The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to https://regence.com or call 1 (866) 240-9580. 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 (866) 240-9580 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $300 individual / $600 family per plan year. Out-of-network: $1,000 individual / $2,000 family per plan year.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Certain preventive care and those services listed below as "deductible does not apply" 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?	Yes. $75 individual / $225 family per plan year for prescription drug coverage. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	In-network: $3,200 individual / $6,500 family per plan year. Out-of-network: $5,000 individual / $10,000 family per plan 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-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See https://regence.com/go/UT/PVCU or call 1 (866) 240-9580 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$12 copay / office visit, deductible does not apply; $12 copay / retail clinic visit, deductible does not apply; $12 copay / expanded office services, deductible does not apply; 0% coinsurance for all other services	40% coinsurance	Copayment applies to each in-network office, expanded office services and retail clinic visit only. Expanded office services include medical/surgical services and therapeutic injections. All other services are covered at the coinsurance specified, after deductible.
	Specialist visit	$17 copay / office visit, deductible does not apply; $17 copay / expanded office services, deductible does not apply; 0% coinsurance for all other services	40% coinsurance	
	Preventive care/screening/ immunization	No charge	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	$25 copay / per visit	40% coinsurance after $25 copay / per visit	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://regence.com/go/2022/UT/6tierLG	Preferred generic drugs & generic drugs	$3.50 copay / preferred retail and mail order prescription $3.50 copay / retail and mail order prescription 20% coinsurance for diabetic supplies		Prescription drugs not on the Drug List are not covered, unless an exception is approved. Deductible does not apply for generic (including preferred) drugs, mail order drugs or self-administrable cancer chemotherapy drugs. Out-of-pocket limit: $2,000 per individual / $6,000 family per year. 90-day supply / retail prescription (1 copayment per 90-day supply for generic drugs / 1 copayment per 30-day supply for brand and specialty drugs) 90-day supply / mail order prescription 30-day supply / specialty drug retail prescription or self-administrable cancer chemotherapy drugs Coverage includes compound medications at 50% coinsurance, refer to your plan for further information. Cost shares for preferred brand insulin will not exceed $28 / 30-day supply retail prescription or $84 / 90-day supply mail order prescription, whether or not any applicable deductible has been met. Specialty drugs are not available through mail order. No charge for certain preventive drugs, women's contraceptives and immunizations at a participating pharmacy. The first fill of specialty drugs may be provided at a retail pharmacy; additional refills must be provided by a specialty pharmacy. Medications used as part of an outpatient cancer drug treatment regimen that is provided and dispensed in a professional setting will be subject to these prescription benefits. You are responsible for the difference in cost between a dispensed brand-name drug and the equivalent generic drug, in addition to the copayment and/or coinsurance.
	Preferred brand drugs	12.5% coinsurance up to $75 copay maximum / retail prescription 12.5% coinsurance up to $150 copay maximum / mail order prescription 0% coinsurance for diabetic supplies		
	Brand drugs	15% coinsurance up to $87.50 copay maximum / retail prescription 15% coinsurance up to $175 copay maximum / mail order prescription 0% coinsurance for diabetic supplies		
	Preferred specialty drugs & specialty drugs	5% coinsurance up to $125 copay maximum / preferred retail prescription 7.5% coinsurance up to $150 copay maximum / retail prescription		

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	40% coinsurance	None
	Physician/surgeon fees	0% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	0% coinsurance	0% coinsurance	In-network deductible applies to in-network and out-of-network services.
	Emergency medical transportation	0% coinsurance	0% coinsurance	
	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)	0% coinsurance	40% coinsurance	None
	Physician/surgeon fees	0% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$12 copay / office visit, deductible does not apply; 0% coinsurance for all other services	40% coinsurance	Copayment applies to each in-network office/psychotherapy visit only. All other services are covered at the coinsurance specified, after deductible.
	Inpatient services	0% coinsurance	40% coinsurance	None
If you are pregnant	Office visits	0% coinsurance	40% coinsurance	Adoption coverage is paid at the in-network benefit, limited to $3,000 / pregnancy. The adoption indemnity benefit is not exchangeable for infertility treatment benefits. 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).
	Childbirth/delivery professional services	0% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	0% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	$12 copay / visit, deductible does not apply	40% coinsurance	Copayment applies to each in-network outpatient visit only.
	Rehabilitation services	$12 copay / visit, deductible does not apply for outpatient services; 0% coinsurance for inpatient services	40% coinsurance	60 inpatient days / year 30 outpatient visits / year combined with neurodevelopmental visit limit Copayment applies to each in-network outpatient visit only. Includes physical therapy, occupational therapy and speech therapy.
	Habilitation services	$12 copay / visit, deductible does not apply	40% coinsurance	30 neurodevelopmental visits / year combined with outpatient rehabilitation visit limit Neurodevelopmental therapy limited to individuals under age 19. Includes physical therapy, occupational therapy and speech therapy.
	Skilled nursing care	0% coinsurance	40% coinsurance	60 inpatient days / year
	Durable medical equipment	0% coinsurance	40% coinsurance	None
	Hospice services	No charge	40% coinsurance	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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, incest or to avert the death of the Member) • Acupuncture • Bariatric surgery	• Cosmetic surgery, except congenital anomalies • Dental care • Long-term care • Private-duty nursing	• Routine eye care • Routine foot care • Vision hardware • Weight loss programs

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 • Hearing aids	• Infertility treatment	• 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 ext. 61565 or cciio.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) 957-9200 or the toll-free message line at 1 (800) 439-3805; by writing to the Utah Department of Insurance, 4315 S 2700 W, Suite 2300, Taylorsville, UT 84129; 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**
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:
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo 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.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$300**
Specialist copayment	**$17**
Hospital (facility) coinsurance	**0%**
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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$300
Copayments	$237
Coinsurance	$2,156
What isn't covered	
Limits or exclusions	$61
The total Peg would pay is	**$2,754**

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

The plan's overall deductible	**$300**
Specialist copayment	**$17**
Hospital (facility) coinsurance	**0%**
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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$300
Copayments	$267
Coinsurance	$505
What isn't covered	
Limits or exclusions	$178
The total Joe would pay is	**$1,250**

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

The plan's overall deductible	**$300**
Specialist copayment	**$17**
Hospital (facility) coinsurance	**0%**
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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Copayments	$153
Coinsurance	$355
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$788**

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).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 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, maaari 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。

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 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 sluhom: 711)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-888-344-6347 (TTY: 711)។

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-344-6347 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

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

ማስታወሻ:- የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፤ በሚከተለው ቁጥር ይደውሉ 1-888-344-6347 (መስማት ለተሳናቸው:- 711)።

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-344-6347 (телетайп: 711)

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-888-344-6347 (टिटिवाइ: 711

ATENȚIE: Dacă vorbiți limba 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 ballooji-ma to ekkitaaki wolde caahu. Noddu 1-888-344-6347 (TTY: 711)

โปรดทราบ: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-344-6347 (TTY: 711)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-344-6347 (TTY: 711)

Afaan dubbattan Oroomiffaa tiif, tajaajila gargaarsa afaanii tola ni jira. 1-888-344-6347 (TTY: 711) tiin bilbilaa.

توجه: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-344-6347 (TTY: 711) تماس بگیرید.

ملحوظة: إذا كنت تتحدث فاذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-344-6347 (رقم هاتف الصم والبكم TTY: 711)