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?	$0 individual / $0 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?	No	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?	$4,000 individual / $8,000 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.

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

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	$1 Copay / visit	Not covered	
	Specialist visit	$15 Copay / visit	Not covered	
	Preventive care/screening/ immunization	No charge	Not covered	
If you have a test	Diagnostic test (X-ray, blood work)	$15 Copay / visit for laboratory & professional services $20 Copay / visit for X-ray & diagnostic imaging	Not covered	
	Imaging (CT/PET scans, MRIs)	15% Coinsurance; deductible does not apply	Not covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at individualandfamily.chpw.org/2027formulary	Generic drugs	$5 Copay/ 30-day supply; $13.50 Copay/ 90-day supply.	Not covered	Prescription drugs are provided up to a 90-day supply at participating retail pharmacies or through mail order.
	Preferred brand drugs	$15 Copay/ 30-day supply; $45.50 Copay/ 90-day supply.	Not covered	Prescription drugs are provided up to a 90-day supply at participating retail pharmacies or through mail order.
	Non-preferred brand drugs	$35 Copay / prescription	Not covered	Coverage is limited to a 30-day supply
	Specialty drugs	$35 Copay / prescription	Not covered	Coverage is limited to a 30-day supply. Asthma Inhalers (corticosteroid/ corticosteroid combination, Epinephrine auto injectors, EpiPens & insulin total monthly OOP cap at $35 /30-day supply
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 Copay / visit	Not covered	
	Physician/surgeon fees	$65 Copay / visit	Not covered	

[* 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	$225 Copay / visit	$150 Copay / visit	Copay is waived if admitted as inpatient within 24 hours.
	Emergency medical transportation	$75 Copay / trip	$75 Copay / trip	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	$15 Copay / visit	Not covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	$100 Copay / day	Not covered	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	$1 Copay / visit; Other outpatient services: $1 Copay / visit	Not covered	
	Inpatient services	$100 Copay / day	Not covered	Limit of 5 copayments per inpatient treatment stay. Preauthorization required.
If you are pregnant	Office visits	No charge	Not covered	
	Childbirth/delivery professional services	No charge	Not covered	Professional services fees are included with the facility charge.
	Childbirth/delivery facility services	$100 Copay / day	Not covered	Limit of 5 copayments per hospital day.
If you need help recovering or have other special health needs	Home health care	$5 Copay / day	Not covered	Limit to 130 visits per calendar year. Preauthorization required.
	Rehabilitation services	Outpatient: $15 Copay / visit Inpatient: $100 Copay / day	Not covered	Includes physical, speech, and occupational therapies. Inpatient: 30-day maximum for all rehabilitation therapy services per calendar year. Limit of 5 copayments per hospital stay; Outpatient: 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	Outpatient: $15 Copay / visit Inpatient: $100 Copay / day	Not covered	Includes physical, speech, and occupational therapies. Inpatient: 30-day maximum for all habilitation therapy services per calendar year. Limit of 5 copayments per hospital stay; Outpatient: 25-visit maximum for all habilitation therapy services per calendar year.
	Skilled nursing care	$100 Copay / day	Not covered	60 days per calendar year; limit of 5 copayments per stay.
	Durable medical equipment	15% Coinsurance	Not covered	
	Hospice services	Outpatient: $5 Copay / day Inpatient: $100 Copay / day	Not covered	Preauthorization required. Limit of 5 copayments per hospital stay. Respite Care: 14 days lifetime maximum.
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
- Infertility Treatment (except for Artificial Insemination)
- Routine Eye Exams for Adults
- Private Duty Nursing
- Non-emergency care when traveling outside the U.S.
- Dental Services
- Adult Orthodontia

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

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Abortion	• Acupuncture	• Chiropractic Care (10 visits per calendar year)
• Hearing Aids	• Newborn Care	• Reconstruction Surgery
• 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: WAHBE 1-855-923-4633 and WA OIC 1-800-562-6900. 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. The contact information for those agencies is: WA OIC 1-800-562-6900. 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? **Not applicable**
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	**$0**
Specialist copayment	**$15**
Hospital (facility) copayment	**$100**
Other *[cost sharing]*	**15%**

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	$270
Coinsurance	$60
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$330**

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

The plan's overall deductible	**$0**
Specialist copayment	**$15**
Hospital (facility) copayment	**$100**
Other *[cost sharing]*	**15%**

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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$10
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$330**

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

The plan's overall deductible	**$0**
Specialist copayment	**$15**
Hospital (facility) copayment	**$100**
Other *[cost sharing]*	**15%**

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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$320
Coinsurance	$20
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$340**

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

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

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English
For free language assistance services and auxiliary aids and services, call 1-866-907-1906 (TTY: 711).

Español (Spanish)
Para obtener servicios gratuitos de asistencia lingüística así como ayudas y servicios auxiliares,
llame al 1-866-907-1906 (TTY: 711).

中文（简体) (Chinese)
如需免费的语言协助服务以及辅助工具和服务，请致电1-866-907-1906
(听障人士请拨打 TTY：711）。

Tiếng Việt (Vietnamese)
Để sử dụng dịch vụ hỗ trợ ngôn ngữ miễn phí cũng như các dịch vụ và tính năng hỗ trợ thêm,
hãy gọi 1-866-907-1906 (TTY: 711).

한국인 (Korean)
무료 언어 지원 서비스와 보조 지원 및 서비스를 원하시면 1-866-907-1906 (TTY: 711)로 문의해 주시기 바랍니다.

Русский (Russian)
Для получения бесплатных услуг языковой помощи а также вспомогательных средств и услуг, звоните по номеру 1-866-907-1906 (TTY: 711).

Tagalog
Para sa mga libreng serbisyo sa tulong sa wika at mga pantulong na kagamitan at serbisyo,
tumawag sa 1-866-907-1906 (TTY: 711).

Українська (Ukrainian)
Для отримання безкоштовної мовної допомоги, допоміжних засобів та послуг телефонуйте за номером 1-866-907-1906 (TTY: 711).

ខ្មែរ (Mon-Khmer Cambodian)
សម្រាប់សេវាកម្មជំនួយផ្នែកភាសា និងឧបករណ៍ និងសេវាកម្មជំនួយដោយឥតគិតថ្លៃ សូមទូរសព្ទទៅលេខ
1-866-907-1906 (TTY: 711)។

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

日本語 (Japanese)
言語サポートサービス（無料）および補助的な器具やサービスをご希望の方は、
1-866-907-1906 (TTY: 711) までお電話ください。

አማርኛ (Amharic)
ለ ለነጻ የቋንቋ እርዳታ አገልግሎቶች እንዲሁም ለአካል ጉዳተኞች እርዳታ እና አገልግሎቶች፣ ወደ 1-866-907-1906 (TTY: 711) ይደውሉ።

العربية (Arabic)
لتلقي خدمات المساعدة اللغوية المجانية والأدوات المساعدة والخدمات الإضافية، يرجى الاتصال على الرقم
1-866-907-1906 (الهاتف النصي TTY: اتصل على الرقم 711).

ਪੰਜਾਬੀ (Punjabi)
ਮੁਫਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਸਹਾਇਕ ਸਾਧਨਾਂ ਅਤੇ ਸੇਵਾਵਾਂ ਲਈ, 1-866-907-1906 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

Deutsch (German)
Kostenlose Sprachassistenzdienste, Hilfsmittel und Dienstleistungen erhalten Sie unter
1-866-907-1906 (TTY: 711).

ພາສາລາວ (Laotian)
ສໍາລັບການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ແລະ ອຸປະກອນ ແລະ ການບໍລິການເສີມແບບບໍ່ເສຍຄ່າ,
ໃຫ້ໂທ 1-866-907-1906 (TTY: 711).

Cushite Afaan Oromoo
Tajaajiloota hiikkaa afaanii, fi namoota hanqina dubbachuu, arguu fi dhagahuu qabaniif deeggarsa dubbii, argaa fi dhageettii meeshaatiinii bilisaan argachuuf, gara 1-866-907-1906 (TTY: 711) tti bilbilaa.

ትግርኛ (Tigrinya)
ብነጻ ናይ ቋንቋ ሓገዝ ኣገልግሎት፣ ከምኡ'ውን ናይ ረድኤት ሓገዝን ኣገልግሎትን ንምርካብ ናብ
1-866-907-1906 (TTY፡- 711) ደውሉ።

Soomaali (Somali)
Si aad u hesho adeegyada caawinta luqadda bilaashka ah iyo qalabka iyo adeegyada kaalmada ah,
wac 1-866-907-1906 (TTY: 711).

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

Français (French)
Pour bénéficier d'une assistance linguistique gratuite et d'aides et services auxiliaires,
appelez le 1-866-907-1906 (TTY : 711).

دری (Dari)
برای درخواست خدمات ترجمه رایگان، و کمک ها و خدمات پشتیبان مخصوص افراد ناتوان یا کم توان، با
1-866-907-1906 (TTY: 711) به تماس شوید.