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, visit individualandfamily.chpw.org or call 1-866-907-1906. 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 https://www.healthcare.gov/sbc-glossary/ or call 1-800-318-2596 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$600 for an individual; $1,200 for a family**	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?	Preventive care services, primary care, laboratory tests, urgent care visits, and generic brand drugs are covered before you meet your deductible.	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?	**$600 for an individual; $1,200 for a family**	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	**$5,900 for an individual; $11,800 for a family**	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?	Out-of-network services are not included in out-of-pocket limit	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. There are no out-of-network providers in this plan.	This plan uses a provider network. You will pay less if you use a provider in the plan's 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 referral is required to see an in-network specialist or provider	You can see the in-network specialist you choose without a referral.

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
		Network Provider (You will pay the least)	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	$15 copay	Not Covered	
	Specialist visit	$40 copay	Not Covered	
	Preventive care/screening/ immunization	No Charge	Not Covered	
If you have a test	Diagnostic test (x-ray, blood work)	Lab work: $20 copay X-rays: $30 copay	Not Covered	Does not include genetic tests. Genetic tests are $20 copay.
	Imaging (CT/PET scans, MRIs)	$300 copay	Not Covered	Copay after deductible
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at individualandfamily.chpw.org/prescriptiondrugs	Generic drugs	$10 per 30-day supply $27 per 90-day supply	Not Covered	Copay. Prescription drugs are provided up to a 90-day supply at participating retail pharmacies or through mail order.
	Preferred brand drugs	$60 per 30-day supply $162 per 90-day supply	Not Covered	Copay. Prescription drugs are provided up to a 90-day supply at participating retail pharmacies or through mail order.
	Non-preferred brand drugs	$100 per 30-day supply	Not Covered	Copay. Coverage is limited to a 30-day supply.
	Specialty drugs	$100 per 30-day supply	Not Covered	Copay. Coverage is limited to a 30-day supply at specialty pharmacy. *Member cost sharing for insulin as follows: (1) cap total monthly out-of-pocket at $100 / 30-day supply; (2) insulin is not subject to deductible.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$350 copay	Not Covered	Copay after deductible
	Physician/surgeon fees	$75 copay	Not Covered	Copay after deductible

[* For more information about limitations and exceptions, see the plan or policy document at https://individualandfamily.chpw.org.]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$450 copay	$450 copay	Copay after deductible. Copay is waived if admitted as inpatient within 24 hours. Cost-sharing for Emergency Care Services is the same whether a member obtains services from an in-network or out-of-network provider in an emergency situation
	Emergency medical transportation	$375 copay	$375 copay	Cost-sharing for Emergency Care Services is the same whether a member obtains services from an in-network or out-of-network provider in an emergency situation
	Urgent care	$35 copay	Not covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	$525 per day	Not Covered	Copay. Limit of 5 copayments per hospital stay. Preauthorization required.
	Physician/surgeon fees	No Charge	Not Covered	Physician/surgeon hospital visit fees are included with the facility copay.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay	Not Covered	
	Inpatient services	$525 per day	Not Covered	Copay. Limit of 5 copayments per inpatient treatment stay.
If you are pregnant	Office visits	$15 copay	Not Covered	
	Childbirth/delivery professional services	No Charge	Not Covered	Professional services fees are included with the facility charge.
	Childbirth/delivery facility services	$525 per day	Not Covered	Copay. Limit of 5 copayments per hospital day.
If you need help recovering or have other special health needs	Home health care	$15 per day	Not Covered	Copay. Limit to 130 visits per calendar year. Preauthorization required.
	Rehabilitation services	$25 copay	Not Covered	Includes physical, speech, and occupational therapies. 25-visit maximum for all rehabilitation therapy services per calendar year.

[* For more information about limitations and exceptions, see the plan or policy document at https://individualandfamily.chpw.org.]

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Habilitation services	$25 copay	Not Covered	Includes physical, speech, and occupational therapies. 25-visit maximum for all habilitation therapy services per calendar year.
	Skilled nursing care	$350 per day	Not Covered	Copay after deductible. 60 days per calendar year; limit of 5 copayments per stay.
	Durable medical equipment	20% coinsurance	Not Covered	Coinsurance after deductible
	Hospice services	$15 per day	Not Covered	Copay. Preauthorization required.
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	1 exam per calendar year for routine vision screening and 1 comprehensive eye exam per calendar year.
	Children's glasses	No Charge	Not Covered	Limited to children under age 19. One pair of prescription lenses or contacts every calendar year, including polycarbonate lenses and scratch-resistant coating. One pair of frames per calendar year, or contact lenses (in lieu of lenses and frames). Includes fitting fee.
	Children's dental check-up	Not Covered	Not Covered	

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.)

- Out-of-network providers
- Dental Services
- Infertility Treatment
- Private Duty Nursing
- Routine Eye Exams for Adults
- Hearing Care
- Adult Orthodontia

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

- Reconstruction Surgery
- Abortion
- Newborn Care
- Acupuncture
- Chiropractic Care
- Cochlear Implants

[* For more information about limitations and exceptions, see the plan or policy document at https://individualandfamily.chpw.org.]

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: [WAHBE 1-855-923-4633]. 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 on how 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: 1-866-907-1906.

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 1-866-907-1906.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-907-1906.]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-866-907-1906.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-907-1906.]

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

[* For more information about limitations and exceptions, see the plan or policy document at https://individualandfamily.chpw.org.]

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	$600
Specialist *[cost sharing]*	$40
Hospital (facility) *[cost sharing]*	$525 per day
Other *[cost sharing]*	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**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$60**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$600
Specialist *[cost sharing]*	$40
Hospital (facility) *[cost sharing]*	$525 per day
Other *[cost sharing]*	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	**$5,700**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$20**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$600
Specialist *[cost sharing]*	$40
Hospital (facility) *[cost sharing]*	$525 per day
Other *[cost sharing]*	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	**$2,900**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$0**

Note: These numbers assume the patient received care from an IHCP provider or with IHCP referral at a non-IHCP. If you receive care from a non-IHCP provider without a referral from an IHCP your costs may be higher.

The plan would be responsible for the other costs of these EXAMPLE covered services.