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</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Yes. Certain preventive care and those services listed below as deductible does not apply or as No charge.</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><strong>Are there other deductibles for specific services?</strong></td>
<td>No.</td>
<td>You don't have to meet deductibles for specific services.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>$4,000 individual / $8,000 family per plan 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, the overall family out-of-pocket limit must be met.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></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><strong>Will you pay less if you use a network provider?</strong></td>
<td>Yes. See regence.com/go/PreferredValueCare or call 1 (866) 240-9580 for lists of network providers.</td>
<td>You pay the least if you use a provider in the preferred network. You 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><strong>Do you need a referral to see a specialist?</strong></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>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>Primary care visit to treat an injury or illness</td>
<td>$17 copay / visit for BDTC* providers; $35 copay / visit for all other providers; all other services 30% coinsurance; 0% coinsurance for expanded services</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$17 copay / visit for BDTC providers; $35 copay / visit for all other providers; all other services 30% coinsurance; 0% coinsurance for expanded services</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/ immunization</td>
<td>No charge</td>
<td>40% coinsurance, deductible does not apply</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>0% coinsurance for the first $1,000 / year, then 30% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>0% coinsurance for the first $1,000 / year, then 30% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Generic drugs</td>
<td>$10 copay / retail prescription</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>35% coinsurance / retail prescription</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>50% coinsurance / retail prescription</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>20% coinsurance (increments of 5% up to $150) / generic and preferred brand prescription</td>
<td></td>
</tr>
<tr>
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</tr>
<tr>
<td>-------------------------------------------------------------------------------------</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><strong>In-network Provider</strong> (You will pay the least): $250 copay / visit</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td><strong>Out-of-network Provider</strong> (You will pay the most): $400 copay / visit and 40% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
<td><strong>In-network Provider</strong> (You will pay the least): $250 copay / visit</td>
<td>Copayment applies to the facility charge for each visit (waived if admitted), whether or not the deductible has been met.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td><strong>Out-of-network Provider</strong> (You will pay the most): $250 copay / visit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td><strong>In-network Provider</strong> (You will pay the least): $40 copay / visit</td>
<td>Copayment applies to each in-network office visit only. All other services are covered at the coinsurance specified.</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td><strong>In-network Provider</strong> (You will pay the least): $250 copay / admission and 30% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td><strong>Out-of-network Provider</strong> (You will pay the most): $250 copay / admission and 40% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td><strong>In-network Provider</strong> (You will pay the least): 15% coinsurance for BDTC providers; 30% coinsurance for all other providers</td>
<td>Limited to 40 inpatient days / year for mental/behavioral health.</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td><strong>Out-of-network Provider</strong> (You will pay the most): $250 copay / admission and 30% coinsurance for mental/behavioral health; 30% coinsurance for substance abuse services</td>
<td>Limited to 40 outpatient visits / year (1 visit / day) for mental/behavioral health. Limited to $10,000 / year for substance abuse services.</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
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<td>-----------------------------------------------</td>
<td>-------------------</td>
<td>--------------------------------------------------------</td>
</tr>
<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 are pregnant</strong></td>
<td>Office visits</td>
<td>30% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>30% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>$250 copay / admission and 30% coinsurance</td>
<td>$250 copay / admission and 40% coinsurance</td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td>Home health care</td>
<td>30% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>30% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$250 copay / admission and 30% coinsurance for inpatient visits; 30% coinsurance, for outpatient visits</td>
<td>$250 copay / admission and 40% coinsurance for inpatient visits; 40% coinsurance, for outpatient visits</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>30% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>30% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>30% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td><strong>If your child needs dental or eye care</strong></td>
<td>Children’s eye exam</td>
<td>No charge</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>
Excluded Services & Other Covered Services:

Exclusion Examples
The following examples of limitations and exclusions are included to illustrate the types of conditions, treatments, services, supplies or accommodations that may not be covered under your plan, including related secondary medical conditions and are not all inclusive:

- charges in connection with reconstructive or plastic surgery that may have limited benefits, such as a chemical peel that does not alleviate a functional impairment;
- complications relating to services and supplies for, or in connection with, gastric or intestinal bypass, gastric stapling, or other similar surgical procedure to facilitate weight loss, or for, or in connection with, reversal or revision of such procedures, or any direct complications or consequences thereof;
- complications by infection from a cosmetic procedure, except in cases of reconstructive surgery:
  - when the service is incidental to or follows a surgery resulting from trauma, infection or other diseases of the involved part; or
  - related to a congenital disease or anomaly of a covered child that has resulted in functional defect; or
- complications that result from an injury or illness resulting from active participation in illegal activities.

<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>• Abortion (except in cases of rape, rape of a child, incest or to avert the death of the mother)</td>
</tr>
<tr>
<td>• Acupuncture</td>
</tr>
<tr>
<td>• Bariatric surgery</td>
</tr>
<tr>
<td>• Cosmetic surgery, except congenital anomalies</td>
</tr>
<tr>
<td>• Dental care</td>
</tr>
<tr>
<td>• Hearing aids</td>
</tr>
<tr>
<td>• Long-term care</td>
</tr>
<tr>
<td>• Prescription medications</td>
</tr>
<tr>
<td>• Private-duty nursing</td>
</tr>
<tr>
<td>• Routine foot care</td>
</tr>
<tr>
<td>• Vision hardware</td>
</tr>
<tr>
<td>• Weight loss programs except for nutritional counseling</td>
</tr>
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<th>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)</th>
</tr>
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<tbody>
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<td>• Chiropractic care, spinal manipulations only</td>
</tr>
<tr>
<td>• Infertility treatment</td>
</tr>
<tr>
<td>• Non-emergency care when traveling outside the U.S.</td>
</tr>
<tr>
<td>• Routine eye care</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 cció.cms.gov or your state insurance department. You may also contact the plan at 1 (866) 240-9580. 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 (866) 240-9580 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 Utah Department of Insurance by calling 1 (801) 538-3077 or the toll-free message line at 1 (800) 439-3805; by writing to the Utah Department of Insurance, State Office Building Suite 3110, Salt Lake City, UT 84114-6901; through the Internet at: www.insurance.utah.gov; or by E-mail at: healthappeals.uid@utah.gov.
**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:**
NAVAJO (Dine): Dinek’ehgo shika at’ohwol ninisingo, kwijigo holne’ 1 (866) 240-9580.

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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby</th>
<th>Managing Joe's type 2 Diabetes</th>
<th>Mia's Simple Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td>(9 months of in-network pre-natal care and a hospital delivery)</td>
<td>(a year of routine in-network care of a well-controlled condition)</td>
<td>(in-network emergency room visit and follow up care)</td>
</tr>
<tr>
<td>The plan’s overall deductible $750</td>
<td>The plan’s overall deductible $750</td>
<td>The plan’s overall deductible $750</td>
</tr>
<tr>
<td>Specialist copayment $35</td>
<td>Specialist copayment $35</td>
<td>Specialist copayment $35</td>
</tr>
<tr>
<td>Hospital (facility) coinsurance 30%</td>
<td>Hospital (facility) coinsurance 30%</td>
<td>Hospital (facility) coinsurance 30%</td>
</tr>
<tr>
<td>Other coinsurance 30%</td>
<td>Other coinsurance 30%</td>
<td>Other coinsurance 30%</td>
</tr>
</tbody>
</table>

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)

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)

This EXAMPLE event includes services like:
- Emergency room care (including medical supplies)
- Diagnostic test (x-ray)
- Durable medical equipment (crutches)
- Rehabilitation services (physical therapy)

<table>
<thead>
<tr>
<th>Total Example Cost $12,800</th>
<th>Total Example Cost $7,400</th>
<th>Total Example Cost $1,925</th>
</tr>
</thead>
</table>

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles $750</th>
<th>Copayments $270</th>
<th>Coinsurance $3,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>What isn’t covered</td>
<td>Limits or exclusions $60</td>
<td>The total Peg would pay is $4,080</td>
<td></td>
</tr>
</tbody>
</table>

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles $495</th>
<th>Copayments $365</th>
<th>Coinsurance $1,858</th>
</tr>
</thead>
<tbody>
<tr>
<td>What isn’t covered</td>
<td>Limits or exclusions $255</td>
<td>The total Joe would pay is $2,973</td>
<td></td>
</tr>
</tbody>
</table>

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles $750</th>
<th>Copayments $293</th>
<th>Coinsurance $234</th>
</tr>
</thead>
<tbody>
<tr>
<td>What isn’t covered</td>
<td>Limits or exclusions $0</td>
<td>The total Mia would pay is $1,277</td>
<td></td>
</tr>
</tbody>
</table>

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)。

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


VНИМАНИЕ: 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。

Dīi baa akō ninizin: Dīi saad bee yánílti’go Diné Bízaad, saad bee aká’ánida’awo’déé’, t’áá jiik’eh, éi ná hóló, koji’ hódiilnih 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 sluham: 711)
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<tr>
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<td>$4,000 individual / $8,000 family per plan 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, the overall family out-of-pocket limit must be 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/Participating or call 1 (866) 240-9580 for lists of network providers.</td>
<td>You pay the least if you use a provider in the preferred network. You 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>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></td>
<td>Primary care visit to treat an injury or illness</td>
<td>$17 copay / visit for BDTC* providers; $35 copay / visit for all other providers; all other services 30% coinsurance; 0% coinsurance for expanded services</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$17 copay / visit for BDTC providers; $35 copay / visit for all other providers; all other services 30% coinsurance; 0% coinsurance for expanded services</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>40% coinsurance, deductible does not apply</td>
</tr>
<tr>
<td></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>0% coinsurance for the first $1,000 / year, then 30% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>0% coinsurance for the first $1,000 / year, then 30% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Generic drugs</td>
<td>$10 copay / retail prescription $15 copay / mail order prescription</td>
<td>Prescription drug coverage is administered through Magellan Rx. Regence BlueCross BlueShield of Utah assumes no liability for the accuracy of your prescription drug benefit information. Contact Magellan Rx at 1 (800) 424-0472 for information on your prescription drug coverage. Out-of-pocket limit: $1,750 individual / $3,500 family per year.</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>35% coinsurance / retail prescription 35% coinsurance / mail order prescription</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>50% coinsurance / retail prescription 50% coinsurance / mail order prescription</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>20% coinsurance (increments of 5% up to $150) / generic and preferred brand prescription 35% coinsurance (increments of 5% up to $300) / preferred brand prescription on the formulary</td>
<td></td>
</tr>
</tbody>
</table>

*Blue Distinction Total Care (BDTC) providers are in-network providers who have an additional contract with us agreeing to take extra measures aimed at improving the quality of care for our members while controlling costs.
<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><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td><strong>In-network Provider (You will pay the least)</strong> $250 <em>copay</em> / visit</td>
<td><strong>Out-of-network Provider (You will pay the most)</strong> $400 <em>copay</em> / visit and 40% <em>coinsurance</em></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>30% <em>coinsurance</em></td>
<td>40% <em>coinsurance</em></td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Emergency room services</td>
<td>$250 <em>copay</em> / visit</td>
<td>$250 <em>copay</em> / visit</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>30% <em>coinsurance</em></td>
<td>30% <em>coinsurance</em></td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$40 <em>copay</em> / visit</td>
<td>40% <em>coinsurance</em></td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>$250 <em>copay</em> / admission and 30% <em>coinsurance</em></td>
<td>$250 <em>copay</em> / admission and 40% <em>coinsurance</em></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>30% <em>coinsurance</em></td>
<td>40% <em>coinsurance</em></td>
</tr>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td>Outpatient services</td>
<td>15% <em>coinsurance</em> for BDTC providers; 30% <em>coinsurance</em> for all other providers</td>
<td>50% <em>coinsurance</em></td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>$250 <em>copay</em> / admission and 30% <em>coinsurance</em> for mental/behavioral health; 30% <em>coinsurance</em> for substance abuse services</td>
<td>50% <em>coinsurance</em></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>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>--------------------------------</td>
<td>--------------------------------------------------------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Office visits</td>
<td>30% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>30% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>$250 copay / admission and 30% coinsurance</td>
<td>$250 copay / admission and 40% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
</tr>
<tr>
<td></td>
<td>Home health care</td>
<td>30% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>30% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$250 copay / admission and 30% coinsurance for inpatient services; 30% coinsurance, for outpatient visits</td>
<td>$250 copay / admission and 40% coinsurance for inpatient services; 40% coinsurance, for outpatient visits</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>30% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>30% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>30% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>No charge</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>
Excluded Services & Other Covered Services:

Exclusion Examples
The following examples of limitations and exclusions are included to illustrate the types of conditions, treatments, services, supplies or accommodations that may not be covered under your plan, including related secondary medical conditions and are not all inclusive:

- charges in connection with reconstructive or plastic surgery that may have limited benefits, such as a chemical peel that does not alleviate a functional impairment;
- complications relating to services and supplies for, or in connection with, gastric or intestinal bypass, gastric stapling, or other similar surgical procedure to facilitate weight loss, or for, or in connection with, reversal or revision of such procedures, or any direct complications or consequences thereof;
- complications by infection from a cosmetic procedure, except in cases of reconstructive surgery:
  - when the service is incidental to or follows a surgery resulting from trauma, infection or other diseases of the involved part; or
  - related to a congenital disease or anomaly of a covered child that has resulted in functional defect; or
- complications that result from an injury or illness resulting from active participation in illegal activities.

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Abortion (except in cases of rape, rape of a child, incest or to avert the death of the mother)
- Acupuncture
- Bariatric surgery
- Cosmetic surgery, except congenital anomalies
- Dental care
- Hearing aids
- Long-term care
- Prescription medications
- Private-duty nursing
- Routine foot care
- Vision hardware
- Weight loss programs except for nutritional counseling

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

- Chiropractic care, spinal manipulations only
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Routine eye care

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 cció.cms.gov or your state insurance department. You may also contact the plan at 1 (866) 240-9580. 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 (866) 240-9580 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 Utah Department of Insurance by calling 1 (801) 538-3077 or the toll-free message line at 1 (800) 439-3805; by writing to the Utah Department of Insurance, State Office Building Suite 3110, Salt Lake City, UT 84114-6901; through the Internet at: www.insurance.utah.gov; or by E-mail at: healthappeals.uid@utah.gov.
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:
NAVAJO (Dine): Dinek’ehgo shika at’ohwol ninisingo, kwijigo holne’ 1 (866) 240-9580.

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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby</th>
<th>Managing Joe's type 2 Diabetes</th>
<th>Mia's Simple Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>(9 months of in-network pre-natal care and a hospital delivery)</strong></td>
<td><strong>(a year of routine in-network care of a well-controlled condition)</strong></td>
<td><strong>(in-network emergency room visit and follow up care)</strong></td>
</tr>
<tr>
<td><strong>The plan’s overall deductible</strong></td>
<td><strong>The plan’s overall deductible</strong></td>
<td><strong>The plan’s overall deductible</strong></td>
</tr>
<tr>
<td>$750</td>
<td>$750</td>
<td>$750</td>
</tr>
<tr>
<td><strong>Specialist copayment</strong></td>
<td><strong>Specialist copayment</strong></td>
<td><strong>Specialist copayment</strong></td>
</tr>
<tr>
<td>$35</td>
<td>$35</td>
<td>$35</td>
</tr>
<tr>
<td><strong>Hospital (facility) coinsurance</strong></td>
<td><strong>Hospital (facility) coinsurance</strong></td>
<td><strong>Hospital (facility) coinsurance</strong></td>
</tr>
<tr>
<td>30%</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td><strong>Other coinsurance</strong></td>
<td><strong>Other coinsurance</strong></td>
<td><strong>Other coinsurance</strong></td>
</tr>
<tr>
<td>30%</td>
<td>30%</td>
<td>30%</td>
</tr>
</tbody>
</table>

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)*

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)*

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** | $12,800 | $7,400 | $1,925

In this example, Peg would pay:

| Cost Sharing | | |
|--------------|-----------------|
| Deductibles  | $750 |
| Copayments   | $270 |
| Coinsurance  | $3,000 |

What isn’t covered

| Limits or exclusions | $60 |

The total Peg would pay is $4,080

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$495</td>
</tr>
<tr>
<td>Copayments</td>
<td>$365</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,858</td>
</tr>
</tbody>
</table>

What isn’t covered

| Limits or exclusions | $255 |

The total Joe would pay is $2,973

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$750</td>
</tr>
<tr>
<td>Copayments</td>
<td>$293</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$234</td>
</tr>
</tbody>
</table>

What isn’t covered

| Limits or exclusions | $0 |

The total Mia would pay is $1,277

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).
