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 individualandfamily.chpw.org or call 1-866-907-1906. 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 1-800-318-2596 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$6,000 for an individual; $12,000 for a 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?	Preventive care services, primary care, laboratory tests, urgent care visits, and generic 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?	**$6,000 for an individual; $12,000 for a family**	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	**$9,200 for an individual; $18,400 for a 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?	Out-of-network services are not included in out-of-pocket limit.	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. There are no out-of-network providers in this plan.	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 referral is required to see an in-network specialist or provider.	You can see the in-network 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	$50 copay, deductible does not apply	Not covered	Eligible for two visits at $1 copay, after which $50 copay applies.
	Specialist visit	$100 copay	Not covered	
	Preventive care/screening/ immunization	$0 copay	Not covered	
If you have a test	Diagnostic test (x-ray, blood work)	40% coinsurance	Not covered	
	Imaging (CT/PET scans, MRIs)	40% coinsurance	Not covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at individualandfamily.chpw.org/2024formulary	Generic drugs	$32 copay per 30-day supply $86.40 copay per 90-day supply Deductible does not apply.	Not covered	Prescription drugs are provided up to a 90-day supply at participating retail pharmacies or through mail order.
	Preferred brand drugs	40% coinsurance	Not covered	Prescription drugs are provided up to a 90-day supply at participating retail pharmacies or through mail order.
	Non-preferred brand drugs	40% coinsurance	Not covered	Coverage is limited to a 30-day supply
	Specialty drugs	40% coinsurance	Not covered	Coverage is limited to a 30-day supply at specialty pharmacy. *Member cost-sharing for insulin as follows: (1) cap total monthly OOP at $35 /30-day supply; (2) insulin is not subject to deductible
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% coinsurance	Not covered	
	Physician/surgeon fees	40% coinsurance	Not covered	

[* For more information about limitations and exceptions, see the plan or policy document at https://individualandfamily.chpw.org.]

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 immediate medical attention	Emergency room care	40% coinsurance	40% coinsurance	Cost-sharing for Emergency Care Services is the same whether a member obtains services from an in-network or out-of-network provider in an emergency situation.
	Emergency medical transportation	40% coinsurance	40% coinsurance	Cost-sharing for Emergency Care Services is the same whether a member obtains services from an in-network or out-of-network provider in an emergency situation.
	Urgent care	$100 copay, deductible does not apply	Not covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	40% coinsurance	Not covered	
	Physician/surgeon fees	40% coinsurance	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$50 copay, deductible does not apply (office visits) 40% coinsurance (other)	Not covered	Eligible for two visits at $1 copay, after which $50 copay applies. (office visits) Coinsurance (other)
	Inpatient services	40% coinsurance	Not covered	
If you are pregnant	Office visits	$50 copay, deductible does not apply	Not covered	Eligible for two visits at $1 copay, after which $50 copay applies.
	Childbirth/delivery professional services	No Charge	Not covered	Professional services fees are included with the facility charge.
	Childbirth/delivery facility services	40% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	$50 per day, deductible does not apply	Not covered	Limit to 130 visits per calendar year. Preauthorization 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)	
	Rehabilitation services	40% coinsurance	Not covered	Includes physical, speech, and occupational therapies. Inpatient: 30-day maximum for all rehabilitation therapy services per calendar year; Outpatient: 25-visit maximum for all rehabilitation therapy services per calendar year.
	Habilitation services	40% coinsurance	Not covered	Includes physical, speech, and occupational therapies. Inpatient: 30-day maximum for all habilitation therapy services per calendar year; Outpatient: 25-visit maximum for all habilitation therapy services per calendar year.
	Skilled nursing care	40% coinsurance	Not covered	60 days per calendar year
	Durable medical equipment	40% coinsurance	Not covered	
	Hospice services	$50 per day, deductible does not apply	Not covered	Preauthorization required Respite Care: 14 days lifetime maximum.
If your child needs dental or eye care	Children's eye exam	No Charge	Not covered	Including dilation as professionally indicated and with refraction. 1 exam per calendar year.
	Children's glasses	No Charge	Not covered	Limited to children under age 19. One pair of prescription lenses or contacts every calendar year, including polycarbonate lenses and scratch-resistant coating. One pair of frames or contact lenses (in lieu of lenses and frames) per calendar year. Includes fitting fee.
	Children's dental check-up	Not covered	Not covered	

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.)

- Out-of-network providers
- Dental Services
- Infertility Treatment
- Private Duty Nursing
- Routine Eye Exams for Adults
- Hearing Care
- Adult Orthodontia

[* For more information about limitations and exceptions, see the plan or policy document at https://individualandfamily.chpw.org.]

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Reconstruction Surgery	• Newborn Care	• Chiropractic Care (10 visits per calendar year)
• Abortion	• Acupuncture (12 visits per calendar year)	• Cochlear Implants

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: [WAHBE 1-855-923-4633]. 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: 1-866-907-1906.

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? Not applicable
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 1-866-907-1906.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-907-1906.]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-866-907-1906.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-907-1906.]

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

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

[* For more information about limitations and exceptions, see the plan or policy document at https://individualandfamily.chpw.org.]

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	$6000
Specialist *[cost sharing]*	$100
Hospital (facility) *[cost sharing]*	40%
Other *[cost sharing]*	40%

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	$6,000
Copayments	$11
Coinsurance	$2,539
What isn't covered	
Limits or exclusions	$61
The total Peg would pay is	**$8,611**

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

The plan's overall deductible	$6000
Specialist *[cost sharing]*	$100
Hospital (facility) *[cost sharing]*	40%
Other *[cost sharing]*	40%

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	$4,338
Copayments	$406
Coinsurance	$0
What isn't covered	
Limits or exclusions	$22
The total Joe would pay is	**$4,766**

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

The plan's overall deductible	$6000
Specialist *[cost sharing]*	$100
Hospital (facility) *[cost sharing]*	40%
Other *[cost sharing]*	40%

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	$2,735
Copayments	$5
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,740**

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

[* For more information about limitations and exceptions, see the plan or policy document at https://individualandfamily.chpw.org.]

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-866-907-1906 (TTY: 711).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-907-1906 (TTY: 711).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-907-1906 (TTY: 711).

繁體中文 (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電
1-866-907-1906 (TTY: 711)。

Af Soomaali (Somali) DIGTOONI: Haddii aad ku hadasho Af Soomaali, adeegyada caawimada luqadda, oo lacag la'aan ah, ayaa laguu heli karaa adiga. Wac 1-866-907-1906. (TTY: 711).

Русский (Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-907-1906 (телетайп: 711).

(Arabic) العربية ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1906-907-866-1 (طابعة هاتفية: 711).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-866-907-1906 (መስማት ለተሳናቸው: 711).

توجه برای دری (Dari) 1906-907-866-1 با شماره تماس بگیرید(TTY: 711) اگر به زبان دری صحبت می کنید، خدمات مساعدت زبان، طور رایگان برای شما موجود می باشد.

ትግርኛ (Tigrinya) ምልክታ፡ ትግርኛ ትዛረብ ተኾይንካ ኣገልግሎት ሓገዝ ቋንቋ ንዓኻ ብናጻ ይርከብ። ደውል
1-866-907-1906 (TTY: 711)።

ဗမာ (Burmese) သတိျပဳရန္ - အကယ္၍ သင္သည္ ျမန္မာစကား ကို ေျပာပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့္အတြက္
စီစဥ္ေဆာင္ရြက္ေပးပါမည္။ ဖုန္းနံပါတ္ 1-866-907-1906
(TTY: 711) သုိ႔ ေခၚဆိုပါ။

ਪੰਜਾਬੀ (Panjabi) ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-866-907-1906 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.1-866-907-1906 (TTY: 711) 번으로 전화해 주십시오.

توجه (Farsi): اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای **فارسی** شما فراهم می باشد. با 1906-907-866-1 تماس بگیرید (TTY: 711).

Українська (Ukrainian) УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером
1-866-907-1906 (телетайп: 711).

ភាសាខ្មែរ (Khmer) កត់ចំណាំ៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ សេវាជំនួយភាសាមិនគិតថ្លៃមានសម្រាប់អ្នក។ សូមទូរសព្ទមកលេខ 1-866-907-1906 (TTY: 711)។