Swedish Health Services: Medical Plan

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2015 – 12/31/2015

Coverage for: Family | Plan Type: PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.myfirstchoice.fchn.com or by calling 1-800-750-5202.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Swedish Network: **$300** person/ **$600** family. In Network: **$450** person/ **$900** family. Non network: **$1,300** person/ **$2,600** family. Doesn't apply to preventive care or pharmacy. Co-payments don't count toward the deductible.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Swedish Network: **$3,000** person/ **$6,000** family. In Network: **$4,500** person/ **$9,000** family. Non network: **$7,300** person/ **$14,600** family Pharmacy: **$2,100** person/ **$4,200** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, penalties for failure to obtain pre-authorization for services, and health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.fchn.com **or call 1-800-750-5202** for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-800-750-5202 or visit us at www.myfirstchoice.fchn.com.
If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.myfirstchoice.fchn.com or call 1-800-750-5202 to request a copy.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an			Limitations & Exceptions
		Swedish Provider	Network Provider	Non Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 co-pay/visit	$35 co-pay/visit	40% co-insurance	none
	Specialist visit	20% co-insurance	30% co-insurance	40% co-insurance	none
	Other practitioner office visit	20% co-insurance	20% co-insurance	20% co-insurance	Combination of acupuncture, nutritionist, and massage limited to 10 visits per calendar year. Chiropractic limited to 10 visits per calendar year.
	Preventive care/ screening/immunization	No charge	No charge	40% co-insurance	Swedish and Network providers not subject to deductible.
If you have a test	Diagnostic test (x-ray, blood work)	Outpatient professional: 20% co-insurance.	Outpatient facility: 40% co-insurance. Outpatient professional: 20% co-insurance.	Outpatient facility: 50% co-insurance. Outpatient professional: 40% co-insurance.	none
	Imaging (CT/PET scans, MRIs)	MRI and CT scan: $100 co-pay/visit for facility; $100 co-pay and 20% co-insurance for professional. PET scan: 20% co-insurance for outpatient	MRI and CT scan: $100 co-pay/visit and 40% co-insurance for facility; $100 co-pay and 20% co-insurance for professional. PET scan: 40% co-insurance for	MRI and CT scan: $100 co-pay/visit and 50% co-insurance for facility; $100 co-pay and 40% co-insurance for professional. PET scan: 50% co-insurance for	Only one co-pay will apply to each MRI and CT scan. Pre-authorization required for PET scans or else claim is denied.

Common Medical Event	Services You May Need	Your cost if you use an			Limitations & Exceptions
		Swedish Provider	Network Provider	Non Network Provider	
		professional.	outpatient facility; 20% co-insurance for outpatient professional.	outpatient facility; 40% co-insurance for outpatient professional.	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.medimpact.com.	Generic drugs	$7.50 co-pay/ prescription for 30-day supply; $18.75 co-pay/prescription for 90-day supply	Retail: $15 co-pay/ prescription. Mail order: $37.50 co-pay/ prescription.	No coverage	Covers up to a 30 day supply at a Swedish and retail pharmacy and up to a 90 day supply at a Swedish pharmacy or by mail order. Not subject to deductible. Initial fill on all medication limited to 30 day supply.
	Preferred brand drugs	$30 co-pay/ prescription for 30-day supply; $75 co-pay/prescription for 90-day supply	Retail: $40 co-pay/ prescription. Mail order: $100 co-pay/prescription	No coverage	
	Non-preferred brand drugs	$60 co-pay/ prescription for 30-day supply; $150 co-pay/prescription for 90-day supply	Retail: $70 co-pay/ prescription. Mail order: $175 co-pay/ prescription	No coverage	
	Specialty drugs	$75 co-pay/prescription	$75 co-pay/prescription	No coverage	Not subject to deductible. Limited to a 30-day supply. Available only through Providence Specialty Pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% co-insurance	40% co-insurance	50% co-insurance	Pre-authorization required for certain services or else claim is denied.
	Physician/surgeon fees	20% co-insurance	20% co-insurance	40% co-insurance	
If you need immediate medical attention	Emergency room services	1st visit: $75 co-pay/visit and 20% co-insurance. 2nd visit: $100 co-pay/visit and 20% co-insurance. Subsequent visits: $150 co-pay/visit and 20% co-insurance.			none
	Emergency medical transportation	$75 co-pay/occurrence and 20% co-insurance			none

Common Medical Event	Services You May Need	Your cost if you use an			Limitations & Exceptions
		Swedish Provider	Network Provider	Non Network Provider	
	Urgent care	20% co-insurance	30% co-insurance	40% co-insurance	none
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 co-pay/stay	$200 co-pay/stay and 40% co-insurance	$200 co-pay/stay and 50% co-insurance	Pre-authorization required or else claim is denied.
	Physician/surgeon fee	20% co-insurance	20% co-insurance	40% co-insurance	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	0% co-insurance	10% co-insurance	40% co-insurance	Swedish and Network providers subject to Swedish deductible and out-of-pocket maximum.
	Mental/Behavioral health inpatient services	$200 co-pay/stay	$200 co-pay/stay and 10% co-insurance	40% co-insurance	Swedish and Network providers subject to Swedish deductible and out-of-pocket maximum. Pre-authorization required or else claim is denied.
	Substance use disorder outpatient services	0% co-insurance	10% co-insurance	40% co-insurance	Swedish and Network providers subject to Swedish deductible and out-of-pocket maximum.
	Substance use disorder inpatient services	$200 co-pay/stay	$200 co-pay/stay and 10% co-insurance	40% co-insurance	Swedish and Network providers subject to Swedish deductible and out-of-pocket maximum. Pre-authorization required or else claim is denied.
If you are pregnant	Prenatal and postnatal care	$350 co-pay	$350 co-pay	40% co-insurance	Swedish and Network providers not subject to deductible.
	Delivery and all inpatient services	Facility: $200 co-pay/stay	Facility: $200 co-pay/stay and 40% co-insurance.	Facility: $200 co-pay/stay and 50% co-insurance.	none

Common Medical Event	Services You May Need	Your cost if you use an Swedish Provider	Your cost if you use an Network Provider	Your cost if you use an Non Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% co-insurance	20% co-insurance	40% co-insurance	Coverage is limited to 40 visits per calendar year. Pre-authorization required or else claim is denied.
	Rehabilitation services	Inpatient: $200 co-pay/stay. 20% co-insurance for professional fees. Office visit: 20% co-insurance	Inpatient: $200 co-pay/stay and 40% co-insurance for facility and 20% co-insurance for professional fees. Office visit: 30% co-insurance.	Inpatient: $200 co-pay/stay and 50% co-insurance for facility and 40% co-insurance for professional fees. Office visit: 40% co-insurance.	Coverage for inpatient rehabilitation is limited to 90 days per calendar year combined with skilled nursing. Coverage for outpatient rehabilitation is limited to 45 visits per calendar year. Pre-authorization is required for inpatient or else claim is denied.
	Habilitation services	Inpatient: $200 co-pay/stay. Office visit: $0 co-pay for professional	Inpatient: $200 co-pay/stay and 10% co-insurance. Office visit: $0 co-pay for professional and 10% co-insurance for facility.	40% co-insurance	Covered only for children age 6 and under. Swedish and Network providers subject to Swedish deductible and out-of-pocket maximum.
	Skilled nursing care	20% co-insurance for professional fees, $200 co-pay for facility.	20% co-insurance for professional fees. $200 co-pay for facility & 40% co-insurance.	40% co-insurance for professional fees. $200 co-pay for facility & 50% co-insurance.	Coverage limited to 90 days per calendar year combined with inpatient rehabilitation. Pre-authorization required or else claim is denied.
	Durable medical equipment	20% co-insurance	20% co-insurance	20% co-insurance	Pre-authorization is required for some items or else claim is denied.
	Hospice service	$200 co-pay/ occurrence. 20% co-insurance for professional	$200 co-pay/occurrence and 40% co-insurance for facility. 20% co-insurance for professional.	$200 co-pay/occurrence and 50% co-insurance for facility. 40% co-insurance for professional.	Coverage is limited to 6 months lifetime maximum. Pre-authorization required or else claim is denied.
If your child needs dental or eye care	Eye exam	May be covered by another plan offered through your employer.			none
	Glasses	May be covered by another plan offered through your employer.			none
	Dental check-up	May be covered by another plan offered through your employer.			none

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S
- Private-duty nursing
- Routine eye care (Adult)

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Chiropractic care
- Hearing aids
- Routine foot care
- Weight loss programs

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 800-750-5202. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov."

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: First Choice Health Administrators at 800-750-5202.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-750-5202.

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-750-5202.

CHINESE (中文): **如果需要中文的帮助**, 请拨打这个号码1-800-750-5202.

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-750-5202.

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

This Summary of Benefits and Coverage required by the Affordable Care Act summarizes the benefit options available to eligible employees as of January 1, 2015. The official plan document and summary plan description will provide more complete details regarding the terms of the Plan. If there is any conflict between the statements in this Summary and the official plan documents, the terms of the plan documents will govern all rights and obligations of participants, beneficiaries, plan fiduciaries and the Company. Swedish Health Services reserves the right to amend or terminate these benefits or change the cost of coverage, for any reason, at any time.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,450
- **Patient pays** $ 1,090

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$300
Co-pays	$560
Co-insurance	$80
Limits or exclusions	$150
Total	**$1,090**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,630
- **Patient pays** $ 770

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$300
Co-pays	$380
Co-insurance	$10
Limits or exclusions	$80
Total	**$770**

Note: These numbers assume the patient receives primary care services through Swedish

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.