



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, go to <https://asuris.com> or call 1 (888) 370-6162. 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 healthcare.gov/sbc-glossary or call 1 (888) 370-6162 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	\$500 individual / \$1,000 family per calendar year.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u>?	Yes. Certain <u>preventive care</u> and those services listed below as " <u>deductible</u> does not apply" or as "No charge."	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	\$3,500 individual / \$7,000 family per calendar year.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See https://asuris.com/go/EW/Preferred or call 1 (888) 370-6162 for a list of <u>network providers</u> .	You pay the least if you use a <u>provider</u> in the preferred <u>network</u> . You pay more if you use a <u>provider</u> in the participating <u>network</u> . You will pay the most if you use a <u>nonparticipating provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use a <u>nonparticipating provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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
		Preferred Provider (You pay the least)	Participating Provider (You pay more)	Nonparticipating Provider (You pay the most)	
If you visit a health care <u>provider's office</u> or clinic	Primary care visit to treat an injury or illness	\$25 <u>copay</u> / office visit, <u>deductible</u> does not apply;	\$40 <u>copay</u> / office visit, <u>deductible</u> does not apply;	40% <u>coinsurance</u>	<u>Copayment</u> applies to each preferred or participating office and retail clinic visit only. All other services are covered at the <u>coinsurance</u> specified, after <u>deductible</u> .
		\$20 <u>copay</u> / retail clinic visit, <u>deductible</u> does not apply;	\$20 <u>copay</u> / retail clinic visit, <u>deductible</u> does not apply;		
	20% <u>coinsurance</u> for all other services	40% <u>coinsurance</u> for all other services			
<u>Specialist</u> visit	\$25 <u>copay</u> / office visit, <u>deductible</u> does not apply;	\$40 <u>copay</u> / office visit, <u>deductible</u> does not apply;	40% <u>coinsurance</u>		
	20% <u>coinsurance</u> for all other services	40% <u>coinsurance</u> for all other services			
<u>Preventive care/screening/immunization</u>	No charge	No charge	40% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge for the first \$700 / year, then 20% <u>coinsurance</u> for outpatient services;	No charge for the first \$700 / year, then 40% <u>coinsurance</u> for outpatient services;	No charge for the first \$700 / year, then 40% <u>coinsurance</u> for outpatient services;	Once <u>diagnostic tests</u> and imaging combined reach \$700 / year, services are covered at the <u>coinsurance</u> specified, after <u>deductible</u> .
		20% <u>coinsurance</u> for inpatient services	40% <u>coinsurance</u> for inpatient services	40% <u>coinsurance</u> for inpatient services	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You pay the least)	Participating Provider (You pay more)	Nonparticipating Provider (You pay the most)	
	Imaging (CT/PET scans, MRIs)	No charge for the first \$700 / year, then 20% <u>coinsurance</u> for outpatient services; 20% <u>coinsurance</u> for inpatient services	No charge for the first \$700 / year, then 40% <u>coinsurance</u> for outpatient services; 40% <u>coinsurance</u> for inpatient services	No charge for the first \$700 / year, then 40% <u>coinsurance</u> for outpatient services; 40% <u>coinsurance</u> for inpatient services	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at https://asuris.com/go/2022/EW/4tier	Generic drugs	\$10 <u>copay</u> / retail prescription \$20 <u>copay</u> / mail order prescription			<u>Prescription drugs</u> not on the Drug List are not covered, unless an exception is approved. <u>Deductible</u> does not apply. 90-day supply / retail prescription (your <u>cost share</u> is per 30-day supply) 90-day supply / mail order prescription 30-day supply / <u>specialty drug</u> retail prescription <u>Specialty drugs</u> are not available through mail order. Coverage includes compound medications at 50% <u>coinsurance</u> , refer to your <u>plan</u> for further information. <u>Cost shares</u> for insulin will not exceed \$100 / 30-day supply retail prescription or \$300 / 90-day supply mail order prescription. No charge for certain preventive drugs, contraceptives and immunizations at a participating pharmacy, or for self-administrable cancer chemotherapy drugs. You are responsible for the difference in cost between a dispensed brand drug and the equivalent generic drug, in addition to the <u>copayment</u> and/or <u>coinsurance</u> . The first fill of <u>specialty drugs</u> may be provided by a retail pharmacy; additional refills must be provided by a specialty pharmacy.
	Preferred brand drugs	\$30 <u>copay</u> / retail prescription \$60 <u>copay</u> / mail order prescription			
	Brand drugs	\$50 <u>copay</u> / retail prescription \$100 <u>copay</u> / mail order prescription			
	<u>Specialty drugs</u>	50% <u>coinsurance</u> / <u>specialty drugs</u>			

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You pay the least)	Participating Provider (You pay more)	Nonparticipating Provider (You pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u> for ambulatory surgery centers; 20% <u>coinsurance</u> for all other facilities	40% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Physician/surgeon fees	10% <u>coinsurance</u> for ambulatory surgery center physicians; 20% <u>coinsurance</u> for all other physicians	40% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u> after \$250 <u>copay</u> / visit	20% <u>coinsurance</u> after \$250 <u>copay</u> / visit	20% <u>coinsurance</u> after \$250 <u>copay</u> / visit	<u>Copayment</u> applies to facility charge for each visit (waived if admitted), whether or not the <u>deductible</u> has been met.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Urgent care</u>	Covered the same as If you visit a health care provider's office or clinic (Primary care visit or <u>Specialist</u> visit) or If you have a test above.			None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <u>copay</u> / office visit, <u>deductible</u> does not apply;	\$25 <u>copay</u> / office visit, <u>deductible</u> does not apply;	40% <u>coinsurance</u>	<u>Copayment</u> applies to each preferred or participating office/psychotherapy visit only. All other services are covered at the <u>coinsurance</u> specified, after <u>deductible</u> .
		20% <u>coinsurance</u> for all other services	20% <u>coinsurance</u> for all other services		
	Inpatient services	20% <u>coinsurance</u>	20% <u>coinsurance</u>	40% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Provider (You pay the least)	Participating Provider (You pay more)	Nonparticipating Provider (You pay the most)	
If you are pregnant	Office visits	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	
If you need help recovering or have other special health needs	Home health care	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	130 visits / year
	Rehabilitation services	20% <u>coinsurance</u> for outpatient services, <u>deductible</u> does not apply; 20% <u>coinsurance</u> for inpatient services	40% <u>coinsurance</u> for outpatient services, <u>deductible</u> does not apply; 40% <u>coinsurance</u> for inpatient services	40% <u>coinsurance</u>	30 inpatient days / year 25 outpatient visits / year Includes physical therapy, occupational therapy and speech therapy.
	Habilitation services	20% <u>coinsurance</u> , <u>deductible</u> does not apply	40% <u>coinsurance</u> , <u>deductible</u> does not apply	40% <u>coinsurance</u>	25 professional neurodevelopmental visits / year Includes physical therapy, occupational therapy and speech therapy.
	Skilled nursing care	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	60 inpatient days / year
	Durable medical equipment	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	None
	Hospice services	20% <u>coinsurance</u>	40% <u>coinsurance</u>	40% <u>coinsurance</u>	14 respite inpatient or outpatient days / lifetime
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	Not covered	None
	Children's dental check-up	Not covered	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, except congenital anomalies
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care, except for diabetic patients
- 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
- Chiropractic care
- Non-emergency care when traveling outside the U.S.

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: the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1 (877) 267-2323 ext. 61565 or ccio.cms.gov or your state insurance department. You may also contact the [plan](#) at 1 (888) 370-6162. 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 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 the [plan](#) at 1 (888) 370-6162 or visit asuris.com or the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or dol.gov/ebsa/healthreform. You may also contact the Office of the Insurance Commissioner of Washington State by calling 1 (800) 562-6900, or through the Internet at: www.insurance.wa.gov.

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) 370-6162.

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** \$500
- **Specialist copayment** \$25
- **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	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$11
<u>Coinsurance</u>	\$2,203
<i>What isn't covered</i>	
Limits or exclusions	\$61
The total Peg would pay is	\$2,775

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

- **The plan's overall deductible** \$500
- **Specialist copayment** \$25
- **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	\$5,600
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$674
<u>Coinsurance</u>	\$58
<i>What isn't covered</i>	
Limits or exclusions	\$178
The total Joe would pay is	\$1,410

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

- **The plan's overall deductible** \$500
- **Specialist copayment** \$25
- **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	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$500
<u>Copayments</u>	\$330
<u>Coinsurance</u>	\$318
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,148

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