



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.fbg.com or call 1-855-495-1190. 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 <https://www.healthcare.gov/sbc-glossary/> or call 1-855-495-1190 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$0	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your <u>deductible</u> ?	Yes	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 https://www.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> ?	\$1,500 per person / \$3,000 per Family for In-Network Providers; Out-of-Network Providers – Not Covered	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 limits</u> limit has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance billing</u> charges, penalties 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 www.multiplan.com/awp or call 1-855-495-1190 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network 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> . NOTE: only <u>preventive services</u> by a specialist are covered.

 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	\$30/visit	Not Covered	Limited to a combined 8 visits per person per calendar year (combined with maternity and mental health/substance abuse visits)
	Specialist visit	Not Covered	Not Covered	Excluded Service
	Preventive care/screening/immunization	No Charge	Not Covered	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. Certain age restrictions may apply.
If you have a test	Diagnostic test (x-ray, blood work)	\$30/testing day	Not Covered	Limited to 4 testing days per person per calendar year. Ultrasounds are limited to 3 per pregnancy.
	Imaging (CT/PET scans, MRIs)	Not Covered	Not Covered	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available by visiting www.CerpassRx.com or calling 844-636-7506	Generic drugs	Not Covered	Not Covered	Preventive medications are covered at No Charge. Not all drugs are covered. Limited to a 30-day supply.
	Preferred brand drugs	Not Covered	Not Covered	
	Non-preferred brand drugs	Not Covered	Not Covered	
	Specialty drugs	Not Covered	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Covered	Not Covered	Excluded Service
	Physician/surgeon fees	Not Covered	Not Covered	Excluded Service
If you need immediate medical attention	Emergency room care	Not Covered	Not Covered	Excluded Service
	Emergency medical transportation	Not Covered	Not Covered	Excluded Service
	Urgent care	Not Covered	Not Covered	Excluded Service
If you have a hospital stay	Facility fee (e.g., hospital room)	Not Covered	Not Covered	Excluded Service

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)	
	Physician/surgeon fees	Not Covered	Not Covered	Excluded Service
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30/visit for office visit setting; All other outpatient services Not Covered	Not Covered	Limited to a combined 8 visits per person per calendar year (combined with maternity and primary care visits)
	Inpatient services	Not Covered	Not Covered	Excluded Service
If you are pregnant	Office visits	\$30/visit	Not Covered	Cost sharing does not apply for <u>preventive services</u> . Limited to a combined 8 visits per person per calendar year (combined with primary care and mental health/substance abuse visits). Visits bundled under a global fee are not covered. They must be billed separately.
	Childbirth/delivery professional services	Not Covered	Not Covered	
	Childbirth/delivery facility services	Not Covered	Not Covered	
If you need help recovering or have other special health needs	Home health care	Not Covered	Not Covered	Excluded Service
	Rehabilitation services	Not Covered	Not Covered	Excluded Service
	Habilitation services	Not Covered	Not Covered	Excluded Service
	Skilled nursing care	Not Covered	Not Covered	Excluded Service
	Durable medical equipment	Not Covered	Not Covered	Excluded Service
	Hospice services	Not Covered	Not Covered	Excluded Service
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Excluded Service
	Children's glasses	Not Covered	Not Covered	Excluded Service
	Children's dental check-up	Not Covered	Not Covered	Excluded Service

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 .)		
• Acupuncture • Cosmetic surgery • Durable medical equipment • Habilitation services • Hospice • Infertility treatment • Rehabilitation • Skilled nursing care	• Bariatric surgery • Dental care (Adult) • Emergency services • Hearing aids • Hospital stays • Long-term care • Non-emergency care when traveling outside the U.S • Routine eye care (Adult) • Surgery	• Dental care (Child) • Eye care (Child) • Home health • Imaging • Maternity • 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.)		
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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 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.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? No

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 855-495-1190.

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

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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	\$0
■ Specialist [cost sharing]	100%
■ Hospital (facility) [cost sharing]	100%
■ Other [cost sharing]	100%

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>	
Deductibles	\$0
Copayments	\$120
Coinsurance	\$0

<i>What isn't covered</i>	
Limits or exclusions	\$11,599

The total Peg would pay is	\$11,719
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Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$0
■ Specialist [cost sharing]	100%
■ Hospital (facility) [cost sharing]	100%
■ Other [cost sharing]	100%

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>	
Deductibles	\$0
Copayments	\$240
Coinsurance	\$0

<i>What isn't covered</i>	
Limits or exclusions	\$4,543

The total Joe would pay is	\$4,783
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Mia's Simple Fracture

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

■ The plan's overall deductible	\$0
■ Specialist [cost sharing]	100%
■ Hospital (facility) [cost sharing]	100%
■ Other [cost sharing]	100%

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>	
Deductibles	\$0
Copayments	\$60
Coinsurance	\$0

<i>What isn't covered</i>	
Limits or exclusions	\$2,687

The total Mia would pay is	\$2,747
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The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.