



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/Silver6500+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 <u>deductible</u>?	\$0 at an Indian Health Care <u>Provider</u> (IHCP) or with IHCP <u>referral</u> to a non-IHCP; or \$6,500 individual / \$13,000 family per calendar year.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u>?	Yes. Certain <u>preventive care</u> and those services listed below as " <u>deductible</u> does not apply" or as "No charge."	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	\$9,100 individual / \$18,200 family per calendar year.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	Pediatric vision services, <u>premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See https://regence.com/go/OR/LegacyLHP or call 1 (888) 675-6570 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .



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	\$10 <u>copay</u> / office visit, <u>deductible</u> does not apply; 10% <u>coinsurance</u> for all other services	Not covered	<u>Cost sharing</u> waived at a non-IHCP with an IHCP referral. <u>Copayment</u> applies to each in-network office visit only. All other services are covered at the <u>coinsurance</u> specified, after <u>deductible</u> . Acupuncture services are subject to \$10 <u>copayment</u> / visit, <u>deductible</u> does not apply. 12 acupuncture visits / year Spinal manipulations are subject to \$10 <u>copayment</u> / visit, <u>deductible</u> does not apply. 20 spinal manipulation visits / year You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
	<u>Specialist</u> visit	No charge	\$80 <u>copay</u> / office visit, <u>deductible</u> does not apply; 10% <u>coinsurance</u> for all other services	Not covered	
	<u>Preventive care/screening/immunization</u>	No charge	No charge	Not covered	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	10% <u>coinsurance</u>	Not covered	<u>Cost sharing</u> waived at a non-IHCP with an IHCP referral.
	Imaging (CT/PET scans, MRIs)	No charge	10% <u>coinsurance</u>	Not covered	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at https://regence.com/go/2023/OR/6tier	Preferred generic drugs & generic drugs	No charge	\$5 <u>copay</u> / preferred retail prescription \$15 <u>copay</u> / preferred home delivery prescription 20% <u>coinsurance</u> / retail prescription 20% <u>coinsurance</u> / home delivery prescription	Not covered	<u>Prescription drugs</u> not on the Drug List are not covered, unless an exception is approved. <u>Cost sharing</u> waived at a non-IHCP with an IHCP referral. <u>Deductible</u> 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. 90-day supply / retail prescription (your <u>cost share</u> is per 30-day supply) 90-day supply / home delivery (mail order)
	Preferred brand drugs	No charge	30% <u>coinsurance</u> / retail prescription	Not covered	

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		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)	
			30% <u>coinsurance</u> / home delivery prescription		<p>prescription 30-day supply / <u>specialty drug</u> prescription <u>Specialty drugs</u> are not available through home delivery (mail order). <u>Cost shares</u> 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 <u>specialty drug</u> when there is an equivalent generic drug or specialty biosimilar drug available, you pay the difference in cost in addition to the <u>copayment</u> and/or <u>coinsurance</u>. The first fill of <u>specialty drugs</u> 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% <u>coinsurance</u>.</p>
	Brand drugs	No charge	50% <u>coinsurance</u> / retail prescription 50% <u>coinsurance</u> / home delivery prescription	Not covered	
	Preferred <u>specialty drugs</u> & <u>specialty drugs</u>	No charge	40% <u>coinsurance</u> / preferred <u>specialty drug</u> 50% <u>coinsurance</u> / <u>specialty drug</u>	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	10% <u>coinsurance</u>	Not covered	<u>Cost sharing</u> waived at a non-IHCP with an IHCP referral.
	Physician/surgeon fees	No charge	10% <u>coinsurance</u>	Not covered	
If you need immediate medical attention	<u>Emergency room care</u>	No charge	10% <u>coinsurance</u>	10% <u>coinsurance</u>	<u>Cost sharing</u> waived at a non-IHCP with an IHCP referral.
	<u>Emergency medical transportation</u>	No charge	10% <u>coinsurance</u>	10% <u>coinsurance</u>	
	<u>Urgent care</u>	No charge	\$80 <u>copay</u> / office visit, <u>deductible</u> does not apply;	\$80 <u>copay</u> / office visit, <u>deductible</u> does not apply;	<p><u>Cost sharing</u> waived at a non-IHCP with an IHCP referral. <u>Copayment</u> applies to each in-<u>network</u> or out-of-<u>network</u> office visit only. All other services are</p>

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
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			10% <u>coinsurance</u> for all other services	10% <u>coinsurance</u> for all other services	covered at the <u>coinsurance</u> specified, after <u>deductible</u> .
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	10% <u>coinsurance</u>	Not covered	<u>Cost sharing</u> waived at a non-IHCP with an IHCP referral.
	Physician/surgeon fees	No charge	10% <u>coinsurance</u>	Not covered	<u>Cost sharing</u> 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 <u>copay</u> / office visit, <u>deductible</u> does not apply; 10% <u>coinsurance</u> for all other services	Not covered	<u>Cost sharing</u> waived at a non-IHCP with an IHCP referral. <u>Copayment</u> applies to each in-network office/psychotherapy visit only. All other services are covered at the <u>coinsurance</u> specified, after <u>deductible</u> .
	Inpatient services	No charge	10% <u>coinsurance</u>	Not covered	<u>Cost sharing</u> waived at a non-IHCP with an IHCP referral.
If you are pregnant	Office visits	No charge	10% <u>coinsurance</u>	Not covered	<u>Cost sharing</u> waived at a non-IHCP with an IHCP referral. <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	10% <u>coinsurance</u>	Not covered	
	Childbirth/delivery facility services	No charge	10% <u>coinsurance</u>	Not covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	10% <u>coinsurance</u>	Not covered	<u>Cost sharing</u> waived at a non-IHCP with an IHCP referral.
	<u>Rehabilitation services</u>	No charge	10% <u>coinsurance</u>	Not covered	30 inpatient days (up to 60 days for head or spinal cord injury) each for <u>rehabilitation</u> and <u>habilitation services</u> / year 30 outpatient visits each for <u>rehabilitation</u> and <u>habilitation services</u> / year <u>Cost sharing</u> waived at a non-IHCP with an IHCP referral. Includes physical therapy, occupational therapy and speech therapy.
	<u>Habilitation services</u>	No charge	10% <u>coinsurance</u>	Not covered	
	<u>Skilled nursing care</u>	No charge	10% <u>coinsurance</u>	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)	
					<u>Cost sharing</u> waived at a non-IHCP with an IHCP referral.
	<u>Durable medical equipment</u>	No charge	10% <u>coinsurance</u>	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 <u>Cost sharing</u> waived at a non-IHCP with an IHCP referral.
	<u>Hospice services</u>	No charge	10% <u>coinsurance</u>	Not covered	30 respite inpatient or outpatient days / lifetime Respite limited to 5 consecutive days at a time. <u>Cost sharing</u> 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 <u>Cost sharing</u> 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. <u>Cost sharing</u> 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 <u>plan</u> for further information. Coverage includes basic and major dental services for individuals under age 19, refer to your <u>plan</u> for

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					further information. <u>Cost sharing</u> 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.)

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

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

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| • Abortion (Laws prohibit public funding of certain covered terminations of pregnancy. <u>Premium</u> payments are segregated to ensure compliance.) | • Acupuncture | • Hearing aids |
| | • Chiropractic care, spinal manipulations only | |

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 <u>plan's</u> overall <u>deductible</u>	\$6,500
■ <u>Specialist copayment</u>	\$80
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	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
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In this example, Peg would pay:

Cost Sharing

<u>Deductibles</u>	\$0
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0

What isn't covered

Limits or exclusions	\$61
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The total Peg would pay is	\$61
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Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$6,500
■ <u>Specialist copayment</u>	\$80
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	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
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In this example, Joe would pay:

Cost Sharing

<u>Deductibles</u>	\$0
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0

What isn't covered

Limits or exclusions	\$178
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The total Joe would pay is	\$178
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Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$6,500
■ <u>Specialist copayment</u>	\$80
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	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
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In this example, Mia would pay:

Cost Sharing

<u>Deductibles</u>	\$0
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0

What isn't covered

Limits or exclusions	\$0
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The total Mia would pay is	\$0
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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'déé', t'áá jiik'eh, éí ná hóló, koji' hódíílnih 1-888-344-6347 (TTY: 711.)

FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea te ke lava 'o ma'u ia. ha'o telefonimai mai ki he fika 1-888-344-6347 (TTY: 711)

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-344-6347 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតល្អិត គឺអាចមានសំរាប់អ្នក។ ចូរ ទូរស័ព្ទ 1-888-344-6347 (TTY: 711)។

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-344-6347 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachdienstleistungen zur Verfügung. Rufnummer: 1-888-344-6347 (TTY: 711)

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