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 regence.com or call 1 (855) 877-0047. 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 (855) 877-0047 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$250 individual / $500 family per calendar year.</td>
<td>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.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Certain preventive care and those services listed below as &quot;deductible does not apply&quot; or as &quot;No charge.&quot;</td>
<td>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.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don't have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>$1,500 individual / $3,000 family per calendar year.</td>
<td>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.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billed charges, and health care this plan doesn't cover.</td>
<td>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See regence.com/go/WW/Preferred or call 1 (855) 877-0047 for a list of network providers.</td>
<td>You will pay the least if you use a provider in the preferred network. You will pay more if you use a provider in the participating network. You will pay the most if you use a provider, and you might receive a bill from a nonparticipating provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use a nonparticipating provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Preferred Network Provider (You pay the least)</th>
<th>Participating Network Provider (You pay more)</th>
<th>Nonparticipating Provider (You pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a healthcare provider’s office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>$20 copay / visit, deductible does not apply; other services 0% coinsurance</td>
<td>40% coinsurance after $20 copay / visit, deductible does not apply; other services 40% coinsurance</td>
<td>50% coinsurance after $20 copay / visit, deductible does not apply; other services 50% coinsurance</td>
<td>Copayment applies to each office and retail clinic visit only. All other services are covered at the coinsurance specified, after deductible. Acupuncture services are limited to 12 visits / year, subject to coinsurance, after deductible. Spinal manipulations are limited to 15 / year, subject to $20 copay / visit for preferred or participating providers after deductible.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$20 copay / visit, deductible does not apply; other services 0% coinsurance</td>
<td>40% coinsurance after $20 copay / visit, deductible does not apply; other services 40% coinsurance</td>
<td>50% coinsurance after $20 copay / visit, deductible does not apply; other services 50% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>No charge</td>
<td>50% coinsurance</td>
<td>Coinsurance and deductible do not apply for childhood immunizations from nonparticipating providers. 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.</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>0% coinsurance</td>
<td>40% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>0% coinsurance</td>
<td>40% coinsurance</td>
<td>50% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
<td>-----------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Preferred generic drugs &amp; generic drugs</td>
<td>Preferred Network Provider (You pay the least): $5 copay / preferred generic retail prescription $10 copay / preferred generic mail order prescription</td>
<td>Deductible does not apply. Limited to a 90-day supply retail (1 copay per 30-day supply), 90-day supply mail order or 30-day supply of specialty drugs. No charge for certain FDA-approved contraceptives and certain preventive drugs and immunizations at a participating pharmacy. Coverage includes compound medications, refer to your plan for further information. For specialty drugs (including preferred), the first fill is allowed at a retail pharmacy. Additional fills must be provided at a specialty pharmacy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>Participating Network Provider (You pay more): $35 copay / retail prescription $70 copay / mail order prescription</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Brand drugs</td>
<td>Nonparticipating Provider (You pay the most): $60 copay / retail prescription $120 copay / mail order prescription</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preferred specialty drugs &amp; specialty drugs</td>
<td>$75 copay / preferred specialty drugs $150 copay / specialty drugs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>Facility fee (e.g., ambulatory surgery center): 0% coinsurance 40% coinsurance 50% coinsurance</td>
<td>None</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>Physician/surgeon fees: 0% coinsurance 40% coinsurance 50% coinsurance</td>
<td>None</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>Emergency room care: 10% coinsurance after $150 copay for facility, 0% coinsurance for professional services 10% coinsurance after $150 copay for facility, 0% coinsurance for professional services 10% coinsurance after $150 copay for facility, 0% coinsurance for professional services</td>
<td>Copayment applies to the facility charge for each visit (waived if admitted). Includes licensed ground and air ambulance providers.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>Emergency medical transportation: 20% coinsurance 20% coinsurance 20% coinsurance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>Covered the same as If you visit a health care provider’s office or clinic (Primary care visit or Specialist visit) or If you have a test above.</td>
<td>None</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

More information about prescription drug coverage is available at regence.com/go/druglist/2020WW/6tierLG.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Preferred Network Provider (You pay the least)</th>
<th>Participating Network Provider (You pay more)</th>
<th>Nonparticipating Provider (You pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>0% coinsurance</td>
<td>40% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>10% coinsurance for facility; 0% for professional services</td>
<td>10% coinsurance for facility; 0% for professional services</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>10% coinsurance for facility; 0% for professional services</td>
<td>10% coinsurance for facility; 0% for professional services</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>0% coinsurance</td>
<td>40% coinsurance</td>
<td>50% coinsurance</td>
<td>Cost sharing does not apply to certain 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).</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>0% coinsurance</td>
<td>40% coinsurance</td>
<td>50% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
<td>50% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>Preferred Network Provider (You pay the least)</td>
<td>Participating Network Provider (You pay more)</td>
<td>Nonparticipating Provider (You pay the most)</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>-----------------------</td>
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<td>-----------------------------------------------</td>
<td>-----------------------------------------------</td>
<td>-----------------------------------------------</td>
<td>-----------------------------------------------------</td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td>Home health care</td>
<td>0% coinsurance</td>
<td>40% coinsurance</td>
<td>50% coinsurance</td>
<td>Limited to 130 visits / year.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>Inpatient: 10% coinsurance for facility; 0% coinsurance for professional services</td>
<td>40% coinsurance</td>
<td>50% coinsurance</td>
<td>Inpatient limited to 40 days / year. Outpatient limited to 99 visits / year. Includes physical therapy, occupational therapy and speech therapy services.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>50% coinsurance</td>
<td>Includes physical therapy, occupational therapy and speech therapy services.</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>0% coinsurance</td>
<td>0% coinsurance</td>
<td>50% coinsurance</td>
<td>Limited to 100 inpatient days / year.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>0% coinsurance</td>
<td>0% coinsurance</td>
<td>50% coinsurance</td>
<td>Respite care limited to 14 days / lifetime.</td>
</tr>
<tr>
<td><strong>If your child needs dental or eye care</strong></td>
<td>Children’s eye exam</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
<td>None</td>
</tr>
</tbody>
</table>
### Excluded Services & Other Covered Services:

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Bariatric surgery</td>
</tr>
<tr>
<td>• Cosmetic surgery, except congenital anomalies</td>
</tr>
<tr>
<td>• Dental care (Adult)</td>
</tr>
<tr>
<td>• Hearing aids</td>
</tr>
<tr>
<td>• Infertility treatment</td>
</tr>
<tr>
<td>• Long-term care</td>
</tr>
<tr>
<td>• Private-duty nursing</td>
</tr>
<tr>
<td>• Routine eye care (Adult)</td>
</tr>
<tr>
<td>• Routine foot care</td>
</tr>
<tr>
<td>• Weight loss programs, except as covered under preventive care</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Acupuncture</td>
</tr>
<tr>
<td>• Chiropractic care</td>
</tr>
<tr>
<td>• Non-emergency care when traveling outside the U.S.</td>
</tr>
</tbody>
</table>
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 x61565 or cciio.cms.gov or your state insurance department. You may also contact the plan at 1 (855) 877-0047. 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 (855) 877-0047. You may also contact your state insurance department at 1 (800) 562-6900 or insurance.wa.gov or the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes
If you don’t have Minimum Essential Coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 (855) 877-0047.

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: $250
- Specialist copayment: $20
- Hospital (facility) coinsurance: 10%
- Other coinsurance: 0%

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**: $12,800

**In this example, Peg would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$250</td>
</tr>
<tr>
<td>Copayments</td>
<td>$20</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$896</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: $60

**The total Peg would pay is**: $1,226

---

#### Managing Joe’s type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan’s overall deductible: $250
- Specialist copayment: $20
- Hospital (facility) coinsurance: 10%
- Other coinsurance: 0%

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**: $7,400

**In this example, Joe would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$102</td>
</tr>
<tr>
<td>Copayments</td>
<td>$510</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: $255

**The total Joe would pay is**: $867

---

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

- The plan’s overall deductible: $250
- Specialist copayment: $20
- Hospital (facility) coinsurance: 10%
- Other coinsurance: 0%

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**: $1,925

**In this example, Mia would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$102</td>
</tr>
<tr>
<td>Copayments</td>
<td>$510</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**
- Limits or exclusions: $255

**The total Mia would pay is**: $867

---

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:
Provided Entrance 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)

Provided 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).

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)。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-344-6347 (TTY: 711) 번으로 전화해 주십시오.


ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-344-6347 (телетайп: 711).

ATENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appellez 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。

Dií baa akò nínizin: Dií saad bee yánilti’go Dínë Bizaad, saad bee áká’anída’åwo’déè’, t’áa jiik’e, eí ná hóló, koji’ hódíilnih 1-888-344-6347 (TTY: 711).

FAKATOKANGÁ’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 sluham: 711)

Tوجه: إذا كنت تتحدث فارسية باللغة، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل برقم 6347-344-888-888 (TTY: 711)

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