



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 360-671-1450. 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.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or call 360-671-1450 to request a copy.

| Important Questions                                                 | Answers                                                                                                                                                                        | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|---------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <u>deductible</u> ?                             | <b>\$3,500</b> individual/ <b>\$7,000</b> family for all Networks.                                                                                                             | 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> .                                                                                                                                                                             |
| Are there services covered before you meet your <u>deductible</u> ? | <b>Yes.</b> Breast pumps, Cologuard preventive, flu shots and immunizations for all Networks. Preventive care & services for Preferred and Participating Networks.             | 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                                          |
| Are there other <u>deductibles</u> for specific services?           | <b>No.</b> There are no other specific <u>deductibles</u> .                                                                                                                    | 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> ?       | <b>\$6,000</b> person/ <b>\$12,000</b> family for Preferred & Participating Networks. Includes Pharmacy.<br><b>\$12,000</b> person/ <b>\$24,000</b> family for Out-of-Network. | 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> ?            | Penalties, ineligible charges, premiums, balance-billed charges and health care this plan 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 <a href="http://www.accessrga.com">www.accessrga.com</a> or call 1-866-738-3924 for a list of network providers.                                                      | You pay the least if you use a <u>provider</u> in the Preferred Network. You pay more if you use a <u>provider</u> in the Participating Network. You will pay the most if you use an out-of-network <u>provider</u> and you might receive a bill from a <u>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>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 <a href="#">referral</a> to see a <a href="#">specialist</a> ? | No. | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> . |
|------------------------------------------------------------------------------|-----|--------------------------------------------------------------------------------------------|



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<br>(You will pay the least)       | Participating or Out-of-Network Provider<br>(You will pay the most)                                                                    |                                                                                                                                                                                                                                                                                                     |
| If you visit a health care <a href="#">provider's</a> office or clinic | Primary care visit to treat an injury or illness       | 20% coinsurance                                      | 20% coinsurance                                                                                                                        | —————none—————                                                                                                                                                                                                                                                                                      |
|                                                                        | <a href="#">Specialist</a> visit                       | 20% coinsurance                                      | 20% coinsurance                                                                                                                        | —————none—————                                                                                                                                                                                                                                                                                      |
|                                                                        | <a href="#">Preventive care/screening/immunization</a> | No charge, <a href="#">deductible</a> does not apply | <b>Participating Network:</b><br>No charge, <a href="#">deductible</a> does not apply<br><br><b>Out-of-Network:</b><br>20% coinsurance | Out-of-Network breast pumps, flu shots and immunizations covered at no charge, <a href="#">deductible</a> does not apply. You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive, then check what your plan will pay for. |
| If you have a test                                                     | <a href="#">Diagnostic test</a> (x-ray, blood work)    | 20% coinsurance                                      | 20% coinsurance                                                                                                                        | —————none—————                                                                                                                                                                                                                                                                                      |
|                                                                        | Imaging (CT/PET scans, MRIs)                           | 20% coinsurance                                      | 20% coinsurance                                                                                                                        | —————none—————                                                                                                                                                                                                                                                                                      |

| Common Medical Event                                                                                                                                                                                                     | Services You May Need                          | What You Will Pay                                                                                                                                                                                                                  |                                                                         | Limitations, Exceptions, & Other Important Information                                                                  |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                          |                                                | Preferred Provider<br>(You will pay the least)                                                                                                                                                                                     | Participating or Out-of-<br>Network Provider<br>(You will pay the most) |                                                                                                                         |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="https://Navitus.com">prescription drug coverage</a> is available at <a href="https://Navitus.com">https://Navitus.com</a> | Generic drugs                                  | \$10 copay after <u>deductible</u> (1-90 day supply Costco retail and mail order), \$20 copay after <u>deductible</u> (34 day supply Non-Costco retail), \$30 copay after <u>deductible</u> (35-90 day supply Non-Costco retail)   | Not Covered                                                             | Covers up to a 90-day supply (retail & mail order prescription). See Plan Document for non-use of generic drug penalty. |
|                                                                                                                                                                                                                          | Preferred brand drugs                          | \$25 copay after <u>deductible</u> (1-90 day supply Costco retail and mail order), \$50 copay after <u>deductible</u> (34 day supply Non-Costco retail), \$75 copay after <u>deductible</u> (35-90 day supply Non-Costco retail)   | Not Covered                                                             |                                                                                                                         |
|                                                                                                                                                                                                                          | Non-preferred brand drugs                      | \$50 copay after <u>deductible</u> (1-90 day supply Costco retail and mail order), \$100 copay after <u>deductible</u> (34 day supply Non-Costco retail), \$150 copay after <u>deductible</u> (35-90 day supply Non-Costco retail) | Not Covered                                                             |                                                                                                                         |
|                                                                                                                                                                                                                          | <a href="#">Specialty drugs</a>                | \$150 copay after <u>deductible</u> (30 day supply)                                                                                                                                                                                | Not Covered                                                             | Please contact Navitus, your specialty pharmacy, for more information on what is covered.                               |
| <b>If you have outpatient surgery</b>                                                                                                                                                                                    | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance                                                                                                                                                                                                                    | 20% coinsurance                                                         | Preauthorization is required.                                                                                           |
|                                                                                                                                                                                                                          | Physician/surgeon fees                         | 20% coinsurance                                                                                                                                                                                                                    | 20% coinsurance                                                         | _____none_____                                                                                                          |
| <b>If you need immediate medical attention</b>                                                                                                                                                                           | <a href="#">Emergency room care</a>            | 20% coinsurance                                                                                                                                                                                                                    |                                                                         | _____none_____                                                                                                          |

| Common Medical Event                                                             | Services You May Need                            | What You Will Pay                              |                                                                         | Limitations, Exceptions, & Other Important Information                                                                                                                                           |
|----------------------------------------------------------------------------------|--------------------------------------------------|------------------------------------------------|-------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                  |                                                  | Preferred Provider<br>(You will pay the least) | Participating or Out-of-<br>Network Provider<br>(You will pay the most) |                                                                                                                                                                                                  |
|                                                                                  | <a href="#">Emergency medical transportation</a> | 20% coinsurance                                |                                                                         | —————none—————                                                                                                                                                                                   |
|                                                                                  | <a href="#">Urgent care</a>                      | 20% coinsurance                                |                                                                         | —————none—————                                                                                                                                                                                   |
| <b>If you have a hospital stay</b>                                               | Facility fee (e.g., hospital room)               | 20% coinsurance                                | 20% coinsurance                                                         | Preauthorization is required.                                                                                                                                                                    |
|                                                                                  | Physician/surgeon fees                           | 20% coinsurance                                | 20% coinsurance                                                         | —————none—————                                                                                                                                                                                   |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                              | 20% coinsurance                                | 20% coinsurance                                                         | Preauthorization is required for partial hospitalization and intensive outpatient.                                                                                                               |
|                                                                                  | Inpatient services                               | 20% coinsurance                                | 20% coinsurance                                                         | Preauthorization is required. Residential treatment is covered.                                                                                                                                  |
| <b>If you are pregnant</b>                                                       | Office visits                                    | 20% coinsurance                                | 20% coinsurance                                                         | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)                                                                                                  |
|                                                                                  | Childbirth/delivery professional services        | 20% coinsurance                                | 20% coinsurance                                                         | —————none—————                                                                                                                                                                                   |
|                                                                                  | Childbirth/delivery facility services            | 20% coinsurance                                | 20% coinsurance                                                         | Hospital stays that extend beyond 48 hours for a normal vaginal delivery or beyond 96 hours for a cesarean section must be preauthorized at the time your provider recommends the extended stay. |
| <b>If you need help recovering or have other special health needs</b>            | <a href="#">Home health care</a>                 | 20% coinsurance                                | 20% coinsurance                                                         | Preauthorization is required. Limited to a 130-visit calendar year maximum.                                                                                                                      |
|                                                                                  | <a href="#">Rehabilitation services</a>          | 20% coinsurance                                | 20% coinsurance                                                         | Preauthorization is required for inpatient and limited to 15 days per calendar year, with an additional 15 days for the treatment of stroke, head, or brain injury. Swim therapy is covered.     |

| Common Medical Event                          | Services You May Need                     | What You Will Pay                              |                                                                     | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                |
|-----------------------------------------------|-------------------------------------------|------------------------------------------------|---------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                               |                                           | Preferred Provider<br>(You will pay the least) | Participating or Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                       |
|                                               | <a href="#">Habilitation services</a>     | 20% coinsurance                                | 20% coinsurance                                                     | Habilitation services, including neurodevelopmental therapy and rehabilitative therapies for the treatment of a mental health diagnosis and substance use disorder, are covered under the Outpatient Rehabilitation Services benefit. |
|                                               | <a href="#">Skilled nursing care</a>      | 20% coinsurance                                | 20% coinsurance                                                     | Preauthorization is required. Limited to a 120-day calendar year maximum.                                                                                                                                                             |
|                                               | <a href="#">Durable medical equipment</a> | 20% coinsurance                                | 20% coinsurance                                                     | Preauthorization is required for DME over \$2,000.                                                                                                                                                                                    |
|                                               | <a href="#">Hospice services</a>          | 20% coinsurance                                | 20% coinsurance                                                     | Preauthorization is required. Respite care limited to 120 hours every 3 months.                                                                                                                                                       |
| <b>If your child needs dental or eye care</b> | Children's eye exam                       | Not covered                                    | Not covered                                                         | Please contact vision administrator.                                                                                                                                                                                                  |
|                                               | Children's glasses                        | Not covered                                    | Not covered                                                         | Please contact vision administrator.                                                                                                                                                                                                  |
|                                               | Children's dental check-up                | Not covered                                    | Not covered                                                         | Please contact dental administrator.                                                                                                                                                                                                  |

#### Excluded Services & Other Covered Services:

| Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .) |                                                                                                                                                            |                                                                                                                                                                     |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>Bariatric surgery</li> <li>Cosmetic surgery</li> <li>Dental care (Adult)</li> <li>Infertility treatment</li> </ul>                                         | <ul style="list-style-type: none"> <li>Long-term care</li> <li>Non-emergency care when traveling outside the U.S.</li> <li>Private-duty nursing</li> </ul> | <ul style="list-style-type: none"> <li>Routine eye care (Adult)</li> <li>Routine foot care (except if medically necessary)</li> <li>Weight loss programs</li> </ul> |

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

- Acupuncture (20-visit yearly limit)
- Chiropractic care
- Hearing aids (Limited to \$3,000 per ear every 3 calendar years)

**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: WEX, 1-866-451-3399, and the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). 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](http://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: 1-866-738-3924, and the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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 1-866-738-3924.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-738-3924.]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-738-3924.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-738-3924.]

*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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$3,500 |
| ■ <a href="#">Specialist</a> coinsurance                        | 20%     |
| ■ 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$3,500        |
| <a href="#">Copayments</a>        | \$10           |
| <a href="#">Coinsurance</a>       | \$1,810        |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$5,380</b> |

### Managing Joe's type 2 Diabetes

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

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$3,500 |
| ■ <a href="#">Specialist</a> coinsurance                        | 20%     |
| ■ 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$3,500        |
| <a href="#">Copayments</a>        | \$200          |
| <a href="#">Coinsurance</a>       | \$20           |
| What isn't covered                |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$3,740</b> |

### Mia's Simple Fracture

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

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$3,500 |
| ■ <a href="#">Specialist</a> coinsurance                        | 20%     |
| ■ 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$2,800        |
| <a href="#">Copayments</a>        | \$00           |
| <a href="#">Coinsurance</a>       | \$00           |
| What isn't covered                |                |
| Limits or exclusions              | \$00           |
| <b>The total Mia would pay is</b> | <b>\$2,800</b> |