurance	Not covered	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 Cost sharing waived at a non-IHCP with an IHCP referral. Includes physical therapy, occupational therapy
	Habilitation services	No charge	10% coinsurance	Not covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You pay the least)	Non-IHCP In-Network Provider (You pay more)	Non-IHCP Out-of-Network Provider (You pay the most)	
					and speech therapy.
	Skilled nursing care	No charge	10% coinsurance	Not covered	60 inpatient days / year Cost sharing waived at a non-IHCP with an IHCP referral.
	Durable medical equipment	No charge	10% coinsurance	Not covered	1 synthetic wig / year 1 pair of glasses or contacts / year for individuals with severe medical or surgical problems other than refractive procedures Cost sharing waived at a non-IHCP with an IHCP referral.
	Hospice services	No charge	10% coinsurance	Not covered	30 respite inpatient or outpatient days / lifetime Respite limited to 5 consecutive days at a time. Cost sharing waived at a non-IHCP with an IHCP referral.
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Not covered	1 routine eye examination / year for individuals under age 19 Cost sharing waived at a non-IHCP with an IHCP referral. VSP doctors are the only non-IHCP in-network providers.
	Children's glasses	No charge	No charge	Not covered	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. Cost sharing waived at a non-IHCP with an IHCP referral. VSP doctors are the only non-IHCP in-network providers.
	Children's dental check-up	No charge	No charge	Not covered	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.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You pay the least)	Non-IHCP In-Network Provider (You pay more)	Non-IHCP Out-of-Network Provider (You pay the most)	
					Coverage includes basic and major dental services for individuals under age 19, refer to your plan for further information. Cost sharing waived at a non-IHCP with an IHCP referral.

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
- Cosmetic surgery, except congenital anomalies
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care, except for diabetic patients
- Weight loss programs

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

- Abortion (Laws prohibit public funding of certain covered terminations of pregnancy. Premium payments are segregated to ensure compliance.)
- Acupuncture
- Chiropractic care, spinal manipulations only
- 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) 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 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 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) 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 plan's overall deductible	**$8,000**
Specialist copayment	**$60**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

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	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$61
The total Peg would pay is	**$61**

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

The plan's overall deductible	**$8,000**
Specialist copayment	**$60**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

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	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$178
The total Joe would pay is	**$178**

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

The plan's overall deductible	**$8,000**
Specialist copayment	**$60**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

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	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$0**

Note: These numbers assume the patient received care from an IHCP or with an IHCP referral to a non-IHCP. If you received care from a non-IHCP without a referral from an IHCP your costs may be higher.

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 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'dęę', t'áá jiik'eh, éí ná hóló, kojį' 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 ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ 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 ሊያግዝዎት ተዘጋጀተዋል፤ 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 (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)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 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 TTY: 711)