



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/2026/booklet/WW/Silver3000Preferred> 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](https://healthcare.gov/sbc-glossary) or call 1-888-367-2112 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	In- <u>network provider</u> : \$3,000 individual / \$6,000 family per calendar year. Out-of- <u>network provider</u> : \$5,000 individual / \$10,000 family per calendar year.	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> .
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. Certain <u>preventive care</u> and those services listed below as " <u>deductible</u> does not apply." "No charge" means \$0 <u>copayment</u> or 0% <u>coinsurance</u> , regardless of <u>deductible</u> applicability.	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://healthcare.gov/coverage/preventive-care-benefits/">healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	In- <u>network provider</u> : \$8,650 individual / \$17,300 family per calendar year. Out-of- <u>network provider</u> : \$10,000 individual / \$20,000 family per calendar year.	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.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="https://regence.com/go/WW/Preferred">https://regence.com/go/WW/Preferred</a> or call 1-888-367-2112 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network 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.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$40 <u>copay</u> / office visit, <u>deductible</u> does not apply;  35% <u>coinsurance</u> for other services	50% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$60 <u>copay</u> / office visit, <u>deductible</u> does not apply;  35% <u>coinsurance</u> for other services	50% <u>coinsurance</u>	
	<u>Preventive care/screening/immunization</u>	No charge, <u>deductible</u> does not apply	50% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	35% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	35% <u>coinsurance</u>	50% <u>coinsurance</u>	
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="https://regence.com/go/2026/WW/6tier">https://regence.com/go/2026/WW/6tier</a>	Preferred generic drugs	\$20 <u>copay</u> , <u>deductible</u> does not apply / retail prescription;  \$60 <u>copay</u> , <u>deductible</u> does not apply / home delivery prescription	Not covered	<u>Prescription drugs</u> not on the Drug List are not covered, unless an exception is approved. <u>Deductible</u> does not apply for insulin, covered diabetic supplies, or certain inhaled asthma medication and epinephrine autoinjectors. 90-day supply / retail prescription (your <u>cost share</u> is per 30-day supply) 90-day supply / home delivery prescription 30-day supply / <u>specialty drug</u> prescription <u>Specialty drugs</u> are not available through home delivery. Coverage includes self-administrable cancer chemotherapy drugs at 35% <u>coinsurance</u> , <u>deductible</u> does not apply for preferred generic drugs, generic drugs, preferred brand name drugs and brand name
	Generic drugs	\$35 <u>copay</u> , <u>deductible</u> does not apply / retail prescription;  \$105 <u>copay</u> , <u>deductible</u> 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	\$60 <u>copay, deductible</u> does not apply / retail prescription;  \$180 <u>copay, deductible</u> does not apply / home delivery prescription	Not covered	<p>drugs.</p> <p><u>Cost shares</u> 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.</p> <p>No charge, <u>deductible</u> does not apply for certain preventive drugs, contraceptives and immunizations at a participating pharmacy.</p> <p>If you fill a brand drug or <u>specialty drug</u> when there is an equivalent generic drug or specialty biosimilar drug available, you pay the difference in cost in addition to the <u>copayment</u> and/or <u>coinsurance</u>.</p> <p>The first fill of <u>specialty drugs</u> may be provided by a retail pharmacy; additional refills must be provided by a specialty pharmacy.</p>
	Brand drugs	50% <u>coinsurance, deductible</u> does not apply / retail prescription;  50% <u>coinsurance, deductible</u> does not apply / home delivery prescription	Not covered	
	Preferred <u>specialty drugs</u>	20% <u>coinsurance / specialty drug</u>	Not covered	
	<u>Specialty drugs</u>	50% <u>coinsurance / specialty drug</u>	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	25% <u>coinsurance</u> for ambulatory surgery centers;  35% <u>coinsurance</u> for all other facilities	50% <u>coinsurance</u>	None
	Physician/surgeon fees	25% <u>coinsurance</u> for ambulatory surgery center physicians;  35% <u>coinsurance</u> for all other physicians	50% <u>coinsurance</u>	

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)	
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	35% <u>coinsurance</u> after \$400 <u>copay</u> / visit	35% <u>coinsurance</u> after \$400 <u>copay</u> / visit	<u>Copayment</u> applies to facility charge for each visit (waived if admitted), whether or not the <u>deductible</u> has been met. <u>Out-of-network provider services</u> apply to the in-network <u>deductible</u> and in-network <u>out-of-pocket limit</u> .
	<u>Emergency medical transportation</u>	35% <u>coinsurance</u>	35% <u>coinsurance</u>	<u>Out-of-network provider services</u> apply to the in-network <u>deductible</u> and in-network <u>out-of-pocket limit</u> .
	<u>Urgent care</u>	\$60 <u>copay</u> / visit, <u>deductible</u> does not apply; 35% <u>coinsurance</u> for other services	50% <u>coinsurance</u>	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	35% <u>coinsurance</u>	50% <u>coinsurance</u>	\$4,000 / day for inpatient non-emergency admission in non-participating facilities
	Physician/surgeon fees	35% <u>coinsurance</u>	50% <u>coinsurance</u>	None
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$40 <u>copay</u> / office or psychotherapy visit, <u>deductible</u> does not apply; 35% <u>coinsurance</u> for other services	50% <u>coinsurance</u>	None
	Inpatient services	35% <u>coinsurance</u>	50% <u>coinsurance</u>	\$4,000 / day for inpatient non-emergency admission in non-participating facilities
<b>If you are pregnant</b>	Office visits	35% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	35% <u>coinsurance</u>	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	35% <u>coinsurance</u>	50% <u>coinsurance</u>	\$4,000 / day for inpatient non-emergency admission in non-participating facilities

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)	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	35% <u>coinsurance</u>	50% <u>coinsurance</u>	130 visits / year
	<u>Rehabilitation services</u>	\$40 <u>copay</u> / outpatient visit, <u>deductible</u> does not apply; 35% <u>coinsurance</u> for inpatient services	50% <u>coinsurance</u>	30 inpatient days / year 25 outpatient visits / year Includes physical therapy, occupational therapy and speech therapy. \$4,000 / day for inpatient non-emergency admission in non-participating facilities
	<u>Habilitation services</u>	\$40 <u>copay</u> / visit, <u>deductible</u> does not apply; 35% <u>coinsurance</u> for inpatient services	50% <u>coinsurance</u>	30 inpatient habilitative days / year 25 outpatient habilitative visits / year 25 professional neurodevelopmental visits / year <u>Copayment</u> applies to in-network provider neurodevelopmental and outpatient habilitative visits only. Inpatient habilitative services are covered at the <u>coinsurance</u> specified, after <u>deductible</u> . Includes physical therapy, occupational therapy and speech therapy. \$4,000 / day for inpatient non-emergency admission in non-participating facilities
	<u>Skilled nursing care</u>	35% <u>coinsurance</u>	50% <u>coinsurance</u>	60 inpatient days / year
	<u>Durable medical equipment</u>	35% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Hospice services</u>	35% <u>coinsurance</u>	50% <u>coinsurance</u>	14 respite inpatient or outpatient days / lifetime

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)	
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge, <u>deductible</u> does not apply	50% <u>coinsurance</u> , <u>deductible</u> does not apply	For services provided by an <u>out-of-network provider</u> , you pay all charges up front then submit a <u>claim</u> for reimbursement. Limited to 1 routine exam / year for individuals under age 19. VSP doctors are the only <u>in-network providers</u> .
	Children's glasses	No charge, <u>deductible</u> does not apply	50% <u>coinsurance</u> , <u>deductible</u> does not apply	For services provided by an <u>out-of-network provider</u> , you pay all charges up front then submit a <u>claim</u> for reimbursement. Limited to 1 pair of lenses (2 lenses) and 1 standard frame / year for individuals under age 19. Frames from VSP doctors are limited to Otis & Piper Eyewear Collection. VSP doctors are the only <u>in-network providers</u> .
	Children's dental check-up	No charge, <u>deductible</u> does not apply	No charge, <u>deductible</u> does not apply	2 cleanings* / year 2 preventive oral examinations / year Coverage limited to individuals under age 19. *Coverage may include additional cleanings, refer to your <u>plan</u> for further information. Coverage includes basic and major dental services for individuals under age 19, refer to your <u>plan</u> 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                             | • Infertility treatment | • Routine eye care (Adult) |
| • Cosmetic surgery, except congenital anomalies | • Long-term care        | • Weight loss programs     |
| • Dental care (Adult)                           | • Private-duty nursing  |                            |

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

- |               |   |  |
|---------------|---|--|
| • Abortion    | • Chiropractic care, 10 spinal manipulation visits / year | • Non-emergency care when traveling outside the U.S. |
| • Acupuncture | • Hearing aids, 1 per ear / 36 months                     | • 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](http://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](http://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](http://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](http://regence.com) or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [dol.gov/ebsa/healthreform](http://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](http://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** **\$3,000**
- **Specialist copayment** **\$60**
- **Hospital (facility) coinsurance** **35%**
- **Other coinsurance** **35%**

**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>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
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<u>Deductibles</u>	\$3,000
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$3,200

<i>What isn't covered</i>	
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Limits or exclusions	\$60
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<b>The total Peg would pay is</b>	<b>\$6,270</b>
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**Managing Joe's Type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **\$3,000**
- **Specialist copayment** **\$60**
- **Hospital (facility) coinsurance** **35%**
- **Other coinsurance** **35%**

**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>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
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<u>Deductibles</u>	\$900
<u>Copayments</u>	\$800
<u>Coinsurance</u>	\$0

<i>What isn't covered</i>	
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Limits or exclusions	\$200
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<b>The total Joe would pay is</b>	<b>\$1,900</b>
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**Mia's Simple Fracture**  
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **\$3,000**
- **Specialist copayment** **\$60**
- **Hospital (facility) coinsurance** **35%**
- **Other coinsurance** **35%**

**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>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
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<u>Deductibles</u>	\$1,700
<u>Copayments</u>	\$700
<u>Coinsurance</u>	\$0

<i>What isn't covered</i>	
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Limits or exclusions	\$0
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<b>The total Mia would pay is</b>	<b>\$2,400</b>
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The plan would be responsible for the other costs of these EXAMPLE covered services.