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 deductible?	**$0**	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	**Yes**	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?	**$6,500** per person / **$13,000** per family.	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?	**Not Applicable**	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	**Yes.** See www.multiplan.com/awp or call 1-855-495-1190 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. NOTE: only preventive services 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	$20/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	$30/visit	Not Covered	Limited to 2 visits per Calendar Year.
	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)	$50/testing day	Not Covered	Ultrasounds are limited to 3 per pregnancy.
	Imaging (CT/PET scans, MRIs)	Not Covered	Not Covered	Excluded Service
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	$15/prescription	Not Covered	Preventive medications are covered at No Charge. Not all drugs are covered. Limited to a 31-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	$75/visit	Not Covered	Limited to 4 visits per Calendar Year.
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	$20/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	$20/visit	Not Covered	Cost sharing does not apply for preventive services. 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
- Surgery
- Dental care (Child)
- Chiropractic Care
- Eye care (Child)
- Home health
- Imaging
- 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.)

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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.

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

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.

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]*	$50
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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$180
Coinsurance	$0
What isn't covered	
Limits or exclusions	$11,141.44
The total Peg would pay is	**$11,321.44**

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]*	$50
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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$360
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,302.86
The total Joe would pay is	**$4,662.86**

Mia's Simple Fracture

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

The plan's overall deductible	$0
Specialist *[cost sharing]*	$50
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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$180
Coinsurance	$0
What isn't covered	
Limits or exclusions	$2,346.07
The total Mia would pay is	**$2,526.07**

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