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) 226-5116. 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 deductible?	For network providers $3,000 individual / $9,000 family; for out-of-network providers $6,000 individual / $18,000 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, the overall family deductible must be met before the plan begins to pay. Deductible does not include premiums, balance-billing charges, amounts over the allowed amount and health care this plan doesn't cover.
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. A 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 must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For network providers $6,000 individual / $12,000 family; for out-of-network providers there is no out-of-pocket limit.	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, the overall out-of-pocket limits must be met before the plan begins to pay.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, amounts over the allowed amount and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit. The allowed amount for out-of-network provider's is 150% of what Medicare would pay for the same service.
Will you pay less if you use a network provider?	Yes. Visit www.myfirsthealth.com or call (800) 226-5116 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**.** This plan encourages members to notify Assured Benefits Administrators at (800) 226-5116 before receiving any non-emergent specialty care.

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019) (DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022) (HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

All 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 provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	50% coinsurance	None
	Specialist visit	20% coinsurance	50% coinsurance	Out-of-network Otolaryngologist (ENT) and Dermatologist office visits are paid as network to the allowed amount.
	Preventive care/screening/ immunization	No charge	50% coinsurance	Not all services are categorized as preventive. Ask your provider.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	Preauthorization required.
If you need drugs to treat illness/condition More information about **prescription drug coverage** is available at **www.verus-rx.com**	Generic drugs	20% coinsurance	Not covered	Preauthorization required for all specialty drugs greater than $1,500 per 30-day supply.
	Preferred brand drugs	20% coinsurance	Not covered	
	Non-preferred brand drugs	20% coinsurance	Not covered	
	Specialty drugs	20% coinsurance	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Preauthorization required.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	Preauthorization required.
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	
	Emergency medical transportation	20% coinsurance	20% coinsurance	Preauthorization required for air/flight to another hospital or facility.
	Urgent care	20% coinsurance	50% coinsurance	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)	20% coinsurance	50% coinsurance	Preauthorization required.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	20% coinsurance	Preauthorization required after 12 visits.
	Inpatient services	20% coinsurance	50% coinsurance	Preauthorization required.
If you are pregnant	Office visits	20% coinsurance	50% coinsurance	None
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	Preauthorization required after 48 hours vaginal/96 hours c-section.
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	Preauthorization required after 48 hours vaginal/96 hours c-section.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Preauthorization required Limited to 60 days per coverage period.
	Habilitation/Rehabilitative Therapies: ST, OT and Cardiac Therapy	20% coinsurance	50% coinsurance	Preauthorization required after 12 visits. Limited to 35 combined visits per coverage period.
	Habilitation/Rehabilitative Therapies: PT	20% coinsurance	50% coinsurance	Preauthorization required after 12 visits. Limited to 35 combined visits per coverage period.
	Skilled nursing care	20% coinsurance	50% coinsurance	Preauthorization required. Limited to 25 days per coverage period.
	Durable medical equipment	20% coinsurance	50% coinsurance	Preauthorization required for purchases over $1500 or rentals over $500/month.
	Hospice services	20% coinsurance	50% coinsurance	Preauthorization 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
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Out-of-network emergency ground transportation charges over the allowed amount
- 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.)

- Chiropractic care (Preauthorization required after 12 visits, maximum 18 visits per coverage period)
- Hearing aids ($3000 limit /ear every 2 coverage periods)

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. 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 your employer or the 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.

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): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo 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 plan's overall deductible	$3,000
Specialist coinsurance	20%
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	$3,000
Copayments	$0
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,960**

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

The plan's overall deductible	$3,000
Specialist coinsurance	20%
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	$3,000
Copayments	$0
Coinsurance	$500
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,520**

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

The plan's overall deductible	$3,000
Specialist coinsurance	20%
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	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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