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 (800) 752-9985. 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 (800) 752-9985 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$250 individual / $750 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?	$3,000 individual / $6,000 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-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 (800) 752-9985 for a list of network providers.	You pay the least if you use a provider in the preferred network. You 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 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 Provider (You pay the least)	Participating 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	10% coinsurance	30% coinsurance	30% coinsurance	Coverage includes primary care visits at a retail clinic. Deductible does not apply to the first 4 preferred or participating office/retail clinic visits / year (combined limit includes mental health/substance abuse psychotherapy visits). 20 acupuncture visits / year 20 spinal manipulations / year
	Specialist visit	10% coinsurance	30% coinsurance	30% coinsurance	
	Preventive care/screening/ immunization	No charge	No charge	30% coinsurance	No charge 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)	10% coinsurance	30% coinsurance	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	30% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://regence.com/go/2022/WW/4tier	Generic drugs	$5 copay / retail prescription $10 copay / mail order prescription			Prescription drugs not on the Drug List are not covered, unless an exception is approved. Deductible does not apply. 30-day supply / retail prescription (for oral contraceptives, a maximum of 3 prepackaged monthly cycles may be purchased at one time for 1 copay per 30-day supply) 90-day supply / mail order prescription 30-day supply / specialty drug prescription Specialty drugs are not available through mail order. Cost shares for insulin will not exceed $100 / 30-day supply retail prescription or $300 / 90-day supply mail order prescription. No charge for certain preventive drugs, contraceptives and immunizations at a
	Preferred brand drugs	$25 copay / retail prescription $50 copay / mail order prescription			
	Brand drugs	$50 copay / retail prescription $100 copay / mail order prescription			
	Specialty drugs	$100 copay / prescription			

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You pay the least)	Participating Provider (You pay more)	Nonparticipating Provider (You pay the most)	
					participating pharmacy, or for self-administrable cancer chemotherapy drugs. The first fill of specialty drugs may be provided by a retail pharmacy; additional refills must be provided by a specialty pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	30% coinsurance	None
	Physician/surgeon fees	10% coinsurance	30% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care	10% coinsurance after $75 copay / visit	10% coinsurance after $75 copay / visit	10% coinsurance after $75 copay / 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	20% coinsurance	20% 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	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	10% coinsurance	10% coinsurance	30% coinsurance	Deductible does not apply to the first 4 preferred or participating mental health/substance abuse psychotherapy visits / year (combined limit includes office/retail clinic visits).
	Inpatient services	10% coinsurance	10% coinsurance	30% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You pay the least)	Participating Provider (You pay more)	Nonparticipating Provider (You pay the most)	
If you are pregnant	Office visits	10% coinsurance	30% coinsurance	30% 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 professional services	10% coinsurance	30% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	10% coinsurance	10% coinsurance	130 visits / year
	Rehabilitation services	10% coinsurance	30% coinsurance	30% coinsurance	15 inpatient days / year 99 outpatient visits / year Includes physical therapy, occupational therapy and speech therapy.
	Habilitation services	10% coinsurance	30% coinsurance	30% coinsurance	60 professional neurodevelopmental visits / year Includes physical therapy, occupational therapy and speech therapy.
	Skilled nursing care	10% coinsurance	30% coinsurance	30% coinsurance	90 inpatient days / year
	Durable medical equipment	10% coinsurance	30% coinsurance	30% coinsurance	None
	Hospice services	10% coinsurance	10% coinsurance	10% coinsurance	14 respite inpatient or outpatient 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)
- 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
- Acupuncture
- Chiropractic care
- 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 (800) 752-9985. 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 (800) 752-9985 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.

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 (800) 752-9985.

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	**$250**
Specialist coinsurance	**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	$250
Copayments	$9
Coinsurance	$1,197
What isn't covered	
Limits or exclusions	$61
The total Peg would pay is	**$1,517**

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

The plan's overall deductible	**$250**
Specialist coinsurance	**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	$250
Copayments	$436
Coinsurance	$141
What isn't covered	
Limits or exclusions	$178
The total Joe would pay is	**$1,005**

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

The plan's overall deductible	**$250**
Specialist coinsurance	**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	$250
Copayments	$80
Coinsurance	$316
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$646**

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