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.commconnect.rehnonline.com or call 1-800-872-8979. 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.dol.gov/ebsa/healthreform to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall Deductible?	**$2,800 Individual $5,600 Family**	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**	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?	**$2,800 Individual $5,600 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?	**This limit never includes your premium, balance-billed charges or health care your 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.fchn.com or call 1-800-231-6935 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).
Do you need a referral to see a specialist?	**No**	You can see the specialist you choose without a referral.

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

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	Deductible, then no charge	Deductible, then 40% of UCR	Utilizing an out-of-network Provider may result in the Provider billing the difference between the billed amount and the UCR (Usual, Customary & Reasonable) amount.
	Specialist visit	Deductible, then no charge	Deductible, then 40% of UCR	
	Preventive care/screening/ immunization	No charge	No charge	
If you have a test	Diagnostic test (x-ray, blood work)	Deductible, then no charge	Deductible, then 40% of UCR	
	Imaging (CT/PET scans, MRIs)	Deductible, then no charge	Deductible, then 40% of UCR	Some imaging services may require that a Pre-Authorization be obtained.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.elixirsolutions.com	Generic drugs	Deductible, then no charge		Covers up to a 30-day supply (retail subscription); 31-90 day supply can be obtained through the mail order program.
	Preferred brand drugs	Deductible, then no charge		
	Non-preferred brand drugs	Deductible, then no charge		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible, then no charge	Deductible, then 40% of UCR	
	Physician/surgeon fees	Deductible, then no charge	Deductible, then 40% of UCR	
If you need immediate medical attention	Emergency room care	$350 copay, deductible, then no charge	$350 copay, deductible, then no charge	Copay waived if admitted
	Emergency medical transportation	Deductible, then no charge	Deductible, then 40% of billed	
	Urgent care	Deductible, then no charge	Deductible, then 40% of UCR	
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible, then no charge	Deductible, then 40% of UCR	Pre-authorization is required for these services.
	Physician/surgeon fees	Deductible, then no charge	Deductible, then 40% of UCR	

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 need mental health, behavioral health, or substance abuse services	Outpatient services	Deductible, then no charge	Deductible, then 40% of UCR	
	Inpatient services	Deductible, then no charge	Deductible, then 40% of UCR	Pre-authorization is required for these services.
If you are pregnant	Office visits	Deductible, then no charge	Deductible, then 40% of UCR	Limit of 2 ultrasounds per pregnancy. Additional ultrasounds will require preauthorization.
	Childbirth/delivery professional services	Deductible, then no charge	Deductible, then 40% of UCR	
	Childbirth/delivery facility services	Deductible, then no charge	Deductible, then 40% of UCR	
If you need help recovering or have other special health needs	Home health care	Deductible, then no charge	Deductible, then 40% of UCR	Limit of 130 visits per calendar year.
	Rehabilitation services (Outpatient)	Deductible, then no charge	Deductible, then 40% of UCR	Limit of 45 visits per calendar year. Includes physical therapy, speech therapy, occupational therapy, and massage, cardiac & pulmonary and chronic pain combined.
	Rehabilitation services (Inpatient)	Deductible, then no charge	Deductible, then 40% of UCR	Preauthorization is required. Limit of 30 days per calendar year.
	Skilled nursing care	Deductible, then no charge	Deductible, then 40% of UCR	Preauthorization is required. Limit of 60 days per calendar year. Must be subsequent to a hospital stay in an acute care facility for at least 3 days.
	Durable medical equipment	Deductible, then no charge	Deductible, then 40% of UCR	Preauthorization may be required.
	Hospice services	Deductible, then no charge	Deductible, then 40% of UCR	Preauthorization is required. Limit of 6 months per lifetime (includes up to 10 days inpatient and 240 hours of respite care).
If your child needs dental or eye care	Children's eye exam	N/A		Covered under a separate Dental and Vision Plan.
	Children's glasses	N/A		
	Children's dental check-up	N/A		

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.)		
• Bariatric surgery	• Cosmetic surgery	• Dental care
• Habilitation services	• Hearing aids	• Infertility treatment
• Long term care	• Non-emergency care when traveling outside the U.S.	• Private duty nursing
• Weight loss programs	• Routine eye care	• Routine foot care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture	• Chiropractic care	• Massage Therapy
• Orthotics	• Smoking Cessation Classes	• Sleep Studies

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. 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: Rehn & Associates, Appeals Department, P O Box 5433, Spokane WA 99205, Phone (509) 534-0600, Toll Free (800) 872-8979. 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? **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

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

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	$2,800
Specialist Copayment	$0
Hospital (facility) Coinsurance	0%
Other Coinsurance	0%

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,870**

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

The plan's overall Deductible	$2,800
Specialist Copayment	$0
Hospital (facility) Coinsurance	0%
Other Coinsurance	0%

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	$2,800
Copayments	$960
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,780**

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

The plan's overall Deductible	$2,800
Specialist Copayment	$0
Hospital (facility) Coinsurance	0%
Other Coinsurance	0%

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	$2,800
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,810**

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