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 1-800-918-7668. 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 www.fchn.com or call 1-800-918-7668 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For First Choice Health network providers: **$300** person/ **$900** Family. For out-of-network providers: **$600** person/ **$1,800** family. Copayments do not accrue toward the deductible.	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?	Yes. Preventive care services 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For First Choice Health network providers: **$4,000** person/ **$12,000** family. There is no cap on your out of pocket costs for out-of-network providers.	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?	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. See www.fchn.com or call 1-800-918-7668 for a list of network providers.	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.	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
		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	$25 copay/visit, deductible does not apply	50% coinsurance	Out-of-network provider charges do not apply to the out-of-pocket limit.
	Specialist visit	$40 copay/visit, deductible does not apply	50% coinsurance	
	Preventive care/screening/ immunization	No Charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. Out-of-network provider charges do not apply to the out-of-pocket limit.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance; deductible does not apply	50% coinsurance	Preauthorization is required for PET scans. If services are not preauthorized the claim may be denied. Out-of-network provider charges do not apply to the out-of-pocket limit.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.medimpact.com	Generic drugs (Tier 1)	Retail: $15 copay/ prescription. Mail order: $30 copay/ prescription	Retail: reimbursement only less applicable copay. Mail order: N/A	Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription); 90 day supply may be available at participating (Choice 90) pharmacies.
	Preferred brand drugs (Tier 2)	Retail: $40 copay/ prescription. Mail order: $80 copay/ prescription.	Retail: reimbursement only less applicable copay. Mail order: N/A	
	Non-preferred brand drugs (Tier 3)	Retail: $60 copay/ prescription. Mail order: $120 copay/ prescription.	Retail: reimbursement only less applicable copay. Mail order: N/A	
	Specialty drugs (Tier 4)	$80 Copay / prescription	Not Covered	Must be obtained through MedImpact Specialty Pharmacy program.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Preauthorization is required for certain services. If services are not preauthorized the claim may be denied. See your Summary Plan Document for a complete list of required preauthorizations. Out-of-network provider charges do not apply to the out-of-pocket limit.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	$150 copay then 20% coinsurance	$150 copay then 20% coinsurance	Copay waived if admitted. Out-of-network provider charges do not apply to the out-of-pocket limit.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Out-of-network provider charges do not apply to the out-of-pocket limit.
	Urgent care	$50 copay/visit	20% coinsurance	Deductible does not apply. Out-of-network provider charges do not apply to the out-of-pocket limit.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	$250 copay then 50% coinsurance	Preauthorization is required for certain services. If services are not preauthorized the claim may be denied. Out-of-network provider charges do not apply to the out-of-pocket limit.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	

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 mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	50% coinsurance	Out-of-network provider charges do not apply to the out-of-pocket limit.
	Inpatient services	20% coinsurance	$250 copay then 50% coinsurance	Preauthorization is required. If services are not preauthorized your claim may be denied. Out-of-network provider charges do not apply to the out-of-pocket limit.
If you are pregnant	Office visits	20% coinsurance	50% coinsurance	20% coinsurance if billed as part of the global (or) $25 copay /visit and deductible does not apply if billed separately.
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	Out-of-network provider charges do not apply to the out-of-pocket limit. Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	20% coinsurance	$250 copay then 50% coinsurance	
If you need help recovering or have other special health needs	Home health care	No Charge	No Charge	Limited to 100 visits/ calendar year. Preauthorization is required for wound therapy. If services are not preauthorized, the claim may be denied.
	Rehabilitation services	Outpatient: $25 copay/visit, deductible does not apply Inpatient: 20% coinsurance	50% coinsurance	Outpatient facility and professional limited to 25 visits/calendar year. Includes physical, speech and occupational therapies combined. Preauthorization is required for inpatient rehabilitation. If services are not preauthorized, the claim may be denied. Out-of-network provider charges do not apply to the out-of-pocket limit.
	Habilitation services	Outpatient: $25 copay/visit, deductible does not apply Inpatient: 20% coinsurance	Outpatient: 50% coinsurance Inpatient: $250 copay then 50% coinsurance	Preauthorization is required for inpatient services. If services are not preauthorized, the claim may be denied. Out-of-network provider charges do not apply to the out-of-pocket limit.

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)	
	Skilled nursing care	No Charge	No Charge	Limited to 90 days/calendar year. Preauthorization is required. If services are not preauthorized the claim may be denied.
	Durable medical equipment	20% coinsurance	20% coinsurance	Preauthorization is required for certain services. If services are not preauthorized the claim may be denied. See your Summary Plan Document for a complete list of required preauthorizations.
	Hospice services	20% coinsurance	20% coinsurance	Preauthorization is required. If services are not preauthorized the claim may be denied.
If your child needs dental or eye care	Children's eye exam	Not Applicable	Not Applicable	No coverage.
	Children's glasses	Not Applicable	Not Applicable	No coverage.
	Children's dental check-up	Not Applicable	Not Applicable	No 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.)

- Bariatric Surgery
- Cosmetic Surgery
- Dental Care
- Hearing Aids
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- 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
- Chiropractic Care
- Routine eye care (Adult)

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: 1-800-918-7668 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 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: 1-800-918-7668.

Does this plan provide Minimum Essential Coverage? **Yes**.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet 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 1-855-713-1336.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-713-1336.
Chinese (中文): 如果需要中文的帮助， 请拨打这个号码1-855-713-1336.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-713-1336.

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	$300
Specialist copayment	$40
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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$300
Copayments	$110
Coinsurance	$2,480
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,950**

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

The plan's overall deductible	$300
Specialist copayment	$40
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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$300
Copayments	$1,135
Coinsurance	$372
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,863**

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

The plan's overall deductible	$300
Specialist copayment	$40
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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Copayments	$370
Coinsurance	$283
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$953**

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