



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 or call (360) 671-1450 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$1,000 person/\$2,500 family for all Networks.	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. ABA therapy, breast pumps, Cologuard medical & preventive, flu shots, immunizations, laboratory and outpatient office visits for all Networks. Mammograms-medical, preventive care & services and urgent care facility for Preferred and Participating Networks.	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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No. There are no other specific deductibles .	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	\$3,000 person/\$6,000 family for Preferred & Participating Networks. Includes Pharmacy. \$5,000 person/\$10,000 family for Out-of-Network.	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 ?	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 out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. See www.accessrga.com or call 1-866-738-3924 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 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 .
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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 will pay the least)	Participating or 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	\$25/visit, deductible does not apply	\$25/visit, deductible does not apply	_____none_____
	Specialist visit	\$40/visit, deductible does not apply	\$40/visit, deductible does not apply	_____none_____
	Preventive care/screening/immunization	No charge, deductible does not apply	Participating Network: No charge, deductible does not apply Out-of-Network: 20% coinsurance	Out-of-Network breast pumps, flu shots and immunizations covered at no charge, deductible does not apply. 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)	Diagnostic Testing: \$75/visit, deductible does not apply Laboratory: \$50/visit, deductible does not apply	Diagnostic Testing: \$75/visit, deductible does not apply Laboratory: \$50/visit, deductible does not apply	
	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 (You will pay the least)	Participating or 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 https://Navitus.com	Generic drugs	\$10 copay (1-90 day supply Costco retail and mail order), \$20 copay (34 day supply Non-Costco retail), \$30 copay (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	\$40 copay (1-90 day supply Costco retail and mail order), \$80 copay (34 day supply Non-Costco retail), \$120 copay (35-90 day supply Non-Costco retail)	Not Covered	
	Non-preferred brand drugs	Not Covered	Not Covered	
	Specialty drugs	20% coinsurance, up to \$100 maximum copay	Not Covered	Please contact Navitus, your specialty pharmacy, for more information on what is covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	20% coinsurance	Preauthorization is required.
	Physician/surgeon fees	20% coinsurance	20% coinsurance	_____none_____
If you need immediate medical attention	Emergency room care	\$250/visit, then 20% coinsurance		_____none_____
	Emergency medical transportation	20% coinsurance		_____none_____
	Urgent care	\$40/visit, <u>deductible</u> does not apply	Participating Network: \$40/visit, <u>deductible</u> does not apply Out-of-Network: 20% coinsurance	_____none_____

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Participating or Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	20% coinsurance	Preauthorization is required.
	Physician/surgeon fees	20% coinsurance	20% coinsurance	—————none—————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25/visit, <u>deductible</u> does not apply	\$25/visit, <u>deductible</u> does not apply	Preauthorization is required for partial hospitalization and intensive outpatient.
	Inpatient services	20% coinsurance	20% coinsurance	Preauthorization is required. Residential treatment is covered.
If you are pregnant	Office visits	\$25/visit, <u>deductible</u> does not apply	\$25/visit, <u>deductible</u> does not apply	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.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	Preauthorization is required. Limited to a 130-visit calendar year maximum.
	Rehabilitation services	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 (You will pay the least)	Participating or Out-of-Network Provider (You will pay the most)	
	Habilitation services	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.
	Skilled nursing care	20% coinsurance	20% coinsurance	Preauthorization is required. Limited to a 120-day calendar year maximum.
	Durable medical equipment	20% coinsurance	20% coinsurance	Preauthorization is required for DME over \$2,000.
	Hospice services	20% coinsurance	20% coinsurance	Preauthorization is required. Respite care limited to 120 hours every 3 months.
If your child needs dental or eye care	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 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 - Dental care (Adult) - Infertility treatment	- Long-term care - Non-emergency care when traveling outside the U.S. - Private-duty nursing	- Routine eye care (Adult) - Routine foot care (except if medically necessary) - Weight loss programs

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. 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 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.

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 plan's overall deductible	\$1,000
■ Specialist copayment	\$40
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
[Diagnostic tests](#) (*ultrasounds and blood work*)
[Specialist](#) visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,000
Copayments	\$260
Coinsurance	\$1,740
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$3,060

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$1,000
■ Specialist copayment	\$40
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)
[Diagnostic tests](#) (*blood work*)
[Prescription drugs](#)
[Durable medical equipment](#) (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$760
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$780

Mia's Simple Fracture

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

■ The plan's overall deductible	\$1,000
■ Specialist copayment	\$40
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)
[Diagnostic test](#) (*x-ray*)
[Durable medical equipment](#) (*crutches*)
[Rehabilitation services](#) (*physical therapy*)

Total Example Cost	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,000
Copayments	\$440
Coinsurance	\$220
What isn't covered	
Limits or exclusions	\$00
The total Mia would pay is	\$1,660