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, https://www.boonchapman.com. 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 1-800-252-9653 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,500** per covered individual **$3,000** per family unit	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, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Prescription drug coverage, physician office visits and preventive care 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?	**$3,000** per covered individual **$6,000** per family unit	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, balance-billed charges, prescription drug discounts or coupons, penalties for failure to obtain pre-certification for services, and health care this plan does not 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 **1-855-494-9335** for a list of participating 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
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30/copayment/visit, deductible does not apply	The office visit copayment applies to the office visit charge only. Claims for Out-of-Network providers are limited to the Maximum Allowable Charge.
	Specialist visit	$30/copayment/visit, deductible does not apply	
	Preventive care/screening/immunization	No charge	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. Claims for Out-of-Network providers are limited to the Maximum Allowable Charge.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Claims for Out-of-Network providers are limited to the Maximum Allowable Charge.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	Pre-certification required. Claims for Out-of-Network providers are limited to the Maximum Allowable Charge.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://mysmithrx.com/	Generic Drugs	Retail: $10 copayment/prescription Mail Order: $20 copayment/prescription	Deductible does not apply. Retail: Limited to 30 day supply. Mail Order: Limited to 90 day supply. If a covered person requests a formulary or non-formulary name drug when a generic equivalent is available, they are responsible for the difference in cost between the formulary or non-formulary name drug and the generic drug. No coverage available for non-participating pharmacies.
	Formulary Brand Drugs	Retail:$25 copayment/prescription Mail Order:$50 copayment/prescription	
	Non-Formulary Brand Drugs	Retail: $50 copayment/prescription Mail Order: $100 copayment/prescription	
	Specialty drugs	20% coinsurance up to $200 maximum copayment/prescription deductible does not apply	Limited to a 30 day supply/prescription & requires purchase through the specialty pharmacy program. With some exceptions, only first fill will be eligible through the retail pharmacy. Pre-certification required. No coverage available for non-participating pharmacies.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Some surgeries may require pre-certification. Claims for Out-of-Network providers are limited to the Maximum Allowable Charge.
	Physician/surgeon fees	20% coinsurance	
If you need immediate medical attention	Emergency room care	20% coinsurance	Claims for Out-of-Network providers are limited to the Maximum Allowable Charge.
	Emergency medical transportation	20% coinsurance	
	Urgent care	20% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Coverage limited to the facility's average semi-private room rate. Pre-certification required. Claims for Out-of-Network providers are limited to the Maximum Allowable Charge.
	Physician/surgeon fee	20% coinsurance	Claims for Out-of-Network providers are limited to the Maximum Allowable Charge.
If you need mental health, behavioral health, or substance abuse services	Office visits	$30/copayment/visit, deductible does not apply	The office visit copayment applies to the office visit charge only. Claims for Out-of-Network providers are limited to the Maximum Allowable Charge.
	Outpatient services	20% coinsurance	
	Inpatient services	20% coinsurance	Pre-certification required. Claims for Out-of-Network providers are limited to the Maximum Allowable Charge.
If you are pregnant	Office visits	20% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Claims for Out-of-Network providers are limited to the Maximum Allowable Charge.
	Childbirth/delivery professional services	20% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Limited to 180 visits per calendar year. Pre-certification required. Claims for Out-of-Network providers are limited to the Maximum Allowable Charge.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
	Rehabilitation services	20% coinsurance	Includes occupational, physical, and speech therapies. Applied behavioral analysis and Down Syndrome therapies are limited to covered persons under 19 years old. Pre-certification required. Claims for Out-of-Network providers are limited to the Maximum Allowable Charge.
	Habilitation services	20% coinsurance	
	Skilled nursing care	20% coinsurance	Coverage is limited to the facility's average semi-private room rate. Coverage limited to 60 days per calendar year. Pre-certification required. Claims for Out-of-Network providers are limited to the Maximum Allowable Charge.
	Durable medical equipment	20% coinsurance	Pre-certification required >$2,000. Except in the case that requires immediate and necessary access to DME from the provider's office, this will be covered through ConnectDME. Claims for Out-of-Network providers are limited to the Maximum Allowable Charge.
	Hospice services	20% coinsurance	Pre-certification required. Claims for Out-of-Network providers are limited to the Maximum Allowable Charge.
If your child needs dental or eye care	Children's eye exam	Not covered	No coverage for eye exam.
	Children's glasses	Not covered	No coverage for glasses.
	Children's dental check-up	Not covered	No coverage or dental check-up.

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 • 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
Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Acupuncture	• Chiropractic 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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 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 1-800-252-9653. You may also contact: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. "Additionally, a consumer assistance program can help you file your appeal. A list of states with Consumer Assistance Programs is available at: https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers and http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/.

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: 1-800-252-9653
[Spanish (Español): Para obtener asistencia en Española, llame al.

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)		Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The plan's overall deductible	$1,500	■ The plan's overall deductible	$1,500	■ The plan's overall deductible	$1,500
■ Specialist copayment	$30	■ Specialist copayment	$30	■ Specialist copayment	$30
■ Hospital (facility) coinsurance	20%	■ Hospital (facility) coinsurance	20%	■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%	■ Other 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)*		**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)*		**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	**$12,700**	**Total Example Cost**	**$5,600**	**Total Example Cost**	**$2,800**
In this example, Peg would pay: This condition is not covered, so patient pays 100 percent.		**In this example, Joe would pay:** This condition is not covered, so patient pays 100 percent.		**In this example, Mia would pay:** This condition is not covered, so patient pays 100 percent.	
Cost Sharing		*Cost Sharing*		*Cost Sharing*	
Deductibles	$1.500	Deductibles	$100	Deductibles	$1,500
Copayments	$0	Copayments	$1,200	Copayments	$100
Coinsurance	$1,500	Coinsurance	$0	Coinsurance	$200
What isn't covered		*What isn't covered*		*What isn't covered*	
Limits or exclusions	$60	Limits or exclusions	$20	Limits or exclusions	$0
The total Peg would pay is	**$3,060**	**The total Joe would pay is**	**$1,320**	**The total Mia would pay is**	**$1,800**

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