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 www.FCCIHealthPlan.com or by calling 1-855-497-1223. 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.FCCIHealthPlan.com or call 1-855-497-1223 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$2,500** person / **$5,000** family In-network **$5,000** person / **$15,000** family Out-of-network **$2,800** In-network / **$5,000** Out-of-network Maximum amount that any one person will satisfy toward the annual family deductible	Generally, you must pay all 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?	**$3,500** person / **$7,000** family In-network **$15,000** person / **$45,000** family Out-of-network **$3,500** In-network / **$15,000** Out-of-network Maximum amount that any one person will satisfy toward the annual family out-of-pocket	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?	Penalties, 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.FCCIHealthPlan.com or call 1-855-497-1223 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
		In-network (You will pay the least)	Out-of-network (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	10% Coinsurance	40% Coinsurance	None
	Specialist visit	10% Coinsurance	40% Coinsurance	None
	Preventive care/screening/ immunization	No charge; Deductible Waived	40% 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.
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	Preauthorization is required for MRI/MRA/PET scans.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available www.FCCIHealthPlan.com.	Generic drugs on the Preventative Med List	$10 1-31 Day Supply Retail $20 90 Day Supply Retail* or Mail	Not Covered	**Generic Policy**: If your doctor writes a prescription stating that a Generic may be dispensed, we will only pay for the Generic drug. If you choose to buy the Brand name drug in this situation, you will be required to pay the Brand copay plus the difference in cost between the Generic and Brand name drug. Please note that this difference in cost will not accumulate toward the Deductible or the MOOP. The Generic Policy does not apply if your doctor requires a brand name medication. **Specialty Medications**: Specialty Medications: Specialty medications must be ordered through Caremark Specialty Pharmacy at 1-800- 237-2767 and may require prior authorization or step therapy for preferred products. Contact Member Services for the specialty preferred product listing. **Specialty Copay Component**: Some specialty medications may qualify for third party copayment assistance programs. When a third party copayment assistance is used, the Member shall not receive credit toward their maximum Out-Of-Pocket or Deductible for any Copayment or
	Generic Diabetic Medication and Diabetic Testing Supplies	$0 1-31 Day Supply Retail $0 90 Day Supply Retail* or Mail	Not Covered	
	Generic drugs (Tier 1)	10% coins, after deductible 1-31 Day Supply Retail 10% coins, after deductible 90 Day Supply Retail* or Mail	Not Covered	
	Preferred brand drugs (Tier 2) Non-Preferred brand drugs (Tier 3) Specialty drugs (Tier 4)	10% coins, after deductible 1-31 Day Supply Retail 10% coins, after deductible 90 Day Supply Retail* or Mail 10% coins, after deductible 1-31 Day Supply Retail 10% coins, after deductible 90 Day Supply Retail* or Mail 10% coins, after deductible 1-31 Day Supply Mail ** All Tiers **	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
				Coinsurance amounts that are applied to a manufacturer coupon or rebate. ***Limited pharmacy network**: contact customer service for more information.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% Coinsurance	40% Coinsurance	Preauthorization is required.
	Physician/surgeon fees	10% Coinsurance	40% Coinsurance	
If you need immediate medical attention	Emergency room care	10% Coinsurance	10% Coinsurance	In-network deductible applies to Out-of-network benefits
	Emergency medical transportation	10% Coinsurance	10% Coinsurance	In-network deductible applies to Out-of-network benefits
	Urgent care	10% Coinsurance	40% Coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% Coinsurance	40% Coinsurance	Preauthorization is required.
	Physician/surgeon fee	10% Coinsurance	40% Coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
If you have mental health, behavioral health, or substance abuse services	Outpatient services	10% Coinsurance	40% Coinsurance	Preauthorization is required for Partial hospitalization & Intensive outpatient.
	Inpatient services	10% Coinsurance	40% Coinsurance	Preauthorization is required.
If you are pregnant	Office visits	No charge; Deductible Waived	40% Coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, deductible, copayment or coinsurance 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	10% Coinsurance	40% Coinsurance	60 Maximum visits per calendar year; Preauthorization is required.
	Rehabilitation services	10% Coinsurance	40% Coinsurance	60 Maximum visits per calendar year; Habilitation services for Learning Disabilities are not covered.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-network (You will pay the least)	Out-of-network (You will pay the most)	
	Habilitation services	10% Coinsurance	40% Coinsurance	
	Skilled nursing care	10% Coinsurance	40% Coinsurance	60 Maximum days per calendar year; Preauthorization is required.
	Durable medical equipment	10% Coinsurance	40% Coinsurance	Preauthorization is required for DME in excess of $1,500 for purchases or all rentals.
	Hospice service	10% Coinsurance	40% Coinsurance	Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- 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.)		
• Bariatric surgery (In-network only)	• Chiropractic care	• Infertility treatment

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: U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.HealthCare.gov. 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: U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.HealthCare.gov. Additionally, a consumer assistance program may help you file your appeal. A list of states with Consumer Assistance Programs is available at www.HealthCare.gov and http://cciio.cms.gov/programs/consumer/capgrants/index.html.

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 Standard? 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.

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	$2,500
Specialist coinsurance	10%
Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:
Specialist office visits *(pre-natal 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	$2,500
Copayments	$0
Coinsurance	$900
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$3,470**

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

The plan's overall deductible	$2,500
Specialist coinsurance	10%
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, Joe would pay:

Cost Sharing	
Deductibles*	$1,100
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,300
The total Joe would pay is	**$5,400**

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

The plan's overall deductible	$2,500
Specialist coinsurance	10%
Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$2,500
Copayments	$0
Coinsurance	$30
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$2,540**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: www.FCCIHealthPlan.com or call 1-855-497-1223.
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?"" row above.

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