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 the website: 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.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Uniform-Glossary-01-2020.pdf or call to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $3,500 individual / $7,000 family Out of Network: $7,000 Individual / $14,000 family	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, 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 and primary 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.	There are no other deductibles.
What is the out-of-pocket limit for this plan?	For network providers $3,500 individual / $7,500 family; for out-of-network providers $7,000 individual / $14,000 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?	Copayments for certain services, 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 https://www.firsthealth.com 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 may see any specialist 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
		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	$10 copay	$20 copay	Includes diagnostic services.
	Specialist visit	$35 copay	$50 copay	Includes diagnostic services
	Preventive care/screening/ immunization	100%	$25 copay	None
If you have a test	Diagnostic test (x-ray, blood work)	20% after deductible	30% after deductible	None
	Imaging (CT/PET scans, MRIs)	$75 copay (up to $375 maximum)	$100 copay (up to $500 maximum)	None
If you need drugs to treat your illness or condition	Generic drugs (Tier 1)	Retail: $5 copay Mail Order: $10 copay	N/A	Covers up to a 30-day supply (retail subscription); 31-90-day supply (mail order prescription).
	Preferred brand drugs (Tier 2)	Retail: $20 copay Mail Order: $40 copay	N/A	
	Non-preferred brand drugs (Tier 3)	Retail: $40 copay Mail Order: $80 copay	N/A	
	Specialty drugs (Tier 4)	20% coinsurance ($100 max)	N/A	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% after deductible	30% after deductible	Prior authorization is required. If Prior Authorization is not obtained benefits will be reduced $500. Outpatient Facility (DXL) covered 100%.
	Physician/surgeon fees	20% after deductible	30% after deductible	
If you need immediate medical attention	Emergency room care	20% after deductible		Includes Physician Fee and Diagnostics. Non-Emergent use of ER is not covered.
	Emergency medical transportation	20% after deductible		None
	Urgent care	$25 copay	$50 copay	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% after deductible	30% after deductible	Prior authorization is required. If Prior Authorization is not obtained benefits will be reduced $500. Also included are miscellaneous Hospital services and supplies

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)	
				required for treatment during a Hospital confinement. Includes Inpatient Maternity Care (delivery and postpartum care).
	Physician/surgeon fees	20% after deductible	30% after deductible	Includes Inpatient Surgery. Anesthesia is paid at the same level as Surgery
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35 copay	$50 copay	Includes Autism Behavioral Therapy, Rehab and Detox office visits
	Inpatient services	20% after deductible	30% after deductible	Includes Autism Behavioral Therapy, Rehab, and Detox Inpatient. Prior authorization is required if prior authorization is not received your benefits will be reduces by $500.
If you are pregnant	Office visits	100%	$20 copay	Prior Authorization is not required for a Hospital length of stay in connection with childbirth for the mother or newborn child of less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section delivery.
	Childbirth/delivery professional services	20% after deductible	30% after deductible	
	Childbirth/delivery facility services	20% after deductible	30% after deductible	
If you need help recovering or have other special health needs	Home health care	20% after deductible	30% after deductible	Up to 100 visits per plan year
	Rehabilitation services	20% after deductible	30% after deductible	Rehabilitation and Habilitation services for autism are a $35 copay per visit
	Habilitation services	20% after deductible	30% after deductible	
	Skilled nursing care	20% after deductible	30% after deductible	Prior authorization is required. If Prior Authorization is not obtained benefits will be reduced $500. Up to 60 days per plan year.
	Durable medical equipment	20% after deductible	30% after deductible	None
	Hospice services	20% after deductible	30% after deductible	Includes Bereavement Counseling
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered except services listed under the ACA guidelines (Network)
	Children's glasses	Not covered	Not covered	None.
	Children's dental check-up	Not covered	Not covered	Not covered except services listed under the ACA guidelines (Network)

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 • Dental care (Adult) • Hearing aids	• Long-term care • Non-emergency care when traveling outside the U.S.	• Routine eye care (Adult) • Routine foot care • Sex change operation

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Allergy injections • Birthing Center • Chiropractic Treatment •	• Infertility treatment • Organ Transplant • Private-duty nursing	• Orthotics • Prosthetic devices

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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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: [insert applicable contact information from instructions].

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:

Spanish (Español): Para obtener asistencia en Español, llame al

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa

Chinese (中文): 如果需要中文的帮助，请拨打这个号码

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne'

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** **$3,500**
- **Specialist copayment** **$35**
- **Hospital (facility) 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)*

Total Example Cost	**$12,700**
In this example, Peg would pay: $	
Cost Sharing	
Deductibles	$3,500
Copayments	$5
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,370**

Managing Joe's Type 2 Diabetes

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

- **The plan's overall deductible** **$3,500**
- **Specialist copayment** **$35**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

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*	$1,900
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,720**

Mia's Simple Fracture

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

- **The plan's overall deductible** **$3,500**
- **Specialist copayment** **$35**
- **Hospital (facility) coinsurance** **20%**
- **Other coinsurance** **20%**

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*	$2,500
Copayments	$5
Coinsurance	$259
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,764**