




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/go/2020/booklet/WW/RegenceClassic51-100 or call 1 (888) 367-2112. 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) 367-2112 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$2,000 individual / \$6,000 family per calendar year.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> . This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at healthcare.gov/coverage/preventive-care-benefits .
Are there services covered before you meet your <u>deductible</u> ?	Yes. Certain <u>preventive care</u> and those services listed below as " <u>deductible does not apply</u> " or as "No charge."	
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$5,500 individual / \$11,000 family per calendar year.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billed</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See regence.com/go/WW/Preferred or call 1 (888) 367-2112 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay the least if you use an <u>in-network provider</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from an <u>out-of-network provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>in-network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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	\$30 <u>copay</u> / office visit, <u>deductible</u> does not apply; \$20 <u>copay</u> / retail clinic visit, <u>deductible</u> does not apply; 20% <u>coinsurance</u> for all other services	40% <u>coinsurance</u>	<p><u>Copayment</u> applies to each in-<u>network</u> office and retail clinic visit only. All other services are covered at the <u>coinsurance</u> specified, after <u>deductible</u>.</p> <p>In-<u>network</u> acupuncture services are subject to \$30 <u>copay</u>, <u>deductible</u> does not apply; out-of-network subject to the <u>coinsurance</u> specified, after <u>deductible</u>. Acupuncture services are limited to 12 visits / year.</p> <p>In-<u>network</u> spinal manipulations are subject to \$30 <u>copay</u>, <u>deductible</u> does not apply; out-of-network subject to the <u>coinsurance</u> specified, after <u>deductible</u>. Spinal manipulations are limited to 12 / year.</p> <p><u>Coinsurance</u> and <u>deductible</u> do not apply for childhood immunizations from <u>out-of-network providers</u>. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.</p>
	Specialist visit	\$30 <u>copay</u> / office visit, <u>deductible</u> does not apply; 20% <u>coinsurance</u> for all other services	40% <u>coinsurance</u>	
	Preventive care/screening/immunization	No charge	40% <u>coinsurance</u>	
If you have a test	Diagnostic test (x-ray, blood work)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	

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 regence.com/go/druglist/2020/WW/6tierLG .	Preferred generic drugs & generic drugs	\$10 <u>copay</u> / preferred generic retail prescription \$30 <u>copay</u> / preferred generic mail order prescription 25% <u>coinsurance</u> / generic retail prescription 25% <u>coinsurance</u> / generic mail order prescription No charge for self-administrable cancer chemotherapy drugs.		<u>Deductible</u> does not apply. Limited to a 90-day supply retail (1 <u>copay</u> per 30-day supply), 90-day supply mail order or 30-day supply of <u>specialty drugs</u> (including preferred). No charge for certain FDA-approved contraceptives and certain preventive drugs and immunizations at a participating pharmacy. Coverage includes compound medications at 50% <u>coinsurance</u> , refer to your <u>plan</u> for further information. You are responsible for the difference in cost between a dispensed brand-name drug and the equivalent generic drug, in addition to the <u>copayment</u> and/or <u>coinsurance</u> . For <u>specialty drugs</u> (including preferred), the first fill is allowed at a retail pharmacy. Additional fills must be provided at a specialty pharmacy.
	Preferred brand drugs	\$35 <u>copay</u> / retail prescription \$105 <u>copay</u> / mail order prescription No charge for self-administrable cancer chemotherapy drugs.		
	Brand drugs	\$75 <u>copay</u> / retail prescription \$225 <u>copay</u> / mail order prescription No charge for self-administrable cancer chemotherapy drugs.		
	Preferred <u>specialty drugs</u> & <u>specialty drugs</u>	\$150 <u>copay</u> / preferred <u>specialty drugs</u> 50% <u>coinsurance</u> / <u>specialty drugs</u> No charge for self-administrable cancer chemotherapy drugs.		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u> for ambulatory surgery centers 20% <u>coinsurance</u> for all others	40% <u>coinsurance</u>	None
	Physician/surgeon fees	10% <u>coinsurance</u> for ambulatory surgery center physicians 20% <u>coinsurance</u> for all others	40% <u>coinsurance</u>	None

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 immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u> after \$100 <u>copay</u> / visit	20% <u>coinsurance</u> after \$100 <u>copay</u> / visit	<u>Copayment</u> applies to the facility charge for each visit (waived if admitted).
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Includes licensed ground and air ambulance providers.
	<u>Urgent care</u>	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)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 <u>copay</u> / office visit, <u>deductible</u> does not apply; 20% <u>coinsurance</u> for all other services	40% <u>coinsurance</u>	<u>Copayment</u> applies to each in-network provider outpatient office/psychotherapy visit only. All other outpatient services are covered at the <u>coinsurance</u> specified, after <u>deductible</u> .
	Inpatient services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you are pregnant	Office visits	20% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	

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	<u>Home health care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 130 visits / year.
	<u>Rehabilitation services</u>	Inpatient: 20% <u>coinsurance</u> Outpatient: \$30 <u>copay</u> / visit, <u>deductible</u> does not apply	40% <u>coinsurance</u>	Inpatient limited to 30 days / year. Outpatient limited to 25 visits / year. Includes physical therapy, occupational therapy and speech therapy services.
	<u>Habilitation services</u>	Inpatient: 20% <u>coinsurance</u> Outpatient: \$30 <u>copay</u> / visit, <u>deductible</u> does not apply	40% <u>coinsurance</u>	Outpatient neurodevelopmental therapy limited to 25 visits / year. Includes physical therapy, occupational therapy and speech therapy services.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Limited to 60 inpatient days / year.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	<u>Hospice services</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	Respite care limited to 14 days / lifetime.
	If your child needs dental or eye care	Children's eye exam	Not covered	Not covered
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.)

- 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 ccio.cms.gov or your state insurance department. You may also contact the plan at 1 (888) 367-2112. 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) 367-2112. 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) 367-2112.

————— *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	\$2,000
■ Specialist copayment	\$30
■ 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	\$12,800
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In this example, Peg would pay:

Cost Sharing

Deductibles	\$2,000
Copayments	\$33
Coinsurance	\$2,043

What isn't covered

Limits or exclusions	\$60
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The total Peg would pay is	\$4,136
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Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$2,000
■ Specialist copayment	\$30
■ 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	\$7,400
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In this example, Joe would pay:

Cost Sharing

Deductibles	\$102
Copayments	\$1,819
Coinsurance	\$0

What isn't covered

Limits or exclusions	\$255
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The total Joe would pay is	\$2,176
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Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$2,000
■ Specialist copayment	\$30
■ 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	\$1,925
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In this example, Mia would pay:

Cost Sharing

Deductibles	\$1,536
Copayments	\$250
Coinsurance	\$0

What isn't covered

Limits or exclusions	\$0
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The total Mia would pay is	\$1,786
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The plan would be responsible for the other costs of these EXAMPLE covered services.