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 800-966-4086. 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.healthcare.gov/sbc-glossary or call 800-966-4086 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network provider: $200 individual / $600 family per calendar year. Out-of-network provider: $600 individual / $1,800 family per calendar year.	Generally, you must pay all of the costs from provider, 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. Certain Preventive care, prescription drug coverage and those services listed below as "deductible does not apply." "No charge" means $0 copayment, or 0% coinsurance, regardless of deductible applicability.	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 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?	In-network provider: $1,500 individual / $3,100 family per calendar year. Out-of-network provider: $3,300 individual / $7,100 family per calendar year.	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 limit until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, prescription drug cost sharing, 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 .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See https://kingcountycolliance.orderlyhealth.com/ or call 800-966-4086 for a list of network providers	This plan uses a provider network. You pay the least if you use a provider, in the preferred 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	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/ office visit, deductible does not apply; 10% coinsurance, for other services	40% coinsurance	None.
	Specialist visit	$20 copay/ office visit, deductible does not apply; 10% coinsurance, for other services	40% coinsurance	None.
	Preventive care/screening/ immunization	No charge, deductible does not apply	40% coinsurance	No charge, deductible does not apply for childhood immunizations from out-of-network providers. 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.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	40% coinsurance	None

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

Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition	Tier 1 (Generic drugs)	Retail: $5 copay up to 30-day supply Retail: $10 copay for 31–91 day supply, except at CVS and Walgreens which are limited to 30-day supply Mail order: $10 copay, up to 91-day supply	$5 copay, plus remaining balance after pharmacy is paid at network rate	Your prescription drug coverage is administered through your pharmacy vendor. There is no deductible applied to prescription drug purchases. Prescription drug out-of-pocket limit : $1,500 individual/ $3,000 family per year
	Tier 2 (Preferred drugs)	Retail: $25 copay, up to 30-day supply Retail: $50 copay, for 31-91 day supply, except at CVS and Walgreens which are limited to 30-day supply Mail order: $50 copay, up to 91-day supply	$25 copay, plus remaining balance after pharmacy is paid at network rate	
	Tier 3 (Non-preferred drugs)	Retail: $75 copay, up to 30-day supply Retail: $150 copay, for 31-91 day supply, except at CVS and Walgreens which are limited to 30-day supply Mail-order: $150 copay, up to 91-day supply	$75 copay, plus remaining balance after pharmacy is paid at network rate	
	Tier 4 (Preferred Specialty drugs)	Specialty mail order: $25 copay, per 30-day supply	$25 copay, plus remaining balance after pharmacy is paid at network rate	
	Tier 5 (Non-Preferred Specialty drugs)	Specialty mail order: $75 copay, per 30-day supply	$75 copay, plus remaining balance after pharmacy is paid at network rate	

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

Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	40% coinsurance	Preauthorization may be required for certain surgeries as found on the Preauthorization list.
	Physician/surgeon fees	10% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	10% coinsurance after $200 copay/visit	10% coinsurance after $200 copay/visit	Copayment applies to facility charge for each visit (waived if admitted), whether or not the deductible has been met. Out-of-network provider services apply to the in-network deductible and in-network out-of-pocket limit .
	Emergency medical transportation	10% coinsurance	10% coinsurance	Out-of-network provider services apply to the in-network deductible and in-network out-of-pocket limit .
	Urgent care	$20 copay/ visit, deductible does not apply; 10% coinsurance for all other services	40% coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	40% coinsurance	Preauthorization may be required for inpatient stays as found on the Preauthorization list.
	Physician/surgeon fees	10% coinsurance	40% coinsurance	

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

Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay/ office or psychotherapy visit, deductible does not apply; 10% coinsurance for all other services	40% coinsurance	Preauthorization may be required for inpatient stays as found on the Preauthorization list.
	Inpatient services	10% coinsurance	40% coinsurance	
If you are pregnant	Office visits	10% coinsurance	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	No charge	130 visits / year combined with private duty nursing visit limit.
	Rehabilitation services	10% coinsurance	40% coinsurance	60 inpatient days / year 60 outpatient days / year Includes physical therapy, occupational therapy speech therapies.
	Habilitation services	10% coinsurance	40% coinsurance	Includes physical therapy, occupational therapy, aura and speech therapies.
	Skilled nursing care	10% coinsurance	40% coinsurance	None
	Durable medical equipment	10% coinsurance	40% coinsurance	$100 / lifetime for wigs to replace hair loss caused by radiation therapy or chemotherapy for a covered condition, or with a transgender diagnosis. Preauthorization may be required for certain Durable medical equipment as found on the Preauthorization list.
	Hospice services	No charge	No charge	None.

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

Common Medical Event	Services You May Need	In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	
	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.)

- Cosmetic surgery, except congenital anomalies
- Dental care
- Long-term care
- Routine eye care
- 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, 60 visits / year
- Bariatric surgery
- Chiropractic care, 33 spinal manipulations / year
- Fertility treatment, $25,000 / lifetime except for artificial insemination services, additional limit of $10,000 / lifetime for prescription drugs
- Hearing aids, 1 per ear / 36 months
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing, 130 visits / year (including home health care)
- Routine foot care

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 your state insurance department. 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 the plan.at 800-966-4086 or the U.S. Department of Labor, Employee Benefits Security Administration at 1 (866) 444-3272 or dol.gov/ebsa/healthreform.

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 800-966-4086.

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-966-4086.

[Chinese (中文): 如果需要中文的帮助， 请拨打这个号码[800-966-4086.

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 800-966-4086

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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** **$200**
- **Specialist Copayment** **$20**
- **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	$200
Copayments	$10
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,470**

Managing Joe's Type 2 Diabetes

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

- **The plan's overall deductible** **$200**
- **Specialist Copayment** **$20**
- **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, Mia would pay:

Cost Sharing	
Deductibles	$200
Copayments	$200
Coinsurance	$400
What isn't covered	
Limits or exclusions	$200
The total Mia would pay is	**$1,000**

Mia's Simple Fracture

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

- **The plan's overall deductible** **$200**
- **Specialist Copayment** **$20**
- **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	$200
Copayments	$300
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$700**

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