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 (888) 370-6156. 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) 370-6156 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible? | $500 individual / $1,000 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 the following services: office/urgent care or retail clinic visits, upfront outpatient diagnostic x-ray/laboratory/imaging services and preferred and participating outpatient mental health and substance abuse psychotherapy visits. | 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? | $2,500 individual / $5,000 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? | Premiums, balance-billed 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 regence.com/go/Preferred or call 1 (888) 370-6156 for a list of network providers. | This plan uses a provider network. 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 nonparticipating 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. |
| 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 |
|---|---|---|---|---|---|
| | | Preferred Network Provider (You pay the least) | Participating Network Provider (You pay more) | Nonparticipating Provider (You pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | $20 copay / retail clinic visit, deductible does not apply; $20 copay / office visit, deductible does not apply; other services 10% coinsurance | $20 copay / retail clinic visit, deductible does not apply; $35 copay / office visit, deductible does not apply; other services 30% coinsurance | 30% coinsurance | Copayment applies to each preferred or participating 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 24 / year, subject to coinsurance, deductible does not apply for preferred and participating providers. |
| | Specialist visit | $20 copay / visit, deductible does not apply; other services 10% coinsurance | $35 copay / visit, deductible does not apply; other services 30% coinsurance | 30% coinsurance | |
| | Preventive care/screening/ immunization | No charge | No charge | 30% coinsurance | 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. |
| If you have a test | Diagnostic test (x-ray, blood work) | No charge for the first $600 / year, then 10% coinsurance | No charge for the first $600 / year, then 30% coinsurance | No charge for the first $600 / year, then 30% coinsurance | No charge for the first $600 / year for all upfront outpatient diagnostic tests and imaging combined. Once the limit has been met and for all inpatient services, services are covered at the coinsurance specified, after deductible. |
| | Imaging (CT/PET scans, MRIs) | No charge for the first $600 / year, then 10% coinsurance | No charge for the first $600 / year, then 30% coinsurance | No charge for the first $600 / year, then 30% coinsurance | |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Preferred Network Provider (You pay the least) | Participating Network Provider (You pay more) | Nonparticipating Provider (You pay the most) | |
| If you need drugs to treat your illness or condition<br>More information about prescription drug coverage is available at regence.com/go/WW/4tier. | Generic drugs | $10 copay / retail prescription<br>$20 copay / mail order prescription<br>No charge for self-administrable cancer chemotherapy drugs. | | | 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.<br>No charge for FDA-approved women's contraceptives prescribed by a health care provider and certain preventive drugs and immunizations at a participating pharmacy. No charge for certain tobacco use cessation drugs when obtained with a prescription order at a participating pharmacy.<br>Coverage includes compound medications at 50% coinsurance, refer to your plan for further information.<br>You are responsible for the difference in cost between a dispensed preferred or brand-name drug and the equivalent generic drug, in addition to the copayment and/or coinsurance.<br>For specialty drugs, the first fill is allowed at a retail pharmacy. Additional fills must be provided at a specialty pharmacy. |
| | Preferred brand drugs | $30 copay / retail prescription<br>$60 copay / mail order prescription<br>No charge for self-administrable cancer chemotherapy drugs. | | | |
| | Brand drugs | $50 copay / retail prescription<br>$100 copay / mail order prescription<br>No charge for self-administrable cancer chemotherapy drugs. | | | |
| | Specialty drugs | 50% coinsurance / specialty drug prescription<br>No charge for self-administrable cancer chemotherapy drugs. | | | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 5% coinsurance for ambulatory surgery centers; 10% coinsurance for all others | 30% coinsurance | 30% coinsurance | None |
| | Physician/surgeon fees | 5% coinsurance for ambulatory surgery center physicians; 10% coinsurance for all others | 30% coinsurance | 30% coinsurance | None |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Preferred Network Provider (You pay the least) | Participating Network Provider (You pay more) | Nonparticipating Provider (You pay the most) | |
| If you need immediate medical attention | Emergency room care | 10% coinsurance after $200 copay / visit | 10% coinsurance after $200 copay / visit | 10% coinsurance after $200 copay / visit | Copayment applies to the facility charge for each visit (waived if admitted). |
| | Emergency medical transportation | 10% coinsurance | 10% coinsurance | 10% coinsurance | Includes licensed ground and air ambulance providers. |
| | Urgent care | Covered the same as If you visit a health care provider's office or clinic or If you have a test above. | | | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 10% coinsurance | 30% coinsurance | 30% coinsurance | None |
| | Physician/surgeon fees | 10% coinsurance | 30% coinsurance | 30% coinsurance | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | $20 copay / visit, 10% coinsurance for other services, deductible does not apply for outpatient office/psycho-therapy visits | $20 copay / visit, 10% coinsurance for other services, deductible does not apply for outpatient office/psycho-therapy visits | 30% coinsurance | Copayment applies to each preferred and participating provider outpatient office/psychotherapy visit only. All other outpatient services are covered at the coinsurance specified, after deductible. |
| | Inpatient services | 10% coinsurance | 10% coinsurance | 30% coinsurance | None |
| If you are pregnant | Office visits | 10% coinsurance | 30% coinsurance | 30% coinsurance | 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). |
| | Childbirth/delivery professional services | 10% coinsurance | 30% coinsurance | 30% coinsurance | |
| | Childbirth/delivery facility services | 10% coinsurance | 30% coinsurance | 30% coinsurance | |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Preferred Network Provider (You pay the least) | Participating Network Provider (You pay more) | Nonparticipating Provider (You pay the most) | |
| If you need help recovering or have other special health needs | Home health care | 10% coinsurance | 30% coinsurance | 30% coinsurance | Limited to 130 visits / year. |
| | Rehabilitation services | 10% coinsurance, deductible does not apply for outpatient services | 30% coinsurance, deductible does not apply for outpatient services | 30% coinsurance | Inpatient limited to 30 days / year. Outpatient limited to 25 visits / year. Includes physical therapy, occupational therapy and speech therapy services. |
| | Habilitation services | 10% coinsurance, deductible does not apply for outpatient therapy services | 30% coinsurance, deductible does not apply for outpatient therapy services | 30% coinsurance | Outpatient neurodevelopment therapy limited to 25 visits / year. Includes physical therapy, occupational therapy and speech therapy services. |
| | Skilled nursing care | 10% coinsurance | 30% coinsurance | 30% coinsurance | Limited to 60 inpatient days / year. |
| | Durable medical equipment | 10% coinsurance | 30% coinsurance | 30% coinsurance | None |
| | Hospice services | 10% coinsurance | 30% coinsurance | 30% coinsurance | Respite care limited to 14 days / lifetime. |
| If your child needs dental or eye care | Children's eye exam | Not covered | Not covered | Not covered | None |
| | Children's glasses | Not covered | Not covered | Not covered | None |
| | Children's dental check-up | Not covered | Not covered | Not covered | None |

## Excluded Services & Other Covered Services:

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

- Bariatric surgery
- Cosmetic surgery, except congenital anomalies
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs, except as covered under preventive care

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

- Acupuncture
- Chiropractic care
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1 (877) 267-2323 x61565 or cciio.cms.gov or your state insurance department. You may also contact the plan at 1 (888) 370-6156. 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) 370-6156. 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 (888) 370-6156.

*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 | $500 |
| 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 | $12,800 |

In this example, Peg would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $500 |
| Copayments | $33 |
| Coinsurance | $1,111 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| The total Peg would pay is | $1,704 |

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

| | |
|---|---|
| The plan's overall deductible | $500 |
| 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 | $7,400 |

In this example, Joe would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $1,584 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $255 |
| The total Joe would pay is | $1,839 |

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

| | |
|---|---|
| The plan's overall deductible | $500 |
| 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 | $1,925 |

In this example, Mia would pay:

| *Cost Sharing* | |
|---|---|
| Deductibles | $500 |
| Copayments | $220 |
| Coinsurance | $109 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| The total Mia would pay is | $829 |

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