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/Platinum250 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 deductible?	In-network: $250 individual / $500 family per calendar year. Out-of-network: $3,000 individual / $6,000 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: $4,000 individual / $8,000 family per calendar year. Out-of-network: $10,000 individual / $20,000 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-billed 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 regence.com/go/WW/Preferred or call 1 (888) 367-2112 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	$20 copay / office visit $20 copay / office visit at a retail clinic Deductible does not apply for these visits 10% coinsurance for all other services	50% coinsurance	Coverage includes primary care visits at a retail clinic. In-network acupuncture and spinal manipulations are subject to $20 copay / visit, deductible does not apply. Acupuncture services are limited to 12 visits / year. Spinal manipulations are limited to 10 / year.
	Specialist visit	$30 copay / visit Deductible does not apply for these visits 10% coinsurance for all other services	50% coinsurance	
	Preventive care/screening/ immunization	No charge	50% 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)	No charge	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	50% 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 drugs to treat your illness or condition More information about prescription drug coverage is available at regence.com/go/druglist/2020/WW/6tier.	Preferred generic drugs & generic drugs	$8 copay* / preferred generic retail prescription $16 copay / preferred generic mail order prescription 25% coinsurance* / generic retail prescription 20% coinsurance / generic mail order prescription		No coverage for prescription drugs not on the Drug List or prescription drugs from an out-of-network pharmacy. Limited to a 90-day supply retail (1 copay per 30-day supply), mail order and self-injectable drugs. Limited to a 30-day supply specialty drugs (including preferred) and self-administrable cancer chemotherapy drugs. Deductible does not apply for all prescription drugs. No charge for FDA-approved women's contraceptives prescribed by a health care provider and for certain preventive drugs and immunizations at a participating pharmacy. The first fill for specialty drugs (including preferred) may be provided at a retail pharmacy, additional fills and fills for specialty self-administrable cancer chemotherapy drugs must be provided at a specialty pharmacy. Coverage for self-administrable cancer chemotherapy drugs is subject to 10% coinsurance. *$5 copayment or 5% coinsurance discount when filled at a preferred retail pharmacy.
	Preferred brand drugs	$30 copay* / retail prescription $60 copay / mail order prescription		
	Brand drugs	50% coinsurance* / retail prescription 45% coinsurance / mail order prescription		
	Preferred specialty drugs & specialty drugs	20% coinsurance / preferred specialty drugs 50% coinsurance / specialty drugs		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	5% coinsurance for ambulatory surgery centers; 10% coinsurance for all other facilities	50% coinsurance	None
	Physician/surgeon fees	5% coinsurance for ambulatory surgery center physicians; 10% coinsurance for all other physicians	50% coinsurance	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	Emergency room care	10% coinsurance after $250 copay / visit	10% coinsurance after $250 copay / visit	Copayment applies to the facility charge for each visit (waived if admitted), whether or not the in-network deductible has been met.
	Emergency medical transportation	10% coinsurance	10% coinsurance	In-network deductible applies to in-network and out-of-network services.
	Urgent care	$30 copay / visit, deductible does not apply; other services 10% coinsurance	50% coinsurance	Copayment applies to each in-network urgent care visit only.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	50% coinsurance	Limited to $3,500 / day for inpatient non-emergency admissions in out-of-network facilities.
	Physician/surgeon fees	10% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay / visit, deductible does not apply; other services 10% coinsurance	50% coinsurance	Copayment applies to each in-network office visit and psychotherapy only.
	Inpatient services	10% coinsurance	50% coinsurance	Limited to $3,500 / day for inpatient non-emergency admissions in out-of-network facilities.
If you are pregnant	Office visits	10% coinsurance	50% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, a coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Limited to $3,500 / day for inpatient non-emergency admissions in out-of-network facilities.
	Childbirth/delivery professional services	10% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	50% 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	10% coinsurance	50% coinsurance	Limited to 130 visits / year.
	Rehabilitation services	Inpatient: 10% coinsurance Outpatient: $20 copay / visit, deductible does not apply	50% coinsurance	Inpatient is limited to 30 days / year. Outpatient is limited to 25 visits / year. Copayment applies to each in-network outpatient visit only. Limited to $3,500 / day for inpatient non-emergency admissions in out-of-network facilities.
	Habilitation services	Inpatient: 10% coinsurance Outpatient: $20 copay / visit, deductible does not apply	50% coinsurance	Inpatient habilitative services is limited to 30 days / year. Outpatient habilitative services is limited to 25 visits / year. Neurodevelopmental therapy is subject to deductible and coinsurance; outpatient is limited to 25 visits / year. Limited to $3,500 / day for inpatient non-emergency admissions in out-of-network facilities.
	Skilled nursing care	10% coinsurance	50% coinsurance	Limited to 60 inpatient days / year.
	Durable medical equipment	10% coinsurance	50% coinsurance	None
	Hospice services	10% coinsurance	50% coinsurance	Limited to 14 respite days / lifetime.
If your child needs dental or eye care	Children's eye exam	No charge	50% coinsurance	Limited to 1 routine exam / year for individuals under age 19.
	Children's glasses	No charge	50% coinsurance	Limited to 1 pair of lenses (2 lenses) and 1 standard frame / year for individuals under age 19.
	Children's dental check-up	No charge	No charge	Limited to 2 cleanings and 2 preventive oral examinations / year for individuals under age 19. Additional coverage is provided for basic and major pediatric dental 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.)

- 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
- Vision hardware (Adult)
- 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.
- Termination of pregnancy

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 cciio.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 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**

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	$250
Specialist copayment	$30
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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$29
Coinsurance	$1,110
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,449**

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 copayment	$30
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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,552
Coinsurance	$0
What isn't covered	
Limits or exclusions	$255
The total Joe would pay is	**$1,807**

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

The plan's overall deductible	$250
Specialist copayment	$30
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	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$400
Coinsurance	$107
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$757**

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