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, call (833)-389-0027. 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 www.healthcare.gov/sbc-glossary or call (833) 389-0027 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**In-Network:** $800 Individual/$1,600 Family **Out-of-Network:** $2,400 Individual/$4,800 Family	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, Prescription Drugs from In-Network pharmacies, Office Visits from In-Network providers, and ACA-mandated preventive care from In-Network providers are covered before you meet your deductibles.	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 https://www.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:** $2,000 Individual/$4,000 Family **Out-of-Network:** $6,000 Individual/$12,000 Family	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, penalties, and payments for health care services 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. To find a network medical provider, see www.regence.com or call (866) 240-9580. To find a network pharmacy, see www.optumrx.com or call (844) 368-0083.	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
		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	$20 copay per office visit, Deductible does not apply 20% coinsurance for all other services	40% coinsurance	Copayment applies to each in-network office visit only. All other services are covered at the coinsurance specified, after deductible. In-network acupuncture, spinal manipulation and massage therapy services are limited to 36 combined visits per year and subject to $40 copayment per visit, deductible does not apply; out-of-network subject to the coinsurance specified, after deductible.
	Specialist visit	$40 copay per office visit, Deductible does not apply 20% 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)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com	Generic drugs	0-30-day supply – No Charge 31-90-day supply – No Charge	40% coinsurance	Only maintenance drugs eligible for 90-day supply. Two 30-day grace fills for maintenance drugs are allowed, after which you need to obtain a 90-day supply or there will be no coverage. Brand name drugs with a generic available - brand co-payment plus the difference in cost between brand and generic except if prescribed "dispense as written". Specialty drugs must be obtained through OptumRx's exclusive specialty pharmacy network. Clinical management applies to some drugs.
	Preferred brand drugs	0-30-day supply - $30 copayment per prescription 31-90-day supply – $60 copayment per prescription	40% coinsurance	
	Non-preferred brand drugs	0-30-day supply - $80 copayment per prescription 31-90-day supply – $160 copayment per prescription	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Specialty drugs	0-30-day supply - $100 copayment per prescription 31-90-day supply – Not Covered	Not Covered	For questions about prescription drug coverage, call OptumRx at (844) 368-0083.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Some services require preauthorization. To obtain preauthorization, call Regence at (866) 240-9580.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	20% coinsurance after $160 copay per visit	20% coinsurance after $160 copay per visit	Copayment applies to facility charge for each visit (waived if admitted), whether or not the deductible has been met.
	Emergency medical transportation	20% coinsurance	40% coinsurance	None
	Urgent care	$60 copay per office visit, Deductible does not apply 20% coinsurance for all other services	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Requires preauthorization. To obtain preauthorization, call Regence at (866) 240-9580.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay per office visit, Deductible does not apply 20% 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	20% coinsurance	40% coinsurance	Requires preauthorization. To obtain preauthorization, call Regence at (866) 240-9580.
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	$20 copay for in-network office visit confirming pregnancy. Afterwards, all in-network services (prenatal care, delivery, and postpartum care) are subject to the deductible and coinsurance. 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 facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Limited to 130 visits per year. Requires preauthorization. To obtain preauthorization, call Regence at (866) 240-9580.
	Rehabilitation services	$40 copay per outpatient visit, Deductible does not apply 20% coinsurance for inpatient services	40% coinsurance	Copayment applies to each in-network visit only. 40 outpatient combined visits per year for physical therapy, occupational therapy, and speech therapy. Inpatient services limited to 30 days per year.
	Habilitation services	$40 copay per visit, Deductible does not apply	40% coinsurance	Copayment applies to each in-network visit only. 40 neurodevelopmental visits per year for physical therapy, occupational therapy, and speech therapy combined Neurodevelopmental therapy limited to individuals under age 18.
	Skilled nursing care	20% coinsurance	40% coinsurance	Limited to 60 inpatient days per year. Requires preauthorization. To obtain preauthorization, call Regence at (866) 240-9580.
	Durable medical equipment	20% coinsurance	40% coinsurance	None
	Hospice services	20% coinsurance	40% coinsurance	14 respite inpatient or outpatient days / lifetime
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:

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
- Dental Care (Adult)
- Gene therapy and adoptive cellular therapy treatment and drugs
- Long-term care
- Non-emergency care when traveling outside of the U.S.
- Private-duty nursing
- Routine eye care (Adult)

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

- Acupuncture (visit limits apply)
- Bariatric surgery (limitations apply)
- Chiropractic care, spinal manipulations only (visit limits apply)
- Hearing aids (limitations apply)
- Infertility treatment (limitations apply)
- Routine Foot Care
- Weight Loss Programs (limitations apply)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the Administrative Office at (833)389-0027. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 www.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 Administrative Office at (833)-389-0027 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 (833) 389-0027.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (833) 389-0027.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码(833) 389-0027.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (833) 389-0027.

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** **$800**
- **Specialist *copay*** **$40**
- **Hospital (facility) *coinsurance*** **20%**
- **Other *coinsurance*** **20%**

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	$800
Copayments	$0
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,060**

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

- **The plan's overall deductible** **$800**
- **Specialist *copay*** **$40**
- **Hospital (facility) *coinsurance*** **20%**
- **Other *coinsurance*** **20%**

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	$800
Copayments	$1,200
Coinsurance	$10
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,020**

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

- **The plan's overall deductible** **$800**
- **Specialist *copay*** **$40**
- **Hospital (facility) *coinsurance*** **20%**
- **Other *coinsurance*** **20%**

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	$800
Copayments	$460
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,460**

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