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?	$200 individual / $400 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 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: $2,500 individual / $5,000 family per calendar year. Out-of-network: Not Applicable.	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/WW/Preferred 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	$10 copay and 10% coinsurance / office visit; 10% coinsurance for all other services	$20 copay and 20% coinsurance / office visit; 20% coinsurance for all other services	Copayment for office visits applies first, then deductible and coinsurance. All other services are covered at the coinsurance specified, after deductible.
	Specialist visit	$10 copay and 10% coinsurance / office visit; 10% coinsurance for all other services	$20 copay and 20% coinsurance / office visit; 20% coinsurance for all other services	
	Preventive care/screening/ immunization	No charge	20% 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)	10% coinsurance	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	20% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.Express-Scripts.com	Generic drugs (Tier 1)	$7 copay / retail prescription $14 copay / home delivery prescription	Reimbursed at 100% of "average wholesale price" less appropriate copay	Prescription Drug Benefits are administered by Express Scripts. Express Scripts does not provide BlueCross and/or BlueShield services and is a separate company solely responsible for its products/services. Covers up to a 30-day supply (retail prescription); up to a 90-day supply (home delivery prescription) Preauthorization required for specialty drugs.
	Preferred brand drugs (Tier 2)	$15 copay / retail prescription $30 copay / home delivery prescription	Reimbursed at 100% of "average wholesale price" less appropriate copay	
	Non-preferred brand drugs (Tier 3)	$30 copay / retail prescription $60 copay / home delivery prescription	Reimbursed at 100% of "average wholesale price" less appropriate copay	
	Specialty drugs (Tier 4)	Refer to tier 1, tier 2 and tier 3 drugs above.	Not covered	

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)	10% coinsurance	20% coinsurance	None
	Physician/surgeon fees	10% coinsurance	20% coinsurance	None
If you need immediate medical attention	Emergency room care	10% coinsurance after $50 copay / visit	10% coinsurance after $50 copay / visit	Copayment applies to facility charge for each visit (waived if admitted), whether or not the deductible has been met.
	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	20% coinsurance after $200 copay	Copayment applies to each out-of-network provider inpatient admission, whether or not the deductible has been met.
	Physician/surgeon fees	10% coinsurance	20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 copay and 10% coinsurance / office visit; 10% coinsurance for all other services	$20 copay and 20% coinsurance / office visit; 20% coinsurance for all other services	Copayment for each mental health/behavioral health office/psychotherapy visit applies first, then deductible and coinsurance. Substance abuse services and all other services are covered at the coinsurance specified, after deductible.
	Inpatient services	10% coinsurance	20% coinsurance after $200 copay	Copayment applies to each out-of-network provider inpatient admission, whether or not the deductible has been met.
If you are pregnant	Office visits	10% coinsurance	20% coinsurance	Copayment applies to each out-of-network provider inpatient admission, whether or not the deductible has been met. 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). Maternity services for children, including complications of pregnancy, are not covered.
	Childbirth/delivery professional services	10% coinsurance	20% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	20% coinsurance after $200 copay	

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	0% coinsurance	0% coinsurance	30 visits / year
	Rehabilitation services	10% coinsurance	20% coinsurance after $200 copay / inpatient services; 20% coinsurance / outpatient services	30 inpatient days / year 60 outpatient visits / year (combined with habilitation) Copayment applies to each out-of-network provider inpatient admission, whether or not the deductible has been met. Includes physical therapy, occupational therapy and speech therapy.
	Habilitation services	10% coinsurance	20% coinsurance	60 professional neurodevelopmental visits / year (combined with outpatient rehabilitation) Includes physical therapy, occupational therapy and speech therapy.
	Skilled nursing care	10% coinsurance	20% coinsurance	60 inpatient days / year
	Durable medical equipment	10% coinsurance	20% coinsurance	$550 limit / year for wigs
	Hospice services	No charge	No charge	14 respite inpatient or outpatient days / lifetime
If your child needs dental or eye care	Children's eye exam	Services provided by Vision Service Plan. See www.vsp.com.	Services provided by Vision Service Plan. See www.vsp.com.	Vision Service Plan does not provide BlueCross and/or BlueShield services and is a separate company solely responsible for its products/services.
	Children's glasses	Services provided by Vision Service Plan. See www.vsp.com.	Services provided by Vision Service Plan. See www.vsp.com.	Vision Service Plan does not provide BlueCross and/or BlueShield services and is a separate company solely responsible for its products/services.
	Children's dental check-up	Services provided by Delta Dental of Washington. See www.deltadentalwa.com.	Services provided by Delta Dental of Washington. See www.deltadentalwa.com.	Delta Dental of Washington does not provide BlueCross and/or BlueShield services and is a separate company solely responsible for its products/services.

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.)

- Cosmetic surgery, except congenital anomalies
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care, except for diabetic patients
- Weight loss programs

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

- Abortion, except for services for dependent children
- Acupuncture
- Bariatric surgery, in-network providers only
- Chiropractic care
- Hearing aids
- 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 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 (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	**$200**
Specialist copayment	**$10**
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:

Cost Sharing	
Deductibles	$200
Copayments	$11
Coinsurance	$1,202
What isn't covered	
Limits or exclusions	$61
The total Peg would pay is	**$1,474**

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	**$10**
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:

Cost Sharing	
Deductibles	$200
Copayments	$376
Coinsurance	$140
What isn't covered	
Limits or exclusions	$178
The total Joe would pay is	**$894**

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

The plan's overall deductible	**$200**
Specialist copayment	**$10**
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:

Cost Sharing	
Deductibles	$200
Copayments	$85
Coinsurance	$251
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$536**

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