**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/go/2027/booklet/WW/BronzeEssential8500Preferred 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 provider: $8,500 individual / $17,000 family per calendar year. Out-of-network provider: $10,000 individual / $20,000 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." "No charge" means $0 copayment or 0% coinsurance, regardless of deductible applicability. | 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 provider: $10,500 individual / $21,000 family per calendar year. Out-of-network provider: $15,000 individual / $30,000 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 1-888-367-2112 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 | $40 copay / upfront office visit, deductible does not apply;<br><br>30% coinsurance for other services | 50% coinsurance | 4 upfront office visits / year<br>Limit is for primary care, specialist and urgent care visits combined. Additional visits are covered at the coinsurance specified, after deductible. |
| | Specialist visit | $40 copay / upfront office visit, deductible does not apply;<br><br>30% coinsurance for other services | 50% coinsurance | |
| | Preventive care/screening/ immunization | No charge, deductible does not apply | 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) | 30% coinsurance | 50% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 30% coinsurance | 50% coinsurance | |
| **If you need drugs to treat your illness or condition**<br>More information about **prescription drug coverage** is available at https://regence.com/go/2027/WW/6tier | Preferred generic drugs | $10 copay, deductible does not apply / retail prescription;<br><br>$30 copay, deductible does not apply / home delivery prescription | Not covered | Prescription drugs not on the Drug List are not covered, unless an exception is approved.<br>No coverage for prescription drugs provided by an out-of-network pharmacy.<br>Deductible does not apply for insulin, covered diabetic supplies, or certain inhaled asthma medication and epinephrine autoinjectors.<br>90-day supply / retail prescription (your cost share is per 30-day supply)<br>90-day supply / home delivery prescription<br>30-day supply / specialty drug prescription<br>Specialty drugs are not available through home delivery.<br>Coverage includes self-administrable cancer |
| | Generic drugs | $35 copay, deductible does not apply / retail prescription;<br><br>$105 copay, deductible does not apply / home delivery prescription | 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) | |
| | Preferred brand drugs | 25% coinsurance / retail prescription;<br><br>25% coinsurance / home delivery prescription | Not covered | chemotherapy drugs at 30% coinsurance, deductible does not apply for preferred generic drugs and generic drugs.<br>Cost shares for insulin and for certain inhaled asthma medication and epinephrine autoinjectors (per 2-pack) will not exceed $35 / 30-day supply or $105 / 90-day supply.<br>No charge, deductible does not apply for certain preventive drugs, contraceptives and immunizations at a participating pharmacy.<br>If you fill a brand drug or specialty drug when there is an equivalent generic drug or specialty biosimilar drug available, you pay the difference in cost in addition to the copayment and/or coinsurance.<br>The first fill of specialty drugs may be provided by a retail pharmacy; additional refills must be provided by a specialty pharmacy. |
| | Brand drugs | 50% coinsurance / retail prescription;<br><br>50% coinsurance / home delivery prescription | Not covered | |
| | Preferred specialty drugs | 20% coinsurance / specialty drug | Not covered | |
| | Specialty drugs | 50% coinsurance / specialty drug | Not covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance for ambulatory surgery centers;<br><br>30% coinsurance for all other facilities | 50% coinsurance | None |
| | Physician/surgeon fees | 20% coinsurance for ambulatory surgery center physicians;<br><br>30% coinsurance for all other physicians | 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 immediate medical attention** | Emergency room care | 30% coinsurance | 30% coinsurance | Out-of-network provider services apply to the in-network deductible and in-network out-of-pocket limit. |
| | Emergency medical transportation | 30% coinsurance | 30% coinsurance | |
| | Urgent care | $40 copay / upfront visit, deductible does not apply;<br><br>30% coinsurance for other services | 50% coinsurance | 4 upfront visits / year<br>Limit is for primary care, specialist and urgent care visits combined. Additional visits are covered at the coinsurance specified, after deductible. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 30% coinsurance | 50% coinsurance | $4,000 / day for inpatient non-emergency admission in non-participating facilities |
| | Physician/surgeon fees | 30% coinsurance | 50% coinsurance | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 30% coinsurance | 50% coinsurance | None |
| | Inpatient services | 30% coinsurance | 50% coinsurance | $4,000 / day for inpatient non-emergency admission in non-participating facilities |
| **If you are pregnant** | Office visits | 30% coinsurance | 50% 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).<br>$4,000 / day for inpatient non-emergency admission in non-participating facilities |
| | Childbirth/delivery professional services | 30% coinsurance | 50% coinsurance | |
| | Childbirth/delivery facility services | 30% coinsurance | 50% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | 30% coinsurance | 50% coinsurance | 130 visits / year |
| | Rehabilitation services | 30% coinsurance | 50% coinsurance | 30 inpatient days / year<br>25 outpatient visits / year<br>Includes physical therapy, occupational therapy and speech therapy.<br>$4,000 / day for inpatient non-emergency admission in non-participating facilities |
| | Habilitation services | 30% coinsurance | 50% coinsurance | 30 inpatient habilitative days / year<br>25 outpatient habilitative visits / year<br>25 professional neurodevelopmental visits / year |

| 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) | |
| | | | | Includes physical therapy, occupational therapy and speech therapy.<br>$4,000 / day for inpatient non-emergency admission in non-participating facilities |
| | Skilled nursing care | 30% coinsurance | 50% coinsurance | 60 inpatient days / year |
| | Durable medical equipment | 30% coinsurance | 50% coinsurance | None |
| | Hospice services | 30% coinsurance | 50% coinsurance | 14 respite inpatient or outpatient days / lifetime |
| **If your child needs dental or eye care** | Children's eye exam | No charge, deductible does not apply | 50% coinsurance, deductible does not apply | For services provided by an out-of-network provider, you pay all charges up front then submit a claim for reimbursement.<br>1 routine exam / year for individuals under age 19.<br>VSP doctors are the only in-network providers. |
| | Children's glasses | No charge, deductible does not apply | 50% coinsurance, deductible does not apply | For services provided by an out-of-network provider, you pay all charges up front then submit a claim for reimbursement.<br>1 pair of lenses / year<br>1 set of frames / year<br>Glasses limited to individuals under age 19.<br>Frames from VSP doctors are limited to Otis & Piper Eyewear Collection.<br>VSP doctors are the only in-network providers. |
| | Children's dental check-up | No charge, deductible does not apply | No charge, deductible does not apply | 2 cleanings* / year<br>2 preventive oral examinations / year<br>Coverage limited to individuals under age 19.<br>*Coverage may include additional cleanings, refer to your plan for further information.<br>Coverage includes basic and major dental services for individuals under age 19, refer to your plan for further information. |

## 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)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- 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, 10 spinal manipulation visits / year
- Hearing aids, 1 per ear / 36 months
- Non-emergency care when traveling outside the U.S.
- Routine foot care

**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 1-888-367-2112. 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. 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 1-888-367-2112.

*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** | **$8,500** |
| **Specialist copayment** | **$40** |
| **Hospital (facility) coinsurance** | **30%** |
| **Other coinsurance** | **30%** |

**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 | $8,500 |
| Copayments | $10 |
| Coinsurance | $1,100 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$9,670** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$8,500** |
| **Specialist copayment** | **$40** |
| **Hospital (facility) coinsurance** | **30%** |
| **Other coinsurance** | **30%** |

**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 | $900 |
| Copayments | $400 |
| Coinsurance | $400 |
| *What isn't covered* | |
| Limits or exclusions | $200 |
| **The total Joe would pay is** | **$1,900** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$8,500** |
| **Specialist copayment** | **$40** |
| **Hospital (facility) coinsurance** | **30%** |
| **Other coinsurance** | **30%** |

**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 | $2,500 |
| Copayments | $100 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,600** |

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


VSP is a separate company that provides vision benefit services.

# NONDISCRIMINATION NOTICE

Regence complies with applicable Federal and Washington state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation or gender identity. Regence does not exclude people or treat them less favorably because of race, color, national origin, age, disability, sex, sexual orientation or gender identity.

**Regence:**
**Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:**

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats).

**Provides free language assistance services to people whose primary language is not English, which may include:**

- Qualified interpreters
- Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact the Civil Rights Coordinator.

If you believe that Regence has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation or gender identity, you can file a grievance. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

**Customer Service**
Civil Rights Coordinator
PO Box 1106
Lewiston, ID 83501-1106
Phone: 1-888-344-6347, (TTY: 711)
Fax: 1-888-309-8784
Email: CS@regence.com

**Medicare Customer Service**
Phone: 1-800-541-8981 (TTY: 711)
Email: medicareappeals@regence.com

**VSP Customer Service**
Phone: 1-844-299-3041, (TTY: 711)

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

You can also file a civil rights complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal available at https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status, or by phone at 800-562-6900, 360-586-0241 (TDD).

Complaint forms are available at https://fortress.wa.gov/oic/onlineservices/cc/pub/complaintinformation.aspx

## Language assistance

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-344-6347 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-344-6347 (TTY: 711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-344-6347 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-344-6347 (TTY: 711) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-344-6347 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-344-6347 (телетайп: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-344-6347 (ATS : 711)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-344-6347 (TTY:711）まで、お電話にてご連絡ください。

Díí baa akó nínízin: Díí saad bee yáníłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíilnih 1-888-344-6347 (TTY: 711.)

FAKATOKANGA'I: Kapau 'oku ke Lea-Fakatonga, ko e kau tokoni fakatonu lea 'oku nau fai atu ha tokoni ta'etotongi, pea te ke lava 'o ma'u ia. ha'o telefonimai mai ki he fika 1-888-344-6347 (TTY: 711)

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-344-6347 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711)

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-888-344-6347 (TTY: 711)។

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-888-344-6347 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachdienstleistungen zur Verfügung. Rufnummer: 1-888-344-6347 (TTY: 711)

ማስታወሻ:- የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፤ በሚከተለው ቁጥር ይደውሉ 1-888-344-6347 (መስማት ለተሳናቸው:- 711)።

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-888-344-6347 (телетайп: 711)

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-888-344-6347 (टिटिवाइ: 711

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-888-344-6347 (TTY: 711)

MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1-888-344-6347 (TTY: 711)

โปรดทราบ: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-888-344-6347 (TTY: 711)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-344-6347 (TTY: 711)

Afaan dubbattan Oroomiffaa tiif, tajaajila gargaarsa afaanii tola ni jira. 1-888-344-6347 (TTY: 711) tiin bilbilaa.

**توجه**: اگر به زبان فارسی صحبت می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-888-344-6347 (TTY: 711) تماس بگیرید.

ملحوظة: إذا كنت تتحدث فاذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-344-6347 (رقم هاتف الصم والبكم TTY: 711)