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/2020-brochures.html or call 1-877-687-1197 (TTY/TDD 1-877-941-9238). 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 1-877-941-9238) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$4,250 individual / $8,500 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 services, primary care, specialist, and urgent care office visits, children's eye exam and glasses, generic and preferred 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 don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers: $6,500 individual / $13,000 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?	Premiums, balance-billing charges, health care this plan does not cover, costs for non-covered services and services provided by non-network providers.	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		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	$25 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; deductible does not apply.	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance	Not covered	Prior authorization may be required. Failure to obtain prior authorization for any service that requires prior authorization may result in reduction of benefits. See your policy for more details.
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	Not covered	Prior authorization may be required.

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 drugs to treat your illness or condition More information about prescription drug coverage is available at Preferred Drug List.	Generic drugs (Tier 1)	Retail: $10 Copay / prescription; Mail Order (90 day supply): $25 Copay / prescription; deductible does not apply	Not covered	Prescription drugs are provided up to 30 days retail and up to 90 days through mail order.
	Preferred brand drugs (Tier 2)	Retail: $55 Copay / prescription; Mail Order (90 day supply): $137.50 Copay / prescription; deductible does not apply	Not covered	Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 90 days through mail order.
	Non-preferred brand drugs (Tier 3)	30% Coinsurance	Not covered	Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 90 days through mail order.
	Specialty drugs (Tier 4)	30% Coinsurance	Not covered	Prior authorization may be required. Prescription drugs are provided up to 30 days retail and up to 30 days through mail order.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	Not covered	Prior authorization may be required.
	Physician/surgeon fees	20% Coinsurance	Not covered	Prior authorization may be required.
If you need immediate medical attention	Emergency room care	20% Coinsurance	20% Coinsurance	For emergency services received in Washington, you will only be responsible for in-network cost-sharing amounts. It is impermissible for Washington providers and hospitals to balance bill you, regardless of network status. For out-of-network emergency services received in other states, you may be responsible for additional out-of-pocket costs up to the difference between the billed charges and the plan's allowed amount. (See note on balance billing above this chart.)

*For more information about limitations and exceptions, see plan or policy document at [https://api.centene.com/EOC/2020/61836WA009.pdf].

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)	
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	Payment for emergency transportation within the service area provided by non-network ambulances will be based on the provider's billed charges or a negotiated rate. Payment for emergency transportation outside of the service area will be based on the greatest of the three methods described in your Evidence of Coverage (EOC). Please see your EOC for more specific information.
	Urgent care	$60 Copay / visit; deductible does not apply.	Not covered	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% Coinsurance	Not covered	Prior authorization may be required.
	Physician/surgeon fees	20% Coinsurance	Not covered	Prior authorization may be required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 Copay / office visit (deductible does not apply); 20% Coinsurance for all other outpatient services	Not covered	Prior authorization may be required. (PCP and other practitioner visits do not require prior authorization)
	Inpatient services	20% Coinsurance	Not covered	Prior authorization may be required.
If you are pregnant	Office visits	$25 Copay / visit; deductible does not apply.	Not covered	Prior authorization not required for deliveries within the standard timeframe per federal regulation, but may be required for other services. Cost-sharing does not apply for preventive services. Depending on the type of services, coinsurance, deductible or copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).

*For more information about limitations and exceptions, see plan or policy document at [https://api.centene.com/EOC/2020/61836WA009.pdf].

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)	
	Childbirth/delivery professional services	20% Coinsurance	Not covered	Prior authorization not required for deliveries within the standard timeframe per federal regulation, but may be required for other services. Cost-sharing does not apply for preventive services. Depending on the type of services, coinsurance, deductible or copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	20% Coinsurance	Not covered	Prior authorization not required for deliveries within the standard timeframe per federal regulation, but may be required for other services. Cost-sharing does not apply for preventive services. Depending on the type of services, coinsurance, deductible or copayment may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	Not covered	130 visits per year.
	Rehabilitation services	20% Coinsurance	Not covered	Prior authorization may be required. 25 Outpatient visits per year; 30 Inpatient days per year.
	Habilitation services	20% Coinsurance	Not covered	Prior authorization may be required. 25 Outpatient visits per year; 30 Inpatient days per year.
	Skilled nursing care	20% Coinsurance	Not covered	Prior authorization may be required. 60 days per year.
	Durable medical equipment	20% Coinsurance	Not covered	Prior authorization may be required.
	Hospice services	20% Coinsurance	Not covered	Prior authorization may be required. 14 days per lifetime for respite care covered in conjunction with hospice services.
If your child needs dental or eye care	Children's eye exam	No charge; deductible does not apply.	Not covered	1 visit per year.
	Children's glasses	No charge; deductible does not apply.	Not covered	1 item per year. Limited to one frame and one pair (two lenses) per calendar year or contacts in lieu of glasses.

*For more information about limitations and exceptions, see plan or policy document at [https://api.centene.com/EOC/2020/61836WA009.pdf].

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)	
	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 document for more information and a list of any other excluded services.)

- Bariatric surgery
- Cosmetic surgery
- Dental care
- Long-term care
- Non-emergency care when traveling outside the U. S.
- 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.)

- Abortion
- Acupuncture (Limited to 12 visits per year. Unlimited visits for chemical dependency treatment)
- Chiropractic care (Limited to 10 specialist visits per year)
- Hearing aids (Coverage for cochlear implants only)
- Infertility treatment (Coverage for the diagnosis of infertility only)
- Routine eye care (Adult-one visit & one item per year. Dollar limits apply)
- 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: Ambetter from Coordinated Care at 1-877-687-1197 (TTY/TDD: 1-877-941-9238); Consumer Advocacy/SHIBA Office of the Insurance Commissioner, 5000 Capitol Blvd., SE, Turnwater, 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, Turnwater, 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 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): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo 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	$4,250
Specialist copayment	$60
Hospital (facility) coinsurance	20%
Other coinsurance	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	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$4,100
Copayments	$400
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$6,560

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

The plan's overall deductible	$4,250
Specialist copayment	$60
Hospital (facility) coinsurance	20%
Other coinsurance	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	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$1,300
Coinsurance	$400
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$3,260

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

The plan's overall deductible	$4,250
Specialist copayment	$60
Hospital (facility) coinsurance	20%
Other coinsurance	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	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,300
Copayments	$200
Coinsurance	$300
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.