



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 ? | \$950 individual / \$1,900 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 : \$2,700 individual / \$5,400 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 | No charge; deductible does not apply. | Not covered | -----None----- |
| | Specialist visit | \$10 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. |

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|--|--|---|--|---|
| | | 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) | No charge; 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: \$25 Copay / prescription; Mail Order (90 day supply): \$62.50 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.) |

| 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 | \$10 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 | No charge / 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 | No charge; 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). |

| 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. |

| 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, 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 | \$950 |
| ■ Specialist copayment | \$10 |
| ■ 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 | \$800 |
| Copayments | \$0 |
| Coinsurance | \$1,900 |
| What isn't covered | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$2,760 |

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

| | |
|---|-------|
| ■ The plan's overall deductible | \$950 |
| ■ Specialist copayment | \$10 |
| ■ 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 | \$950 |
| Copayments | \$300 |
| Coinsurance | \$400 |
| What isn't covered | |
| Limits or exclusions | \$60 |
| The total Joe would pay is | \$1,710 |

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

| | |
|---|-------|
| ■ The plan's overall deductible | \$950 |
| ■ Specialist copayment | \$10 |
| ■ 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 | \$950 |
| Copayments | \$30 |
| Coinsurance | \$300 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,280 |