




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:
<p><b>What is the overall <a href="#">deductible</a>?</b></p>	<p>Tier 1: MultiCare Connected Care Clinically Integrated Network (MCC CIN) &amp; FCH Network/First Health Network (FCHN/FHN): <b>\$600</b> person/<b>\$1,800</b>/family</p> <p>Tiers 2 &amp; 3: Prov/Swed/VMFH/PacMed &amp; <a href="#">out-of-network providers</a>: <b>\$1,500</b> person/<b>\$3,000</b> family.</p>	<p>Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a>, each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a>.</p> <p>Higher member out of pocket for services received at Tier 2 First Choice Health contracted Providence (Washington State), Swedish, Virginia Mason Franciscan Health (VMFH) and Pacific Medical Centers (PacMed) and at Tier 3 <a href="#">out-of-network providers</a>.</p>
<p><b>Are there services covered before you meet your <a href="#">deductible</a>?</b></p>	<p>Yes. In-network <a href="#">Preventive care</a> services (Tiers 1&amp; 2) are covered and not subject to your <a href="#">deductible</a>.</p>	<p>This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a>. See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</p>
<p><b>Are there other <a href="#">deductibles</a> for specific services?</b></p>	<p>No.</p>	<p>You don't have to meet <a href="#">deductibles</a> for specific services.</p>

Important Questions	Answers	Why This Matters:
<p><b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b></p>	<p>Tier 1: MultiCare Connected Care Clinically Integrated Network (MCC CIN) &amp; FCH Network/First Health Network (FCHN/FHN): <b>\$3,200</b> person/ <b>\$8,300</b>/family</p> <p>Tiers 2 &amp; 3: Prov/Swed/VMFH/PacMed &amp; <a href="#">out-of-network providers</a>: <b>\$4,850</b> person/ <b>\$12,500</b> family.</p> <p>Separate Pharmacy <a href="#">out-of-pocket limit</a>: <b>\$1,500</b> person/ <b>\$3,000</b> family</p>	<p>The <a href="#">out-of-pocket limits</a> are the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a>, they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> 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).</p>
<p><b>What is not included in the <a href="#">out-of-pocket limit</a>?</b></p>	<p><a href="#">Premiums</a>, <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>
<p><b>Will you pay less if you use a <a href="#">network provider</a>?</b></p>	<p>Yes. Search the provider networks at <a href="http://www.fchn.com/multicare">www.fchn.com/multicare</a> or call 888-889-1112 for a list of <a href="#">network providers</a>.</p>	<p>This <a href="#">plan</a> uses <a href="#">provider networks</a>. You will pay the least if you use a <a href="#">provider</a> in Tier 1. You will pay more if you use a <a href="#">provider</a> in Tier 2. You will pay the most if you use a <a href="#">provider</a> in Tier 3 <a href="#">out-of-network provider</a>, and you might receive a bill from a provider for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays (<a href="#">balance billing</a>). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> 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.</p>
<p><b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b></p>	<p>No.</p>	<p>You can see the <a href="#">specialist</a> you choose without a referral.</p>

 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/FCH Network/FH Network Provider (You will pay the least)	Tier 2: Prov/Swed/VMFH/PacMed	Tier 3: Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$20 <a href="#">copay</a>	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Alternative Care (massage, acupuncture and spinal manipulations) are covered. See your <a href="#">plan</a> 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.
	<a href="#">Specialist</a> visit	\$35 <a href="#">copay</a>	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
	<a href="#">Preventive care/screening/immunization</a>	No charge	No charge	50% <a href="#">coinsurance</a>	
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	PET scans require <a href="#">pre-authorization</a> or claim will be denied.
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.fchn.com](http://www.fchn.com) .

<p><b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at Ventegra at 833-393-0445.</p>	Tier 0 (Wellness Medications)	MHS Pharmacy: No Charge Ventegra Network Pharmacy: No Charge (limited ACA list)			<p>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 Preventive medications are covered at 100% at MHS and Ventegra contracted pharmacies.</p> <p>Not subject to the <a href="#">deductible</a>.</p> <p>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.</p> <p>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 <a href="http://www.fchn.com/multicare">www.fchn.com/multicare</a> under the pharmacy section.</p> <p>Compound drugs over \$400 require <a href="#">pre-authorization</a>. If <a href="#">pre-authorization</a> is not obtained, claims will be denied.</p> <p>Specialty drugs-covered at MHS Pharmacy only, limited to 30-day supply.</p>
	Tier 1 (Generic drugs)	<p><u>Retail:</u> MHS Pharmacy: 20% / \$10 minimum Ventegra Network Pharmacy: 40% / \$20 minimum</p> <p><u>Mail Order:</u> MHS Pharmacy: 20% / \$20 minimum</p>			
	Tier 2 (Preferred brand & some high-cost generics drugs)	<p><u>Retail:</u> MHS Pharmacy: 20% / \$25 minimum Ventegra Network Pharmacy: 40% / \$50 minimum</p> <p><u>Mail Order:</u> MHS Pharmacy: 20% / \$50 minimum</p>			
	Tier 3 (Non-preferred brand drugs)	<p><u>Retail:</u> MHS Pharmacy: 20% / \$40 minimum Ventegra Network Pharmacy: 40% / \$80 minimum</p> <p><u>Mail Order:</u> MHS Pharmacy: 20% / \$80 minimum</p>			
	Tier 4 ( <a href="#">Specialty drugs</a> )	MHS Pharmacy: 20%			
<p><b>If you have outpatient surgery</b></p>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<p><a href="#">Pre-authorization</a> required for certain services or claim will be denied.</p>
	Physician/ surgeon fees	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	

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If you need immediate medical attention	<a href="#">Emergency room care</a>	\$250 <a href="#">copay</a> for visits 1-2, \$350 <a href="#">copay</a> visits 3-4 and \$500 <a href="#">copay</a> visits 5+. Tier 1 <a href="#">deductible</a> applies to Emergency services in all tiers.			<a href="#">Copay</a> waived if admitted.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required for non-emergent ground ambulance transfers to a MultiCare Health System (MHS) facility.
	<a href="#">Urgent care</a>	\$20 <a href="#">copay</a>	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Out-of-network</a> facilities limited to 10 inpatient admissions per calendar year; applies to all <a href="#">out-of-network</a> inpatient admissions. <a href="#">Preauthorization</a> is required or claim will be denied.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None.
	Inpatient services	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Out-of-network</a> facilities limited to 10 inpatient admissions per calendar year; applies to all <a href="#">out-of-network</a> inpatient admissions. <a href="#">Preauthorization</a> is required or claim will be denied.
If you are pregnant	Office visits	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Coverage limited to employees and their spouses/domestic partner.  <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">coinsurance</a> may apply.  Maternity care may include tests and services described elsewhere in the SBC (i.e., imaging).
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.fchn.com](http://www.fchn.com) .

<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Coverage is limited to 130 visits per calendar year. <a href="#">Pre-authorization</a> required or claim will be denied.
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Coverage limited to 30 days per calendar year for inpatient; 45 visits per calendar year for outpatient (includes physical, speech, occupational and cardiac therapy). <a href="#">Pre-authorization</a> 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.
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	<a href="#">Pre-authorization</a> required for inpatient habilitation or claim will be denied.
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Coverage is limited to 90 visits per calendar year. <a href="#">Pre-authorization</a> required or claim will be denied.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Tier 1 annual deductible applies to all tiers. <a href="#">Pre-authorization</a> required for certain items listed on the <a href="#">pre-authorization</a> list or claim will be denied.
	<a href="#">Hospice services</a>	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Inpatient Hospice limited to 14 days per 12 months. Respite Care limited to 30 day maximum within 12 month period. <a href="#">Pre-authorization</a> required or claim will be denied.
<b>If your child needs dental or eye care</b>	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	

## 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
- Bariatric 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)
- 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](http://www.fchn.com) or 1-866-444-EBSA [www.dol.gov/ebsa/healthreform](http://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](http://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, kwijigo holne' 1-888-889-1112.

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

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\* For more information about limitations and exceptions, see the [plan](#) or policy document at [www.fchn.com](http://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](#) \$600
- [Specialist copayments](#) \$35
- 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$600
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$2,400
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,060</b>

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$600
- [Specialist copayments](#) \$35
- 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$600
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$800
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,620</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$600
- [Specialist copayments](#) \$35
- 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$600
<a href="#">Copayments</a>	\$400
<a href="#">Coinsurance</a>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,200</b>

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