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.healthcare.gov/sbc-glossary/ or See your Summary Plan Description (SPD).

Important Questions	Answers		Why This Matters:
What is the overall deductible?	Network Providers $5,000/Individual or $10,000/Family	Out-of-Network Providers $8,000/Individual or $16,000/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 $8,000/Individual, $16,000/Family	Out-of-Network Providers $15,000/Individual, $30,000/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?	20%	40%	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	$25 Copay	30% after Deductible	Virtual Care payable same as in-person visits. Chiropractic Visit maximum of 12 visits per calendar year. Genetic Counseling is limited to a max of 3 visits per person per calendar year.
	Specialist visit	$50 Copay	30% after Deductible	
	Preventive care/screening/ immunization	No charge	30% 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)	20% after Deductible	40% after Deductible	
	Imaging (CT/PET scans, MRIs)	20% after Deductible	40% after Deductible	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com	Generic drugs (Tier 1)	$20 Copay	In-Network Coverage Only	**Deductible does not apply to Tier 4** Mail Order (90 day supply) Tier 1 $60 Tier 2 $120 Tier 3 $210 Tier 4 N/A Medical and Pharmacy costs are combined for In-Network Out-of-Pocket Maximum
	Preferred brand drugs (Tier 2)	$40 Copay	In-Network Coverage Only	
	Non-preferred brand drugs (Tier 3)	$70 Copay	In-Network Coverage Only	
	Specialty drugs (Tier 4)	20% up to $500	In-Network Coverage Only	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% after Deductible	40% after Deductible	
	Physician/surgeon fees	20% after Deductible	40% after Deductible	
If you need immediate medical attention	Emergency room care	$450 Copay, then deductible		Advanced Imaging (i.e. MRIs, CAT Scans, etc) $450 copay per visit, then deductible
	Emergency Transportation	20% after Deductible	20% after Deductible	
	Urgent care	$100 Copay	$100 Copay	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% after Deductible	40% 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)	
	Physician/surgeon fees	20% after Deductible	40% after Deductible	
If you need mental health, behavioral health, or substance abuse services	Inpatient Services	20% after Deductible	40% 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.
	Outpatient Office visits	$50 Copay	30% after Deductible	
	Outpatient Services	20% after Deductible	40% after Deductible	
If you are pregnant	Office visits	$25/$50 Copay	30% after Deductible	
	Childbirth/delivery professional services	20% after Deductible	40% after Deductible	
	Childbirth/delivery facility services	20% after Deductible	40% after Deductible	
If you need help recovering or have other special health needs	Home health care	20% after Deductible	40% after Deductible	Outpatient Therapy Services are limited to a maximum of 20 days combined per calendar year. Cardiac Rehabilitation Services are limited to a maximum of 36 days per calendar year.
	Rehabilitation services	20% after Deductible	40% after Deductible	
	Hospice services	20% after Deductible	40% after Deductible	
	Skilled nursing care	20% after Deductible	40% after Deductible	
	Durable medical equipment	20% after Deductible	40% after Deductible	
	Cardiac Rehabilitation	$50 Copay	30% after Deductible	
Other Benefits	Gene Therapy Medical Services	20% after Deductible	40% after Deductible	Gene Therapy Product covered same as Pharmaceuticals
	Gene Therapy Travel Expenses	No Charge	In-Network Coverage Only	Maximum of $10,000 per episode of authorized therapy
	Abortion Services	20% after Deductible	40% after Deductible	Includes elective and non-elective procedures

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
- Routine Dental Care
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine eye care
- 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.)

- Genetic and Nutritional Counseling
- Obesity/Bariatric Surgery
- Diagnostic Services
- Sterilization for Women
- Transplants
- Hearing Aids

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.]