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 call 1-888-889-1112. 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 1-888-889-1112 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Tiers 1 & 2: MultiCare Connected Care Clinically Integrated Network (MCC CIN) & First Choice Health Network/First Health Network (FCHN/FHN): **$1,650** self-only/ **$3,300**/family Tiers 3 & 4: Prov/Swed/VMFH/PacMed & out-of-network providers: **$2,500** self-only/**$5,000** 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, the overall family deductible must be met before the plan begins to pay. Higher member out of pocket for services received at Tier 3 First Choice Health Network Providence (Washington State), Swedish, Virginia Mason Franciscan Health (VMFH) and Pacific Medical Centers (PacMed) and Tier 4 Out-of-Network providers.
Are there services covered before you meet your deductible?	Yes. In-network Preventive care services (Tiers 1-3) are covered and not subject to 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?	Tiers 1 & 2: MultiCare Connected Care Clinically Integrated Network (MCC CIN) & First Choice Health Network/First Health Network (FCHN/FHN): **$3,500** self-only/ **$6,850**/family Tiers 3 & 4: Prov/Swed/VMFH/PacMed & out-of-network providers: **$6,500** self only/ **$13,000** family.	The out-of-pocket limits are 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. Higher member out of pocket for services received at Providence (Washington State), Swedish, Virginia Mason Franciscan Health (VMFH) and Pacific Medical Centers (PacMed).

Important Questions	Answers	Why This Matters:
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. Search the provider networks at www.fchn.com/multicare.or call 888-889-1112 for a list of network providers.	This plan uses provider networks. You will pay the least if you use a provider in Tier 1. You will pay more if you use a provider in Tier 2. You will pay the most if you use a provider in Tier 3 or Tier 4 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. Tier 1 may not be able to offer all services required for your care. Each service you receive is paid based on the applicable network tier of the provider or facility.
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
		Tier 1: MCC CIN Provider (You will pay the least)	Tier 2: FCH Network /FH Network Provider	Tier 3: Prov/Swed/ VMFH/PacMed	Tier 4: 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	10% coinsurance	30% coinsurance	50% coinsurance	50% coinsurance	Alternative Care (massage, acupuncture and spinal manipulations) are covered. See your plan document for a detailed list of limitations and coverage. Non-manipulation services provided by a chiropractor are covered based on the service billed. For example, an office visit will be billed as a professional visit under the professional benefit.
	Specialist visit	10% coinsurance	30% coinsurance	50% coinsurance	50% coinsurance	
	Preventive care/ screening/ immunization	No charge	No charge	No charge	50% coinsurance	Annual deductible applies to out-of-network services. 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.

* For more information about limitations and exceptions, see the plan or policy document at www.fchn.com.

If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	50% coinsurance	50% coinsurance	PET scans require pre-authorization or claim will be denied.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	50% coinsurance	50% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at Ventegra at 833-393-0445.	Tier 0 (Wellness Medications)	MHS Pharmacy: No Charge Ventegra Network Pharmacy: No Charge (limited ACA list)				The plan's Wellness Drug List provides a list of medications covered 100% if dispensed at a MultiCare Health System (MHS) Pharmacy, and a subset list of certain ACA defined medications covered 100% at MHS and Ventegra contracted pharmacies. Non-preventive medications are subject to the deductible. MHS Pharmacy - Retail covered up to a 34-day supply, and Mail Order covered at MHS Pharmacy up to a 90-day supply. Ventegra Network Retail Pharmacy –up to a 34-day supply. For members residing in WA/ID refill maintenance medications must be filled at MHS Pharmacies. For members residing outside of WA/ID refill maintenance medications must be filled at Costco Mail Order Pharmacy. Refer to maintenance medication list at www.fchn.com/multicare under the pharmacy section. Compound drugs over $400 require pre-authorization. If pre-authorization is not obtained, claims will be denied.
	Tier 1 (Generic drugs)	Retail: MHS Pharmacy: 20% / $10 minimum Ventegra Network Pharmacy: 40% / $20 minimum Mail Order: MHS Pharmacy: 20% / $20 minimum				
	Tier 2 (Preferred brand & some high-cost generics drugs)	Retail: MHS Pharmacy: 10% Ventegra Network Pharmacy: 30% Mail Order: MHS Pharmacy: 10%				
	Tier 3 (Non-preferred brand drugs)	Retail: MHS Pharmacy: 10% Ventegra Network Pharmacy: 30% Mail Order: MHS Pharmacy: 10%				
	Tier 4 (Specialty drugs)	MHS Pharmacy: 10%, after deductible				Specialty drugs- covered at MHS Pharmacy only, limited to 30-day supply.

* For more information about limitations and exceptions, see the plan or policy document at www.fchn.com.

If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	50% coinsurance	50% coinsurance	Pre-authorization required for certain services or claim will be denied.
	Physician/ surgeon fees	10% coinsurance	30% coinsurance	50% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	10% coinsurance	30% coinsurance	30% coinsurance	30% coinsurance	None.
	Emergency medical transportation	10% coinsurance	30% coinsurance	30% coinsurance	30% coinsurance	Preauthorization is required for non-emergent ground ambulance transfers to a MultiCare Health System (MHS) facility.
	Urgent care	10% coinsurance	30% coinsurance	50% coinsurance	50% coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	50% coinsurance	50% coinsurance	Out-of-network facilities limited to 10 inpatient admissions per calendar year; applies to all out-of-network inpatient admissions. Preauthorization is required or claim will be denied.
	Physician/ surgeon fees	10% coinsurance	30% coinsurance	50% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% coinsurance	10% coinsurance	50% coinsurance	50% coinsurance	None.
	Inpatient services	10% coinsurance	10% coinsurance	50% coinsurance	50% coinsurance	Out-of-network facilities limited to 10 inpatient admissions per calendar year; applies to all out-of-network inpatient admissions. Preauthorization is required or claim will be denied.
If you are pregnant	Office visits	10% coinsurance	30% coinsurance	50% coinsurance	50% coinsurance	Coverage limited to employees and their spouses/domestic partner. Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e., imaging).
	Childbirth/ delivery professional services	10% coinsurance	30% coinsurance	50% coinsurance	50% coinsurance	
	Childbirth/ delivery facility services	10% coinsurance	30% coinsurance	50% coinsurance	50% coinsurance	

If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	50% coinsurance	50% coinsurance	Coverage is limited to 130 visits per calendar year. Pre-authorization required or claim will be denied.
	Rehabilitation services	10% coinsurance	30% coinsurance	50% coinsurance	50% coinsurance	Coverage limited to 30 days per calendar year for inpatient; 45 visits per calendar year for outpatient (includes physical, speech, occupational and cardiac therapy). Pre-authorization required for inpatient rehabilitation or claim will be denied. A massage therapy service that is billed as a physical therapy service will be processed under the Outpatient Rehabilitation benefit.
	Habilitation services	10% coinsurance	30% coinsurance	50% coinsurance	50% coinsurance	Pre-authorization required for inpatient habilitation or claim will be denied.
	Skilled nursing care	10% coinsurance	10% coinsurance	50% coinsurance	50% coinsurance	Coverage is limited to 90 visits per calendar year. Pre-authorization required or claim will be denied.
	Durable medical equipment	10% coinsurance	10% coinsurance	50% coinsurance	50% coinsurance	Pre-authorization required for certain items listed on the pre-authorization list or claim will be denied.
	Hospice services	10% coinsurance	30% coinsurance	50% coinsurance	50% coinsurance	Inpatient Hospice limited to 14 days per 12 months. Respite Care limited to 30 day maximum within 12 month period. Pre-authorization required or claim will be denied.
If your child needs dental or eye care	Children's eye exam	Not Covered				Refer to VSP if you are enrolled in vision coverage.
	Children's glasses	Not Covered				Refer to VSP if you are enrolled in vision coverage.
	Children's dental check-up	Not Covered				Refer to your dental coverage if you enrolled in dental coverage.

* For more information about limitations and exceptions, see the plan or policy document at www.fchn.com.

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.)

- Cosmetic surgery
- Dental care
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care
- Routine foot care
- Weight loss programs

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

- Acupuncture (limited to 12 per calendar year)
- Bariatric surgery (limited to Tier 1 MCC and UWMC)
- Chiropractic care (limited to 16 per calendar year)
- Hearing aids

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: 1-888-889-1112 or visit www.fchn.com or 1-866-444-EBSA www.dol.gov/ebsa/healthreform. 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 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: 1-888-889-1112.

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? 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 1-888-889-1112.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-889-1112.

[Chinese (中文): 如果需要中文的帮助， 请拨打这个号码1-888-889-1112.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-889-1112.

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 www.fchn.com.

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	**$1,650**
Specialist copayments	**10%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

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	$1,650
Copayments	$0
Coinsurance	$1,050
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	**$1,650**
Specialist copayments	**10%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

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	$1,650
Copayments	$0
Coinsurance	$650
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,320**

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

The plan's overall deductible	**$1,650**
Specialist copayments	**10%**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

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	$1,650
Copayments	$0
Coinsurance	$50
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,700**

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