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Benefits	Contracting Provider				Non-Contracting Provider			
	Deductible		Maximum Coinsurance		Deductible		Maximum Coinsurance	
Deductible and Coinsurance Maximums (per Calendar Year, 2 per family)	Individual	Family	Individual	Family	Individual	Family	Individual	Family
	$ –	$ –	$1,000	$2,000	$ –	$ –	$1,000	$2,000
	$ 100	$ 200	$1,000	$2,000	$ 100	$ 200	$1,000	$2,000
	$ 250	$ 500	$1,000	$2,000	$ 250	$ 500	$1,000	$2,000
	$ 500	$1,000	$1,500	$3,000	$ 500	$1,000	$1,500	$3,000
	$1,000	$2,000	$2,000	$4,000	$1,000	$2,000	$2,000	$4,000
	$1,500	$3,000	$2,000	$4,000	$1,500	$3,000	$2,000	$4,000
Maximum Benefit	$2,000,000 per Enrollee, further limited to $1,500,000 per Enrollee for Non-Contracting Providers							
Professional Services								
Office Visits for Injury/Sickness • Office Diagnostic X-ray and Laboratory Services	$15 Copayment per Office Visit (Deductible Waived)				After Deductible and Copayment, We pay 80% of Eligible Medical Expenses. You pay balance of billed charge**			
Office Visits for Preventive Care • $500 per Enrollee per Calendar Year; unlimited for children age 5 and under • Designated Adult Preventive and Well Baby Care (including flu vaccination) • Annual Vision Examination	$15 Copayment per Office Visit (Deductible Waived)				After Deductible and Copayment, We pay 80% of Eligible Medical Expenses. You pay balance of billed charge**			
Urgent Care Clinic	$30 Copayment per Visit (Deductible Waived)				After Deductible and Copayment, We pay 80% of Eligible Medical Expenses. You pay balance of billed charge**			
Maternity Care	We pay 80% and You pay 20% of Eligible Medical Expenses (Deductible Waived)				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	$15 Copayment per Office Visit (Deductible Waived)				After Deductible and Copayment, We pay 80% of Eligible Medical Expenses. You pay balance of billed charge**			
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	$75 Copayment per Visit (Deductible Waived)				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 the Hospital	[1] $15 Copayment per Office Visit (Deductible Waived) [2] After Deductible, We pay 80% and You pay 20% of Eligible Medical Expenses				[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**			
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 and Supplies, Prosthetic and Orthotic Devices • DME limited to $5,000 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**			
Benefit Payments for Additional Accidental Injury/Life-Threatening Illness	$1,000 per Enrollee per Calendar Year for Eligible Medical Expenses received within 7 days after Accidental Injury or within 72 hours after onset of Life-Threatening Illness. When services are received from a Non-Contracting Provider, 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.

* 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.

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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
Maximum Coinsurance	$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

Mental Health Condition and Substance Abuse	Option 1	Option 2	Option 3
We Pay/You Pay Small Groups 2 - 50 Large Groups 50+ Benefits	50%/50% Available Not Available 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.	80%/20% Available Available 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 Deductibele, 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 reimubursed at 100% of Eligible Medical Expenses for remainder of the year.	50%/50% Available Available 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 Deductibele, 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 reimubursed at 100% of Eligible Medical Expenses for remainder of the year.

Vision	Option AN Vision
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.

Dental	Option F Available for groups 2-10	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 Family	$1,000 Family	$1,000 Family	$1,000 Family	$1,000 Family
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 Topical Fluoride treatment (to age 23; 2 per Calendar year) Sealants for permanent molars (to age 15)	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.**
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.**
Prosthodontic 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.**

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.

Deductible Waiver for Drug Card	Available

** No benefis are available for Prosthodontic & Endodontic services until enrollee has been covered for 12 consecutive months after their effecive date.*

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

▪ *Further limited to $500 per Enrollee per Calendar Year*