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 (800) 376-7926. 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 (800) 376-7926 to request a copy.

### Important Questions

| **What is the overall deductible?** | **In-network:** $200 individual / $600 family per calendar year.  
Out-of-network: $500 individual / $1,500 family per calendar year. | **Why This Matters:** 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?** | In-network: $1,100 individual / $2,400 family per calendar year.  
Out-of-network: $2,500 individual / $5,500 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. |
<p>| <strong>What is not included in the out-of-pocket limit?</strong> | 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. |
| <strong>Will you pay less if you use a network provider?</strong> | Yes. See <a href="https://regence.com/go/UWM/Preferred">https://regence.com/go/UWM/Preferred</a> or call 1 (800) 376-7926 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. |
| <strong>Do you need a referral to see a specialist?</strong> | No. | You can see the specialist you choose without a referral. |</p>
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td><strong>If you visit a health care provider's office or clinic</strong></td>
<td></td>
<td>$20 copay / office visit, deductible does not apply; $20 copay / retail clinic visit, deductible does not apply; 10% coinsurance for all other services</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td></td>
<td>$20 copay / office visit, deductible does not apply; $20 copay / retail clinic visit, deductible does not apply; 10% coinsurance for all other services</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>$20 copay / office visit, deductible does not apply; 10% coinsurance for all other services</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>40% coinsurance</td>
<td></td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
<td></td>
</tr>
</tbody>
</table>

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

Copayment applies to each in-network office and retail clinic visit only. All other services are covered at the coinsurance specified, after deductible.

Coinsurance and deductible do not apply for childhood immunizations from out-of-network 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.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
</table>
| **If you need drugs to treat your illness or condition**  
More information about [prescription drug coverage](#) is available at [www.cvs.com](http://www.cvs.com). | **Generic drugs**  
$5 copay / retail prescription  
$10 copay / mail-order prescription | **In-Network Provider** (You will pay the least)  
$5 copay / retail prescription  
$10 copay / mail-order prescription | **Out-of-Network Provider** (You will pay the most)  
$5 copay plus remaining balance after pharmacy is paid at network rate | Your prescription drug coverage is administered through CVS. Regence BlueShield assumes no liability for the accuracy of your prescription drug benefits information.  
Out-of-pocket limit $1,500 per individual / $3,000 per family per year.  
Coverage is limited to a 30-day supply retail and 90-day supply mail-order.  
You are responsible for the difference in cost between a dispensed brand-name drug and the equivalent generic drug, in addition to the copayment. For specialty drugs, the first fill is allowed at a retail pharmacy. Additional fills must be provided at a specialty pharmacy. |
| **Preferred brand drugs**  
$25 copay / retail prescription  
$50 copay / mail-order prescription | **In-Network Provider** (You will pay the least)  
$25 copay / retail prescription  
$50 copay / mail-order prescription | **Out-of-Network Provider** (You will pay the most)  
$25 copay plus remaining balance after pharmacy is paid at network rate |
| **Non-preferred brand drugs**  
$75 copay / retail prescription  
$150 copay / mail-order prescription | **In-Network Provider** (You will pay the least)  
$75 copay / retail prescription  
$150 copay / mail-order prescription | **Out-of-Network Provider** (You will pay the most)  
$75 copay plus remaining balance after pharmacy is paid at network rate |
| **Specialty drugs**  
Refer to generic, preferred brand and non-preferred brand drugs above. | | | |
| **If you have outpatient surgery** | **Facility fee (e.g., ambulatory surgery center)**  
10% coinsurance | **Out-of-Network Provider** (You will pay the most)  
10% coinsurance after $200 copay / visit | None |
| | **Physician/surgeon fees**  
10% coinsurance | 40% coinsurance | None |
| **If you need immediate medical attention** | **Emergency room care**  
10% coinsurance after $200 copay / visit | **Out-of-Network Provider** (You will pay the most)  
10% coinsurance after $200 copay / visit | Copayment applies to facility charge for each visit (waived if admitted), whether or not the deductible has been met.  
In-network deductible applies to in-network and out-of-network services.  
In-network deductible applies to in-network and out-of-network services. |
| | **Emergency medical transportation**  
10% coinsurance | 10% coinsurance | None |
| | **Urgent care**  
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. | | None |
| **If you have a hospital stay** | **Facility fee (e.g., hospital room)**  
10% coinsurance | **Out-of-Network Provider** (You will pay the most)  
10% coinsurance | None |
| | **Physician/surgeon fees**  
10% coinsurance | 40% coinsurance | None |
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>In-Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td>Outpatient services</td>
<td>$20 copay / office visit, deductible does not apply; 10% coinsurance for all other services</td>
<td>40% coinsurance</td>
<td>Copayment applies to each in-network office/psychotherapy visit only. All other services are covered at the coinsurance specified, after deductible.</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Office visits</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
<td>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).</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
<td>None</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>0% coinsurance</td>
<td>130 visits / year</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
<td>60 inpatient days / year 60 outpatient visits / year Includes physical therapy, occupational therapy and speech therapy.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
<td>Includes physical therapy, occupational therapy and speech therapy.</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>10% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>0% coinsurance</td>
<td>0% coinsurance</td>
<td>None</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>None</td>
</tr>
<tr>
<td></td>
<td>Children's glasses</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>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>• Cosmetic surgery, except congenital anomalies</td>
</tr>
<tr>
<td>• Dental care (Adult)</td>
</tr>
<tr>
<td>• Long-term care</td>
</tr>
<tr>
<td>• Routine eye care (Adult)</td>
</tr>
<tr>
<td>• Routine foot care, except for diabetic patients</td>
</tr>
<tr>
<td>• Weight loss programs</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>• Abortion</td>
</tr>
<tr>
<td>• Acupuncture</td>
</tr>
<tr>
<td>• Chiropractic care</td>
</tr>
<tr>
<td>• Hearing aids</td>
</tr>
<tr>
<td>• Infertility treatment</td>
</tr>
<tr>
<td>• Non-emergency care when traveling outside the U.S.</td>
</tr>
<tr>
<td>• Private-duty nursing</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 ext. 61565 or cciio.cms.gov or your state insurance department. You may also contact the plan at 1 (800) 376-7926. 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 (800) 376-7926 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 Office of the Insurance Commissioner of Washington State by calling 1 (800) 562-6900, or through the Internet at: www.insurance.wa.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 (800) 376-7926.

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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  $200  
- Specialist copayment  $20  
- 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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$200</td>
</tr>
<tr>
<td>Copayments</td>
<td>$9</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$900</td>
</tr>
</tbody>
</table>

What isn't covered:

Limits or exclusions  $61

The total Peg would pay is  $1,170

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

- The plan's overall deductible  $200  
- Specialist copayment  $20  
- 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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$200</td>
</tr>
<tr>
<td>Copayments</td>
<td>$231</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$380</td>
</tr>
</tbody>
</table>

What isn't covered:

Limits or exclusions  $178

The total Joe would pay is  $989

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

- The plan's overall deductible  $200  
- Specialist copayment  $20  
- 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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$200</td>
</tr>
<tr>
<td>Copayments</td>
<td>$265</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$205</td>
</tr>
</tbody>
</table>

What isn't covered:

Limits or exclusions  $0

The total Mia would pay is  $670

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).

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)。

注意：如果您使用簡體中文，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.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maari 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。

디이 바아 티이 닌실플에 닥씨 날리티이 '고 디니 벽사드, 샤안 babysa 낀디아 애모 낀데예티, 틸 아야 젠킨, 칭난 호학교 단어 변환행이 1-888-344-6347 (TTY: 711.)

FATOKANGA'I: Kapau 'oku ke Lea-Fatokonga, ko e kau tokoni fakatou na 'oku nau fai atu ha tokoni ta'etotangi, pea te ke lava ‘o ma’u ia. ha’o telefonimai mai ki he fika 1-888-344-6347 (TTY: 711)

FAKATAKANGA'I:: Kapau ‘oku ke Lea-Fatokonga, ko e kau tokoni fakatou na ‘oku nau fai atu ha tokoni ta’etotangi, 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 besplatan. Nazovite 1-888-344-6347 (TTY- Telefon za osobe sa oštećenim govorom ili sluham: 711)

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

バリアディコミュニケーション、無料の言語支援をご利用いただけます。1-888-344-6347 (TTY: 711)

이야! 당신은 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-344-6347 (TTY: 711)

ATENCIE: Dacă vorbiți limbă 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 baloojima to okkitaaki wolde caahu. Noddu 1-888-344-6347 (TTY: 711)

โปรดทราบ: อีสานอินดี้เนี่ย้ อุ้มสามารถใช้บริการช่วยเหลือทางภาษาได้ใน 1-888-344-6347 (TTY: 711)

โปรดทราบ: ตู้ข้อมูลอินเทอร์เน็ต แอร์, กระทบธุรกิจผู้มีสิทธิ์ที่จะร้องขอ, ให้บันทึกไว้, แต่ไม่เป็นผลบันทึก. โปรด 1-888-344-6347 (TTY: 711)

Afian dubbattan Oroomiffää tiif, tajajila gargaarsa afaanii tola ni jira. 1-888-344-6347 (TTY: 711) tiin bilbilaa.