

BENEFITS	CONTRACTING PROVIDER				NON-CONTRACTING PROVIDER			
	Deductible		Maximum Coinsurance		Deductible		Maximum Coinsurance	
Aggregate Deductible and Coinsurance Maximums (per Calendar Year) Once an individual deductible is met, benefits begin for that member, OR when the family aggregate deductible is met, benefits begin for the entire family. No one member can contribute more than his or her individual deductible toward the family deductible. Separate deductibles for contracting and non-contracting providers. \$0 Deductible only available to groups size 51 +	Individual	Family	Individual	Family	Individual	Family	Individual	Family
	\$ 0	\$ 0	\$1,000	\$2,000	\$ 200	\$ 400	\$2,000	\$4,000
	\$ 250	\$ 500	\$1,500	\$3,000	\$ 250	\$ 500	\$2,000	\$4,000
	\$ 500	\$1,000	\$2,000	\$4,000	\$ 500	\$1,000	\$2,000	\$4,000
	\$1,000	\$2,000	\$2,000	\$4,000	\$1,000	\$2,000	\$2,000	\$4,000
	\$1,500	\$3,000	\$3,000	\$6,000	\$1,500	\$3,000	\$3,000	\$6,000
	\$2,000	\$4,000	\$4,000	\$8,000	\$2,000	\$4,000	\$4,000	\$8,000
Maximum Benefit	\$2,000,000 per Enrollee							
PROFESSIONAL SERVICES								
Office Visits for Injury/Sickness	Low Deductible Option*		High Deductible Option*		After Deductible and Copayment, We pay 80% of Eligible Medical Expenses. You pay balance of billed charge**			
	After Deductible ▲, \$15 Copayment for Primary Provider/ \$30 Copayment for Specialist		After Deductible ▲, \$20 Copayment for Primary Provider/ \$35 Copayment for Specialist					
Minor Office Surgeries/Diagnostic Tests	After Deductible ▲ and Office Copay, We pay 100%				After Deductible and Copayment, We pay 80% of Eligible Medical Expenses. You pay balance of billed charge**			
Major Office Surgeries/Diagnostic Tests	After Deductible, We pay 80% and You pay 20% of Eligible Medical Expenses				After Deductible and Copayment, We pay 60% of Eligible Medical Expenses. You pay balance of billed charge**			
Office Visits for Preventive Care • \$300 per Enrollee per Calendar Year; unlimited for children age 5 and under • Designated Adult Preventive and Well Baby Care • Annual Vision Examination	Low Deductible Option*		High Deductible Option*		After Deductible and Copayment, We pay 80% of Eligible Medical Expenses. You pay balance of billed charge**			
	After Deductible ▲, \$15 Copayment for Primary Provider/ \$30 Copayment for Specialist		After Deductible ▲, \$20 Copayment for Primary Provider/ \$35 Copayment for Specialist					
Urgent Care Clinic	After Deductible ▲, \$35 Copayment per Visit				After Deductible and Copayment, We pay 80% of Eligible Medical Expenses. You pay balance of billed charge**			
Maternity Care	After Deductible ▲, We pay 80% and You pay 20% of Eligible Medical Expenses				After Deductible, We pay 60% of Eligible Medical Expenses. You pay balance of billed charge**			
Chiropractic Care • Maximum 10 visits per Enrollee per Calendar Year	Low Deductible Option*		High Deductible Option*		After Deductible, We pay 80% of Eligible Medical Expenses. You pay balance of billed charge**			
	After Deductible ▲, \$15 Copayment		After Deductible ▲, \$20 Copayment					
FACILITY SERVICES (INCLUDING RELATED PROFESSIONAL SERVICES)								
Inpatient Hospital Services • Semi-Private Room Accommodations • Related Services and Supplies • Maternity Care • Skilled Nursing Facility – Limited to 60 days per Enrollee per Calendar Year • Inpatient Rehabilitation Services – Limited to 30 days per Enrollee per Calendar Year	After Deductible, We pay 80% and You pay 20%* of Eligible Medical Expenses				After Deductible, We pay 60% of Eligible Medical Expenses. You pay balance of billed charge**			
Outpatient Facility Services • Surgery and Related Services • Diagnostic X-ray and Laboratory Services • Ambulance Services	After Deductible, We pay 80% and You pay 20%* of Eligible Medical Expenses				After Deductible, We pay 60% of Eligible Medical Expenses. You pay balance of billed charge**			
Emergency Department	After Deductible ▲, \$100 Copayment per Visit				After Deductible and Copayment, We pay 80% of Eligible Medical Expenses. You pay balance of billed charge**			
Outpatient Rehabilitation Services • Maximum 30 visits per Enrollee per Calendar Year ¹ When services are rendered in a Physician/Practitioner's office ² When services are rendered in the Outpatient Department of a Hospital	Low Deductible Option*		High Deductible Option*		¹ After Deductible and Copayment, We pay 80% of Eligible Medical Expenses. You pay balance of billed charge** ² After Deductible, We pay 60% of Eligible Medical Expenses. You pay balance of billed charge**			
	¹ After Deductible ▲, \$15 Copayment per Office Visit ² After Deductible, We pay 80% and You pay 20% of Eligible Medical Expenses		¹ After Deductible ▲, \$20 Copayment per Office Visit					
OTHER SERVICES								
Home Health Care/Home Infusion Therapy Services	After Deductible, We pay 80% and You pay 20% of Eligible Medical Expenses				After Deductible, We pay 60% of Eligible Medical Expenses. You pay balance of billed charge**			
Durable Medical Equipment (DME) and Supplies, Prosthetic and Orthotic Devices • DME limited to \$2,500 Maximum per Enrollee per Calendar Year	After Deductible, We pay 80% and You pay 20% of Eligible Medical Expenses				After Deductible, We pay 60% of Eligible Medical Expenses. You pay balance of billed charge**			
Special Beginnings*	You pay nothing							

This is a partial summary of benefits only. The benefits Booklet contains a complete detail of benefits, limitations and exclusions and is the governing document. The benefits Booklet also describes grievance procedures for disputes.

▲Enhanced Partial deductible waiver available to purchase as an additional benefit.

*Low Option refers to \$0–\$500 Deductible plans; High Option refers to \$1,000–\$2,000 Deductible plans.

* If Eligible Medical Expenses for facility charges are greater than the billed charge, Your payment will be the percentage of billed charge.

**Of the balance of billed charges which You pay, amounts in excess of Eligible Medical Expenses do not apply toward Your Maximum Coinsurance/Copayment Maximum.

ADDITIONAL BENEFITS AND/OR RIDERS

RX Drug Card	Option 1	Option 2	Option 3	Option 4
Deductible	\$50 per Enrollee (3 per Family) per Calendar Year	\$50 per Enrollee (3 per Family) per Calendar Year	\$100 per Enrollee (3 per Family) per Calendar Year	\$100 per Enrollee (3 per Family) per Calendar Year
Copayment Maximum	\$3,500 per Enrollee (3 per Family) per Calendar Year	\$3,500 per Enrollee (3 per Family) per Calendar Year	\$3,500 per Enrollee (3 per Family) per Calendar Year	\$3,500 per Enrollee (3 per Family) per Calendar Year
Generic	After Deductible, You pay \$5 Copayment	After Deductible, You pay \$10 Copayment	After Deductible, You pay \$5 Copayment	After Deductible, You pay \$10 Copayment
Formulary	After Deductible, You pay 20% Copayment	After Deductible, You pay 20% Copayment	After Deductible, You pay 40% Copayment	After Deductible, You pay 50% Copayment
Non-Formulary	After Deductible, You pay 50% Copayment	After Deductible, You pay 35% Copayment	After Deductible, You pay 50% Copayment	After Deductible, You pay 50% Copayment

Deductible Waiver for Drug Card Available

Enhanced Partial Deductible Waiver Available

Additional Accidental Injury/Life-Threatening Illness Available

Benefits When you are treated for an Accidental Injury within 7 days or a Life-Threatening Illness within 72 hours, We will pay Covered Services at 100% of Eligible Medical Expenses up to \$500 per Enrollee per Calendar Year. After the maximum under this benefit is reached, all additional services will be covered the same as any other Illness or Injury.

Employee Assistance Program (EAP) Available

Benefits Up to 4 Visits per incident free of charge for employees and covered dependents; 24 hour crisis assistance; Supervisor referral services and educational services.

Mental Health Condition and Substance Abuse Option 1 Option 2 Option 3

	Option 1	Option 2	Option 3
We Pay/You Pay	Small Group 50%/50%	Catastrophic 80%/20%	Catastrophic 50%/50%
Small Groups 2 - 50	Available	Not Available	Available
Large Groups 50+	Not Available	Available	Available
Benefits	Inpatient Mental Health Services Limited to 10 days per Enrollee per Calendar Year. Outpatient Mental Health Services limited to 20 visits per Enrollee per Calendar Year.	Mental Health benefits shall be subject to the same, but separate Deductible, Copayment and Maximum Coinsurance amounts as applicable in the benefits Booklet. Any amount You pay toward the Deductible and Maximum coinsurance for this Mental Health coverage does not apply toward any Deductible or Maximum Coinsurance amount as applicable in the benefits Booklet. The Deductible, Copayments and amounts in excess of Eligible Medical Expenses do not apply toward the Maximum Coinsurance amount applicable to this Mental Health coverage. Once the Maximum Coinsurance amount for this Mental Health coverage has been reached, Mental Health benefits shall be reimbursed at 100% of Eligible Medical Expenses for remainder of the year.	Mental Health benefits shall be subject to the same, but separate Deductible, Copayment and Maximum Coinsurance amounts as applicable in the benefits Booklet. Any amount You pay toward the Deductible and Maximum coinsurance for this Mental Health coverage does not apply toward any Deductible or Maximum Coinsurance amount as applicable in the benefits Booklet. The Deductible, Copayments and amounts in excess of Eligible Medical Expenses do not apply toward the Maximum Coinsurance amount applicable to this Mental Health coverage. Once the Maximum Coinsurance amount for this Mental Health coverage has been reached, Mental Health benefits shall be reimbursed at 100% of Eligible Medical Expenses for remainder of the year.

Note: exclusive provider network applies to Regence HealthWise

Dental Option F Available for groups 2+ Option G Available for groups 10+ Option K Available for groups 20+ Option S Available for groups 20+ Option V Available for groups 20+

	Option F Available for groups 2+	Option G Available for groups 10+	Option K Available for groups 20+	Option S Available for groups 20+	Option V Available for groups 20+
Provider Network	Regence BCBSU Traditional	Regence BCBSU Traditional	Regence ValueCare	Regence BCBSU Traditional	Regence ValueCare
Deductible per Calendar Year	\$50 (2 Individual Max)	\$50 (3 Individual Max)	\$50 (3 Individual Max)	\$50 (3 Individual Max)	\$50 (3 Individual Max)
Maximum Benefit	\$500	\$1,000	\$1,000	\$1,000	\$1,000
Preventative and Diagnostic Services					
Oral Examinations (2 per Calendar Year)					
Prophylaxis treatment (2 per Calendar Year)					
X-rays (full mouth 1 per 3-year period)	After Deductible, We pay 80% and You pay 20% of Eligible Dental Expenses.	We pay 100% of Eligible Dental Expenses.	We pay 100% of Eligible Dental Expenses.**	We pay 100% of Eligible Dental Expenses.	We pay 100% of Eligible Dental Expenses.**
Topical Fluoride treatment (to age 23; 2 per Calendar year)					
Sealants for permanent molars (to age 15)					
Basic Services	After Deductible, We pay 80% and You pay 20% of Eligible Dental Expenses.*	After Deductible, We pay 80% and You pay 20% of Eligible Dental Expenses.	After Deductible, We pay 80% and You pay 20% of Eligible Dental Expenses.**	After Deductible, We pay 80% and You pay 20% of Eligible Dental Expenses.	After Deductible, We pay 80% and You pay 20% of Eligible Dental Expenses.**
Endodontic Services	After Deductible, We pay 50% and You pay 50% of Eligible Dental Expenses.*	After Deductible, We pay 80% and You pay 20% of Eligible Dental Expenses.	After Deductible, We pay 80% and You pay 20% of Eligible Dental Expenses.**	After Deductible, We pay 80% and You pay 20% of Eligible Dental Expenses.	After Deductible, We pay 80% and You pay 20% of Eligible Dental Expenses.**
Prosthetic Services	After Deductible, We pay 50% and You pay 50% of Eligible Dental Expenses.*	After Deductible, We pay 50% and You pay 50% of Eligible Dental Expenses.	After Deductible, We pay 50% and You pay 50% of Eligible Dental Expenses.**	After Deductible, We pay 50% and You pay 50% of Eligible Dental Expenses.	After Deductible, We pay 50% and You pay 50% of Eligible Dental Expenses.**
Orthodontic Services-\$1000 Lifetime per Enrollee	Not Available	Not Available	Not Available	After Deductible, We pay 50% and You pay 50% of Eligible Dental Expenses.■	We pay 50% and You pay 50% of Eligible Dental Expenses.**

Vision Option AN Vision — Available for groups 20+

Benefits \$150 allowance for Lenses and Frames and/or Contact Lenses, limited to one pair of eyeglasses (lenses and frames) and/or one pair of contact lenses each Calendar Year for each Enrollee.

* No benefits are available for Prosthetic & Endodontic services until enrollee has been covered for 12 consecutive months after their effective date.

** Applies to Contracting Provider coverage, see Benefit Summary for Non-Contracting Provider amounts.

■ Further limited to \$500 per Enrollee per Calendar Year