



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, contact Assured Benefits Administrators at (800) 222-8734. 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 1-800-222-8734 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	For <a href="#">network providers</a> \$3,000 individual / \$9,000 family; for <a href="#">out-of-network</a> providers \$6,500 individual / \$19,500 family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> . <a href="#">Deductible</a> does not include <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, amounts over the <a href="#">allowed amount</a> and health care this <a href="#">plan</a> doesn't cover.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> , and primary care services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">network providers</a> \$3,000 individual / \$9,000 family; for <a href="#">out-of-network</a> providers there is no <a href="#">out-of-pocket limit</a> .	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, amounts over the <a href="#">allowed amount</a> and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> . The <a href="#">allowed amount</a> for <a href="#">out-of-network provider's</a> is 150% of what Medicare would pay for the same service.
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. Visit <a href="http://www.myfirsthealth.com">www.myfirsthealth.com</a> or call (800) 226-5116 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> . This <a href="#">plan</a> encourages members to notify Assured Benefits Administrators at (800) 222-8734 before receiving any non-emergent specialty care.



All [copay](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies, unless otherwise stated.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <a href="#">provider's office</a> or clinic	Primary care visit to treat an injury or illness	\$10 <a href="#">copay</a> /visit, <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a> , <a href="#">allowed amount</a> and <a href="#">deductible</a> apply	None
	<a href="#">Specialist</a> visit	\$55 <a href="#">copay</a> /visit, <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a> , <a href="#">allowed amount</a> and <a href="#">deductible</a> apply	<a href="#">Out-of-network</a> Otolaryngologist (ENT) and Dermatologist office visits are paid as <a href="#">network</a> to the <a href="#">allowed amount</a> .
	<a href="#">Preventive care/screening/immunization</a>	No charge	50% <a href="#">coinsurance</a> , <a href="#">allowed amount</a> and <a href="#">deductible</a> apply	Not all services are categorized as <a href="#">preventive</a> . Ask your <a href="#">provider</a> .
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	0% <a href="#">coinsurance</a> , <a href="#">deductible</a> applies	50% <a href="#">coinsurance</a> , <a href="#">allowed amount</a> and <a href="#">deductible</a> apply	
	Imaging (CT/PET scans, MRIs)	0% <a href="#">coinsurance</a> , <a href="#">deductible</a> applies	50% <a href="#">coinsurance</a> , <a href="#">allowed amount</a> and <a href="#">deductible</a> apply	<a href="#">Preauthorization</a> required.
If you need drugs to treat illness/condition More information about <a href="#">prescription drug coverage</a> is available at <a href="#">www.verus-rx.com</a>	Generic drugs	Retail and Mail: \$1 <a href="#">copay</a> , <a href="#">deductible</a> does not apply	Not covered	<a href="#">Preauthorization</a> required for all specialty drugs greater than \$1,500 per 30-day supply.  You are responsible for the generic copay plus the cost difference between the generic and brand equivalent when choosing a brand with generic equivalent.
	Preferred brand drugs	Retail and Mail: \$35 <a href="#">copay</a> , <a href="#">deductible</a> does not apply	Not covered	
	Non-preferred brand drugs	Retail and Mail: \$75 <a href="#">copay</a> , <a href="#">deductible</a> does not apply	Not covered	
	<a href="#">Specialty drugs</a>	\$200 <a href="#">copay</a> , <a href="#">deductible</a> does not apply	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% <a href="#">coinsurance</a> , <a href="#">deductible</a> applies	50% <a href="#">coinsurance</a> , <a href="#">allowed amount</a> and <a href="#">deductible</a> apply	<a href="#">Preauthorization</a> required.
	Physician/surgeon fees	0% <a href="#">coinsurance</a> , <a href="#">deductible</a> applies	50% <a href="#">coinsurance</a> , <a href="#">allowed amount</a> and <a href="#">deductible</a> apply	<a href="#">Preauthorization</a> required.
If you need immediate medical attention	<a href="#">Emergency room care</a>	0% <a href="#">coinsurance</a> , <a href="#">deductible</a> applies	0% <a href="#">coinsurance</a> , <a href="#">deductible</a> applies	
	<a href="#">Emergency medical transportation</a>	0% <a href="#">coinsurance</a> , <a href="#">deductible</a> applies	0% <a href="#">coinsurance</a> , <a href="#">deductible</a> applies	<a href="#">Preauthorization</a> required for air/flight to another hospital or facility.
	<a href="#">Urgent care</a>	\$55 <a href="#">copay</a> /visit, <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a> , <a href="#">allowed amount</a> and <a href="#">deductible</a> apply	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	0% <a href="#">coinsurance</a> , <a href="#">deductible</a> applies	50% <a href="#">coinsurance</a> , <a href="#">allowed amount</a> and <a href="#">deductible</a> apply	<a href="#">Preauthorization</a> required.
	Physician/surgeon fees	0% <a href="#">coinsurance</a> , <a href="#">deductible</a> applies	50% <a href="#">coinsurance</a> , <a href="#">allowed amount</a> and <a href="#">deductible</a> apply	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$10 <a href="#">copay</a> office visit, <a href="#">deductible</a> does not apply	\$10 <a href="#">copay</a> , plus amount over <a href="#">allowed amount</a> per office visit, <a href="#">deductible</a> does not apply	<a href="#">Preauthorization</a> required after 12 visits.
	Inpatient services	0% <a href="#">coinsurance</a> , <a href="#">deductible</a> applies	50% <a href="#">coinsurance</a> , <a href="#">allowed amount</a> and <a href="#">deductible</a> apply	<a href="#">Preauthorization</a> required.
If you are pregnant	Office visits	\$10 <a href="#">copay</a> office visit, <a href="#">deductible</a> does not apply	50% <a href="#">coinsurance</a> , <a href="#">allowed amount</a> and <a href="#">deductible</a> apply	None
	Childbirth/delivery professional services	0% <a href="#">coinsurance</a> , <a href="#">deductible</a> applies	50% <a href="#">coinsurance</a> , <a href="#">allowed amount</a> and <a href="#">deductible</a> apply	<a href="#">Preauthorization</a> required after 48 hours vaginal/96 hours c-section.
	Childbirth/delivery facility services	0% <a href="#">coinsurance</a> , <a href="#">deductible</a> applies	50% <a href="#">coinsurance</a> , <a href="#">allowed amount</a> and <a href="#">deductible</a> apply	<a href="#">Preauthorization</a> required after 48 hours vaginal/96 hours c-section.
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	0% <a href="#">coinsurance</a> , <a href="#">deductible</a> applies	50% <a href="#">coinsurance</a> , <a href="#">allowed amount</a> and <a href="#">deductible</a> apply	<a href="#">Preauthorization</a> required. Limited to 60 days per coverage period.
	<a href="#">Rehabilitation services</a>	0% <a href="#">coinsurance</a> , <a href="#">deductible</a> applies	50% <a href="#">coinsurance</a> , <a href="#">allowed amount</a> and <a href="#">deductible</a> apply	<a href="#">Preauthorization</a> required after 12 visits. Limited to 35 combined visits per coverage period.
	<a href="#">Habilitation services</a>	0% <a href="#">coinsurance</a> , <a href="#">deductible</a> applies	50% <a href="#">coinsurance</a> , <a href="#">allowed amount</a> and <a href="#">deductible</a> apply	<a href="#">Preauthorization</a> required after 12 visits. Limited to 35 combined visits per coverage period.
	<a href="#">Skilled nursing care</a>	0% <a href="#">coinsurance</a> , <a href="#">deductible</a> applies	50% <a href="#">coinsurance</a> , <a href="#">allowed amount</a> and <a href="#">deductible</a> apply	<a href="#">Preauthorization</a> required. Limited to 25 days per coverage period.
	<a href="#">Durable medical equipment</a>	0% <a href="#">coinsurance</a> , <a href="#">deductible</a> applies	50% <a href="#">coinsurance</a> , <a href="#">allowed amount</a> and <a href="#">deductible</a> apply	<a href="#">Preauthorization</a> required for purchases over \$1500 or rentals over \$500/month.
	<a href="#">Hospice services</a>	0% <a href="#">coinsurance</a> , <a href="#">deductible</a> applies	50% <a href="#">coinsurance</a> , <a href="#">allowed amount</a> and <a href="#">deductible</a> apply	<a href="#">Preauthorization</a> required.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Coverage limited to one exam/year.
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	No charge	Not covered	Coverage limited to one exam/year.

## 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         | • Infertility treatment  | • Routine eye care (Adult) |
| • Bariatric surgery   | • Long-term care   | • Routine foot care        |
| • Cosmetic surgery    | • Non-emergency care when traveling outside the U.S.   | • Weight loss programs     |
| • Dental care (Adult) | • <a href="#">Out-of-network</a> emergency ground transportation charges over the <a href="#">allowed amount</a> |                            |

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- |   |   |  |
|---|---|--|
| • Chiropractic care ( <a href="#">Preauthorization</a> required after 12 visits, maximum 18 visits per coverage period) | • Hearing aids (\$3000 limit /ear every 2 coverage periods) | • <a href="#">Deductible</a> may be waived for some services and health care <a href="#">providers</a> , for details, contact Assured Benefits Administrators at (800) 222-8734. |
|---|---|--|

**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: the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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](http://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 your employer or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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](#).

## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 855-615-6705.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 855-615-6705.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 855-615-6705.

Navajo (Dine): Dine'ehgo shika at'ohwol ninisingo, kwijigo holne' 855-615-6705.

*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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,000
■ <a href="#">Specialist</a> copay	\$55
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$3,000
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,060</b>

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,000
■ <a href="#">Specialist</a> copay	\$55
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$900
Copayments	\$1,200
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,120</b>

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,000
■ <a href="#">Specialist</a> copay	\$55
■ Hospital (facility) <a href="#">coinsurance</a>	0%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$2,100
Copayments	\$300
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,400</b>