



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/2024/booklet/OR/StandardBronzePreferred> or call 1 (888) 367-2116. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other undefined terms see the Glossary. You can view the Glossary at healthcare.gov/sbc-glossary or call 1 (888) 367-2116 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network provider: \$9,450 individual / \$18,900 family per calendar year. Out-of-network provider: \$10,000 individual / \$20,000 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."	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network provider: \$9,450 individual / \$18,900 family per calendar year. Out-of-network provider: \$15,000 individual / \$30,000 family per calendar year.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Pediatric vision services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See https://regence.com/go/OR/Preferred or call 1 (888) 367-2116 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

⚠ All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
<p>If you visit a health care provider's office or clinic</p>	<p>Primary care visit to treat an injury or illness</p>	<p>\$5 copay / first 3 upfront primary care, behavioral health, and virtual care visits / year, deductible does not apply; \$50 copay / office visit after 3 upfront visits, deductible does not apply; No charge for all other services</p>	<p>50% coinsurance</p>	<p>None</p>
	<p>Specialist visit</p>	<p>\$150 copay / office visit, deductible does not apply; No charge for all other services</p>	<p>50% coinsurance</p>	
	<p>Preventive care/screening/immunization</p>	<p>No charge, deductible does not apply</p>	<p>50% coinsurance</p>	<p>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.</p>
<p>If you have a test</p>	<p>Diagnostic test (x-ray, blood work) Imaging (CT/PET scans, MRIs)</p>	<p>No charge No charge</p>	<p>50% coinsurance 50% coinsurance</p>	<p>None</p>
<p>If you need drugs to treat your illness or condition More information about prescription drug coverage is available at</p>	<p>Preferred generic drugs</p>	<p>\$25 copay, deductible does not apply / preferred retail prescription \$75 copay, deductible does not apply / preferred home delivery prescription</p>	<p>Not covered</p>	<p>Prescription drugs not on the Drug List are not covered, unless an exception is approved. Deductible does not apply for insulin. 90-day supply / retail prescription (your cost share is per 30-day supply) 90-day supply / home delivery prescription</p>

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
https://regence.com/go/2024/OR/6tier	Generic drugs	No charge / retail prescription No charge / home delivery prescription	Not covered	30-day supply / <u>specialty drug</u> prescription <u>Specialty drugs</u> are not available through home delivery. Coverage includes self-administrable cancer chemotherapy drugs at no charge, <u>deductible</u> does not apply to preferred generic drugs. <u>Cost shares</u> for insulin will not exceed \$85 / 30-day supply retail prescription or \$255 / 90-day supply home delivery prescription. No charge, <u>deductible</u> does not apply for certain preventive drugs, women's 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 <u>specialty biosimilar drug</u> available, you pay the difference in cost in addition to the copayment and/or coinsurance. The first fill of <u>specialty drugs</u> may be provided by a retail pharmacy; additional refills must be provided by a specialty pharmacy.
	Preferred brand drugs	No charge / retail prescription No charge / home delivery prescription	Not covered	
	Brand drugs	No charge / retail prescription No charge / home delivery prescription	Not covered	
	Preferred <u>specialty drugs</u>	No charge / preferred <u>specialty drug</u>	Not covered	
	<u>Specialty drugs</u>	No charge / <u>specialty drug</u>	Not covered	
	If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	
Physician/surgeon fees		No charge	50% <u>coinsurance</u>	
<u>Emergency room care</u>		No charge	No charge	
If you need immediate medical attention	<u>Emergency medical transportation</u>	No charge	No charge	
	<u>Urgent care</u>	\$100 copay / office visit, <u>deductible</u> does not apply; No charge for all other services	50% <u>coinsurance</u>	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	50% <u>coinsurance</u>	In-network deductible applies to in-network provider and out-of-network provider services. None \$3,500 / day for inpatient non-emergency admission in non-participating facilities

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Physician/surgeon fees	No charge	50% coinsurance	None
	Outpatient services	\$5 copay / first 3 upfront primary care, behavioral health, and virtual care visits / year, deductible does not apply; \$50 copay / office visit after 3 upfront visits, deductible does not apply; No charge for all other services	50% coinsurance	None
	Inpatient services	No charge	50% coinsurance	\$3,500 / day for inpatient non-emergency admission in non-participating facilities
If you are pregnant	Office visits	No charge	50% coinsurance	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	No charge	50% coinsurance	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 facility services	No charge	50% coinsurance	\$3,500 / day for inpatient non-emergency admission in non-participating facilities
	Home health care	No charge	50% coinsurance	None
If you need help recovering or have other special health needs	Rehabilitation services	\$50 copay / outpatient visit, deductible does not apply; No charge for inpatient services	50% coinsurance	30 inpatient days (up to 60 days for head or spinal cord injury) each for rehabilitation and habilitation services / year 30 outpatient visits each for rehabilitation and habilitation services / year Copayment applies to each in-network provider outpatient visit only. All inpatient services are covered at the coinsurance specified, after deductible. Includes physical therapy, occupational therapy and speech therapy.
	Habilitation services	No charge for inpatient services	50% coinsurance	\$3,500 / day for inpatient non-emergency admission in non-participating facilities

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Skilled nursing care	No charge	50% coinsurance	60 inpatient days / year
	Durable medical equipment	No charge	50% coinsurance	1 synthetic wig / year 1 pair of glasses or contacts / year for individuals with severe medical or surgical problems other than refractive procedures
	Hospice services	No charge	50% coinsurance	30 respite inpatient or outpatient days / lifetime Respite limited to 5 consecutive days at a time.
	Children's eye exam	No charge, deductible does not apply	50% coinsurance, deductible does not apply	For services provided by an out-of-network provider, you pay all charges up front then submit a claim for reimbursement. 1 routine eye examination / year for individuals under age 19 VSP doctors are the only in-network providers.
	Children's glasses	No charge, deductible does not apply	50% coinsurance, deductible does not apply	For services provided by an out-of-network provider, you pay all charges up front then submit a claim for reimbursement. 1 pair of lenses / year 1 set of frames / year Glasses limited to individuals under age 19. Frames from VSP doctors are limited to Otis & Piper Eyewear Collection. VSP doctors are the only in-network providers.
	Children's dental check-up	Not covered	Not covered	None

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
- Fertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care
- 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
- Acupuncture, 12 visits / year
- Chiropractic care, 20 visits / year
- Hearing aids, 1 / ear every 36 months
- Non-emergency care when traveling outside the U.S.

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 ccio.cms.gov or your state insurance department. You may also contact the [plan at 1 \(888\) 367-2116](http://planat1(888)367-2116). Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit HealthCare.gov or call 1 (800) 318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact the [plan](#) at 1 (888) 367-2116 or visit regence.com or the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or dol.gov/ebsa/healthreform. You may also contact the Oregon Division of Financial Regulation by calling 1 (503) 947-7984 or the toll-free message line at 1 (888) 877-4894; by writing to the Oregon Division of Financial Regulation, Consumer Advocacy Unit, P.O. Box 14480, Salem, OR 97309-0405; through the Internet at: dfc.oregon.gov/help/complaints-licenses/Pages/file-complaint.aspx; or by E-mail at: DFR.InsuranceHelp@oregon.gov.

Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes plans, health insurance available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1 (888) 367-2116.

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.