



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

<https://ambetter.CoordinatedCareHealth.com/2018-brochures.html>, or call 1-877-687-1197 (TTY/TDD: 877-941-9238). 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 1-877-687-1197 (TTY/TDD: 877-941-9238) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$3,000 individual/\$6,000 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 ?	Yes. Preventive care , primary care, specialist , and urgent care office visits, generic and preferred 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 don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	For network \$6,500 individual/\$13,000 family. No, for non- network providers.	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 ?	Premiums , balance-billing charges, and health care this plan doesn't cover.	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. See Find a Provider or call 1-877-687-1197 for a list of network providers .	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.	You can see the 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		Limitation, 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	\$30 Copay /visit; deductible does not apply.	Not covered	----None----
	Specialist visit	\$60 Copay /visit; deductible does not apply.	Not covered	----None----
	Preventive care / screening / immunization	No charge	Not covered	You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive . Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% Coinsurance	Not covered	Prior authorization required. Failure to obtain prior authorization for any services that requires prior authorization may result in the denial of payment for care that may otherwise be covered.
	Imaging(CT/PET scans, MRIs)	30% Coinsurance	Not covered	Prior authorization required.

Common Medical Event	Services You May Need	What You will Pay		Limitation, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at Preferred Drug List .	Generic Drugs (Tier 1)	Retail: \$25 <u>Copay/prescription</u> ; Mail order: \$75 <u>Copay/prescription</u> ; <u>deductible</u> does not apply	Not covered	None. Prescription drugs are provided up to 31 days retail and up to 90 days through mail order. Mail orders are subject to 3X retail <u>cost-sharing</u> amount.
	Preferred brand drugs (Tier 2)	Retail: \$50 <u>Copay/prescription</u> ; Mail order: \$150 <u>Copay/prescription</u> ; <u>deductible</u> does not apply	Not covered	Prior authorization required. Prescription drugs are provided for up to 31 days retail and up to 90 days through mail order. Mail orders are subject to 3X retail <u>cost-sharing</u> amount.
	Non-preferred brand drugs (Tier 3)	30% <u>Coinsurance</u>	Not covered	Prior authorization required. Prescription drugs are provided for up to 31 days retail and up to 90 days through mail order. Mail orders are subject to 3X retail <u>cost-sharing</u> amount.
	Specialty drugs (Tier 4)	30% <u>Coinsurance</u>	Not covered	Prior authorization required. Prescription drugs are provided for up to 31 days retail and up to 90 days through mail order. Mail orders are subject to 3X retail <u>cost-sharing</u> amount.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <u>Coinsurance</u>	Not covered	Prior authorization required.
	Physician/surgeon fees	30% <u>Coinsurance</u>	Not covered	Prior authorization required.
If you need immediate medical attention	Emergency room care	\$600 <u>Copay</u> before <u>deductible</u>	\$600 <u>Copay</u> before <u>deductible</u>	In- <u>network</u> facilities may provide services from <u>out-of-network providers</u> . For out-of- <u>network emergency services</u> , you may be responsible for the difference between the <u>provider's billed charges</u> and the <u>plan's allowed amount</u> . (See note on <u>balance billing</u> above this chart.)
	Emergency Medical transportation	30% <u>Coinsurance</u>	30% <u>Coinsurance</u>	In- <u>network</u> facilities may provide services from <u>out-of-network providers</u> . For out-of- <u>network emergency services</u> , you may be responsible for the difference between the <u>provider's billed charges</u> and the <u>plan's allowed amount</u> . (See note on <u>balance billing</u> above this chart.)

	<u>Urgent Care</u>	\$100 <u>Copay</u> /visit: <u>deductible</u> does not apply	Not covered	-----None-----
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Common Medical Event	Services You May Need	What You will Pay		Limitation, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$750 <u>Copay</u> per day before <u>deductible</u>	Not covered	Prior authorization required.
	Physician/surgeon fees	30% <u>Coinsurance</u>	Not covered	Prior authorization required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 <u>Copay</u> /office visit; <u>deductible</u> does not apply; 30% <u>coinsurance</u> for all other outpatient services	Not covered	Prior authorization required. (PCP and Other Practitioner visits do not require prior authorization)
	Inpatient services	\$750 <u>Copay</u> per day before <u>deductible</u>	Not covered	Prior authorization required.
If you are pregnant	Office visits	\$30 <u>Copay</u> /visit; <u>deductible</u> does not apply	Not covered	Prior authorization required. <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> , <u>copayment</u> and/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	30% <u>Coinsurance</u>	Not covered	Prior authorization required. <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> , <u>copayment</u> and/or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	\$750 <u>Copay</u> per day before <u>deductible</u>	Not covered	Prior authorization required. <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> , <u>copayment</u> and/or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).

Common Medical Event	Services You May Need	What You will Pay		Limitation, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	30% <u>Coinsurance</u>	Not covered	130 Visit(s) per Year.
	Rehabilitation services	30% <u>Coinsurance</u>	Not covered	25 visits combined per year (Inpatient Rehabilitation limited to 30 days per calendar year).
	Habilitation services	30% <u>Coinsurance</u>	Not covered	25 Outpatient visits per benefit per year. 30 Inpatient days per benefit per year.
	Skilled nursing care	30% <u>Coinsurance</u>	Not covered	60 days per year in a facility.
	Durable medical equipment	30% <u>Coinsurance</u>	Not covered	Prior authorization required.
	Hospice services	30% <u>Coinsurance</u>	Not covered	Respite Care - 14 days per lifetime.
If your child needs dental or eye care	Children's eye exam	\$0 <u>Copay</u> /visit; <u>deductible</u> does not apply	Not covered	1 Visit per Year
	Children's glasses	\$0 <u>Copay</u> /item; <u>deductible</u> does not apply	Not covered	1 Item per Year
	Children's dental check-up	Not covered	Not covered	-----None-----

Excluded Services & Other Covered Services

Services your Plan Generally Does NOT cover (Check your policy or plan documentation for more information and a list of any other excluded services .)			
<ul style="list-style-type: none"> Bariatric surgery Long-term care 	<ul style="list-style-type: none"> Cosmetic surgery Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> Dental Care Private-duty nursing Weight loss programs 	

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

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|--|---|--|
| • Abortion (Not limited based on federal funding) | • Acupuncture (Limited to 12 visits per year. Unlimited visits for chemical dependency treatment) | • Chiropractic care (Limited to 10 specialists' visits per year) |
| • Infertility treatment (Coverage for the diagnosis of infertility only) | • Routine eye care (Adult) | • Hearing aids (Coverage for cochlear implants only) |
| | | • Routine foot care (For diabetes treatment) |

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: Consumer Advocacy/SHIBA Office of the Insurance Commissioner, 5000 Capitol Blvd., SE, Tumwater, WA 98501, Phone No. (800) 562-6900 or (360) 725-7080. 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 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: Consumer Advocacy/SHIBA Office of the Insurance Commissioner, 5000 Capitol Blvd., SE, Tumwater, WA 98501, Phone No. (800) 562-6900 or (360) 725-7080.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-877-687-1197, TTY/TDD 1-877-941-9238.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-687-1197, TTY/TDD 1-877-941-9238.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-687-1197, TTY/TDD 1-877-941-9238.

Navajo (Dine): Dinekehgo shika at'ohwol ninisingo, kwijigo holne 1-877-687-1197, TTY/TDD 1-877-941-9238.

—————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) [copayment](#) \$750
- Other [coinsurance](#) 30%

This EXAMPLE even includes services like:

Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery facility Services
Diagnostic test (ultrasounds and blood work)
Specialist visit (anesthesia)

Total Example Cost **\$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$3,000
Copayments	\$1,400
Coinsurance	\$300
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$4,760

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) [copayment](#) \$750
- Other [coinsurance](#) 30%

This EXAMPLE even includes services like:

Primary care physician office visits (includes disease education)
Diagnostic tests (blood work)
Prescription Drugs
Durable medical equipment (glucose meter)

Total Example Cost **\$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1,300
Copayments	\$1,800
Coinsurance	\$600
What isn't covered	
Limits or exclusions	\$60
The total Joe would pay is	\$3,760

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) [copayment](#) \$750
- Other [coinsurance](#) 30%

This EXAMPLE even includes services like:

Emergency room care (including medical supplies)
Diagnostic test (x-ray)
Durable medical equipment (crutches)
Rehabilitation services (Physical therapy)

Total Example Cost **\$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,100
Copayments	\$200
Coinsurance	\$500
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,800

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

Statement of Non-Discrimination

Ambetter from Coordinated Care complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Ambetter from Coordinated Care does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Ambetter from Coordinated Care:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact Ambetter from Coordinated Care at 1-877-687-1197 (TTY/TDD 1-877-941-9238).

If you believe that Ambetter from Coordinated Care has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Grievances Coordinator Coordinated Care, 1145 Broadway, Suite 300, Tacoma, WA 98402, 1-877-687-1197 (TTY/TDD 1-877-941-9238), Fax 1-855-218-0588. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Ambetter from Coordinated Care is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Spanish:	Si usted, o alguien a quien está ayudando, tiene preguntas acerca de Ambetter de Coordinated Care, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-877-687-1197 (TTY/TDD 1-877-941-9238).
Chinese:	如果您，或是您正在協助的對象，有關於 Ambetter from Coordinated Care 方面的問題，您有權利免費以您的母語得到幫助和訊息。如果要與一位翻譯員講話，請撥電話 1-877-687-1197 (TTY/TDD 1-877-941-9238)。
Vietnamese:	Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Ambetter from Coordinated Care, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-877-687-1197 (TTY/TDD 1-877-941-9238).
Korean:	만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Ambetter from Coordinated Care 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-877-687-1197(TTY/TDD 1-877-941-9238)로 전화하십시오.
Russian:	В случае возникновения у вас или у лица, которому вы помогаете, каких-либо вопросов о программе страхования Ambetter from Coordinated Care вы имеете право получить бесплатную помощь и информацию на своем родном языке. Чтобы поговорить с переводчиком, позвоните по телефону 1-877-687-1197 (TTY/TDD 1-877-941-9238).
Tagalog:	Kung ikaw, o ang iyong tinutulongan, ay may mga katanungan tungkol sa Ambetter from Coordinated Care, may karapatan ka na makakuha nang tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-877-687-1197 (TTY/TDD 1-877-941-9238).
Ukrainian:	В разі виникнення у вас або особи, якій ви допомагаєте, будь-яких запитань щодо програми страхування Ambetter from Coordinated Care ви маєте право отримати безкоштовну допомогу та інформацію на своїй рідній мові. Щоб поговорити з перекладачем, зателефонуйте за номером 1-877-687-1197 (TTY/TDD 1-877-941-9238).
Mon-Khmer, Cambodian:	ប្រសិនបើអ្នកឬ អ្នកណាម្នាក់ដែលអ្នកកំពុងជួយមានបញ្ហាអំពី Ambetter from Coordinated Care អ្នកមានសិទ្ធិទទួលបានព័ត៌មានជាភាសាដើមរបស់អ្នកដោយឥតគិតថ្លៃ។ សូមទំនាក់ទំនងអ្នកបកប្រែភាសាខ្មែរ1-877-687-1197 (TTY/TDD 1-877-941-9238)
Japanese:	Ambetter from Coordinated Care について何かご質問がございましたらご連絡ください。ご希望の言語によるサポートや情報を無料でご提供いたします。通訳が必要な場合は、1-877-687-1197 (TTY/TDD 1-877-941-9238) までお電話ください。
Amharic:	እርስዎ ወይም እርስዎ የሚርዱት ሰው ስለ Ambetter from Coordinated Care ግብር ጥያቄ ካለዎት ያለምንም ወጪ በቋንቋዎ ድጋፍ እንዲሁም መረጃ የማግኘት መብት አለዎት፤ እስተርጓሚ ለማነጋገር በ 1-877-687-1197 (TTY/TDD 1-877-941-9238) ይደውሉ፤
Cushite:	Yoo sii ykn namaa gargaaraa jirtuu wa'ee Ambetter from Coordinated Care (Kuununsaa Qindeeffamaa) irra gaaffi qabaatan ta'ee gargaarsaa fi odeeffanoo afaan ketiin kaffaltii alla argachuuf mirgaa qabdaa. Turjumaana wajiin dubadhuu,1-877-687-1197 irra bilbilli (TTY/TDD 1-877-941-9238).
Arabic:	إذا كان لديك أو لدى شخص تساعد أسئلة حول Ambetter from Coordinated Care، لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ (TTY/TDD 1-877-941-9238) 1-877-687-1197.
Punjabi:	ਜੇ ਤੁਹਾਡੇ, ਜਾਂ ਤੁਹਾਡੀ ਮਦਦ ਲੈ ਰਹੇ ਕਿਸੇ ਵਿਅਕਤੀ ਦੇ ਮਨ ਵਿਚ Ambetter from Coordinated Care ਦੇ ਬਾਰੇ ਕੋਈ ਸਵਾਲ ਹਨ, ਤਾਂ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਮੁਫਤ ਮਦਦ ਲੈਣ ਦਾ ਪੂਰਾ ਹੱਕ ਹੈ। ਦੁਆਰੀਏ ਨਾਲ ਗੱਲ ਕਰਨ ਲਈ 1-877-687-1197 (TTY/TDD 1-877-941-9238) 'ਤੇ ਕਾਲ ਕਰੋ।
German:	Falls Sie oder jemand, dem Sie helfen, Fragen zu Ambetter from Coordinated Care hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-877-687-1197 (TTY/TDD 1-877-941-9238) an.
Laotian:	ຖ້າທ່ານ ຫຼືຄົນທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ ມີຄຳຖາມກ່ຽວກັບ Ambetter from Coordinated Care, ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານ ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຈະເວົ້າກັບນາຍພາສາ ໃຫ້ໃບໂທຫາ 1-877-687-1197 (TTY/TDD 1-877-941-9238).