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 Exemplar Health Benefits Administrator at (855) 826-3422. 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. You can view the Glossary at www.cms.gov/CCIIO/Resources or see your Summary Plan Description (SPD).

Important Questions	Answers		Why This Matters:
What is the overall deductible?	Network Providers $6,000/Individual or $12,000/Family	Out-of-Network Providers $9,000/Individual or $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, 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 services are covered before you meet your deductible.	N/A	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	No	No. You don't have to meet deductibles for specific services.

What is the out-of-pocket limit for this plan?	Network Providers $7,000/Individual, $14,000/Family	Out-of-Network Providers $14,000/Individual, $28,000/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 the co-insurance?	30%	50%	Up to the out-of-pocket limit.
What is not included in the out-of-pocket limit?	Penalties for non-compliance with plan provisions; premiums, balance-billing charges, and health care this plan doesn't cover.	Penalties for non-compliance with plan provisions; 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 www.myfirsthealth.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).
Do you need a referral to see a specialist?	No	No	You can see the specialist you choose 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 (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	30% after Deductible	50% after Deductible	
	Specialist visit	30% after Deductible	50% after Deductible	
	Preventive care/screening/ immunization	No charge	50% after Deductible	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% after Deductible	50% after Deductible	
	Imaging (CT/PET scans, MRIs)	30% after Deductible	50% after Deductible	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.prorxsolutions.com	Generic drugs (Tier 1)	$0	N/A	Benefits may vary if more than a 30 day supply is needed.
	Preferred brand drugs (Tier 2)	25% after Deductible	N/A	
	Non-preferred brand drugs (Tier 3)	45% after Deductible	N/A	
	Specialty drugs (Tier 4)	30% after Deductible	N/A	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% after Deductible	50% after Deductible	
	Physician/surgeon fees	30% after Deductible	50% after Deductible	
If you need immediate medical attention	Emergency room care	30% after Deductible		$500 applies if used for non-urgent services.
	Emergency medical transportation	No Charge	No Charge	
	Urgent care	30% after Deductible	30% after Deductible	
If you have a hospital stay	Facility fee (e.g., hospital room)	30% after Deductible	50% after Deductible	
	Physician/surgeon fees	30% after Deductible	50% after Deductible	

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 (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient and inpatient services	30 % after Deductible	50% after Deductible	Behavioral health and mental wellness services that are rendered by a licensed professional in an office visit setting are subject to the same payments as primary care.
	Office visits	30% after Deductible	50% after Deductible	
If you are pregnant	Office visits	No Charge	No Charge	
	Childbirth/delivery professional services	30% after Deductible	50% after Deductible	
	Childbirth/delivery facility services	30% after Deductible	50% after Deductible	
If you need help recovering or have other special health needs	Home health care	30% after Deductible	50% after Deductible	
	Rehabilitation services	30% after Deductible	50% after Deductible	
	Habilitation services	30% after Deductible	50% after Deductible	
	Skilled nursing care	30% after Deductible	50% after Deductible	
	Durable medical equipment	30% after Deductible	50% after Deductible	
	Hospice services	30% after Deductible	50% after Deductible	
If your child needs dental or eye care	Children's eye exam	No Charge	No Benefit	Coverage limited to one exam/year.
	Children's glasses	No Benefit	No Benefit	Per plan provisions
	Children's dental check-up	No Benefit	No Benefit	None

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 (if prescribed for rehabilitation purposes)
- Cosmetic Surgery
- Dental Care
- Infertility Treatment
- Hearing Aids
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- 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.)

- Birth Control
- Colonoscopy
- Diagnostic Services
- Sterilization for Women
- Transplants (inpatient only)

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: U.S. Department of Labor Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323, extension 61565 or www.cciio.cms.gov. 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: Exemplar Health Benefits Administrator at (855) 826-3422.

Does this plan provide Minimum Essential Coverage? Yes.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet 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 855-826-3422.]

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	$6,000
Specialist copayment	$0
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	**$13,615**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,180
Copayments	$0
Coinsurance	$3,720
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6960**

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

The plan's overall deductible	$6,000
Specialist copayment	$0
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	**$8,826**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$2,048
Copayments	$0
Coinsurance	$878
What isn't covered	
Limits or exclusions	$3,637
The total Joe would pay is	**$6563**

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

The plan's overall deductible	$6,000
Specialist copayment	$0
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	**$2,295**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$1,348
Copayments	$0
Coinsurance	$578
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1926**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: NOT APPLICABLE
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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