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/Silver4750Preferred or call 1 (888) 367-2116. 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) 367-2116 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network provider: $4,750 individual / $9,500 family per calendar year. Out-of-network provider: $7,500 individual / $15,000 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: $8,200 individual / $16,400 family per calendar year. Out-of-network provider: $10,000 individual / $20,000 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	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 visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$5 copay / first 3 upfront primary care, behavioral health, and virtual care visits / year, deductible does not apply; $40 copay / office visit after 3 upfront visits, deductible does not apply; 35% coinsurance for all other services	50% coinsurance	None
	Specialist visit	$60 copay / office visit, deductible does not apply; 35% coinsurance for all other services	50% coinsurance	
	Preventive care/screening/ immunization	No charge, deductible does not apply	50% coinsurance	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)	35% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	35% coinsurance	50% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://regence.com/go/2024/OR/6tier	Preferred generic drugs	$25 copay, deductible does not apply / preferred retail prescription $75 copay, deductible does not apply / preferred home delivery prescription	Not covered	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 30-day supply / specialty drug prescription Specialty drugs are not available through home delivery.
	Generic drugs	$35 copay, deductible does not apply / retail prescription	Not covered	

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)	
		$105 copay, deductible does not apply / home delivery prescription		Coverage includes self-administrable cancer chemotherapy drugs at 35% coinsurance, deductible does not apply for preferred generic, generic, preferred brand and brand drugs. Cost shares for insulin will not exceed $85 / 30-day supply retail prescription or $255 / 90-day supply home delivery prescription. No charge, deductible does not apply 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.
	Preferred brand drugs	$60 copay, deductible does not apply / retail prescription $180 copay, deductible does not apply / home delivery prescription	Not covered	
	Brand drugs	50% coinsurance, deductible does not apply / retail prescription 50% coinsurance, deductible does not apply / home delivery prescription	Not covered	
	Preferred specialty drugs	20% coinsurance / preferred specialty drug	Not covered	
	Specialty drugs	50% coinsurance / specialty drug	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance for ambulatory surgery centers; 35% coinsurance for all other facilities	50% coinsurance	None
	Physician/surgeon fees	25% coinsurance for ambulatory surgery center physicians; 35% coinsurance for all other physicians	50% coinsurance	
If you need immediate medical attention	Emergency room care	$400 copay / visit	$400 copay / visit	Copayment applies to facility charge for each visit (waived if admitted), whether or not the deductible has been met.

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)	
	Emergency medical transportation	35% coinsurance	35% coinsurance	In-network deductible applies to in-network provider and out-of-network provider services.
	Urgent care	$60 copay / office visit, deductible does not apply; 35% coinsurance for all other services	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	35% coinsurance	50% coinsurance	$3,500 / day for inpatient non-emergency admission in non-participating facilities
	Physician/surgeon fees	35% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$5 copay / first 3 upfront primary care, behavioral health, and virtual care visits / year, deductible does not apply; $40 copay / office visit after 3 upfront visits, deductible does not apply; 35% coinsurance for all other services	50% coinsurance	None
	Inpatient services	35% coinsurance	50% coinsurance	$3,500 / day for inpatient non-emergency admission in non-participating facilities
If you are pregnant	Office visits	35% coinsurance	50% coinsurance	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). $3,500 / day for inpatient non-emergency admission in non-participating facilities
	Childbirth/delivery professional services	35% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	35% coinsurance	50% coinsurance	
If you need help recovering or have	Home health care	35% coinsurance	50% coinsurance	None
	Rehabilitation services	$40 copay / outpatient visit, deductible does not apply;	50% coinsurance	30 inpatient days (up to 60 days for head or spinal cord injury) each for rehabilitation and habilitation services /

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)	
other special health needs		35% coinsurance for inpatient 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. $3,500 / day for inpatient non-emergency admission in non-participating facilities
	Habilitation services	$40 copay / outpatient visit, deductible does not apply; 35% coinsurance for inpatient services	50% coinsurance	
	Skilled nursing care	35% coinsurance	50% coinsurance	60 inpatient days / year
	Durable medical equipment	35% coinsurance	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	35% coinsurance	50% coinsurance	30 respite inpatient or outpatient days / lifetime Respite limited to 5 consecutive days at a time.
If your child needs dental or eye care	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	No charge, deductible does not apply	No charge, deductible does not apply	2 cleanings* / year 2 preventive oral examinations / year Coverage limited to individuals under age 19.

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)	
				*Coverage may include another cleaning, refer to your plan for further information. Coverage includes basic and major dental services for individuals under age 19, refer to your plan for further information.

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	• Infertility treatment	• Routine eye care
• Cosmetic surgery, except congenital anomalies	• Long-term care	• Routine foot care, except for diabetic patients
• Dental care	• Private-duty nursing	• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Abortion	• Chiropractic care, 20 visits / year	• Non-emergency care when traveling outside the U.S.
• Acupuncture, 12 visits / year	• Hearing aids, 1 / ear every 36 months	

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) 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: dfr.oregon.gov/help/complaints-licenses/Pages/file-complaint.aspx; or by E-mail at: DFR.InsuranceHelp@oregon.gov.

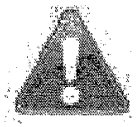
Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum 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) 367-2116.

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	$4,750
Specialist copayment	$60
Hospital (facility) coinsurance	35%
Other coinsurance	35%

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	$4,750
Copayments	$10
Coinsurance	$2,600
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$7,420**

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

The plan's overall deductible	$4,750
Specialist copayment	$60
Hospital (facility) coinsurance	35%
Other coinsurance	35%

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	$900
Copayments	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$200
The total Joe would pay is	**$2,300**

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

The plan's overall deductible	$4,750
Specialist copayment	$60
Hospital (facility) coinsurance	35%
Other coinsurance	35%

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	$1,700
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,400**

The plan would be responsible for the other costs of these EXAMPLE covered services.