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 Preferred Benefit Administrators, Inc. 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 www.PreferredTPA.com or call 1-888-524-2777 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers: $0 individual / $0 family For out-of-network providers: No coverage	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. Emergency room visits, outpatient x-ray & laboratory, physician office visits, urgent care visits, outpatient surgery, prescription drugs and Preventive 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.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers: No maximum. For out-of-network providers: No coverage	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?	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.FirstHealthLBP.com or call 1-888-524-2777 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.

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 copayment; plan pays up to $70 per visit.	Not covered	Primary care, walk-in clinic and Specialist combined maximum benefit of 3 visits per calendar year.
	Specialist visit	$10 copayment; plan pays up to $70 per visit.	Not covered	Primary care, walk-in clinic and Specialist combined maximum benefit of 3 visits per calendar year.
	Preventive care/screening/ immunization	No charge	Not covered	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)	Blood work: plan pays up to $30; 2 times per year. X-ray: plan pays up to $50; 2 times per year.	Not covered	Subject to maximum plan payment and visit maximum each calendar year.
	Imaging (CT/PET scans, MRIs)	CT/PET: plan pays up to $100; 1 time per year. MRI: plan pays up to $250; 1 time per year.	Not covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.PreferredTPA.com	Generic drugs	$10 copayment. No charge for ACA mandated prescriptions such as oral contraceptives and statin drugs		Monthly maximum of $100 for generic and $200 for brand drugs. Retail / Pharmacy covers up to 30-day supply; Mail order copayment is 3X retail pharmacy copayment. Must use network pharmacy.
	Brand drugs with no generic equivalent	$30 copayment		
	Brand drugs with a generic equivalent	$30 copayment		
	Specialty drugs	Not covered		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Plan pays up to $1,000; 1 time per year.	Not covered	If surgery is in hospital, plan pays up to $1,500; 1 time per year.
	Physician/surgeon fees		Not covered	
If you need immediate medical attention	Emergency room care	Plan pays up to $100; 1 time per year.	Not covered	None
	Emergency medical transportation	Not covered	Not covered	None
	Urgent care	$10 copayment; plan pays up to $150 per visit	Not covered	Maximum benefit of 3 visits per calendar year.

* For more information about limitations and exceptions, see the plan or policy document at www.PreferredTPA.com

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 have a hospital stay	Facility fee (e.g., hospital room)	Day 1: plan pays up to $1,500. Day 2-5: plan pays up to $1,000 per day.	Not covered	Per day maximum plan payment applies.
	Physician/surgeon fees	Included in above payment maximum.	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not covered	Not covered	Only Preventive Care / Routine Services are covered
	Inpatient services	Not covered	Not covered	
If you are pregnant	Office visits	Not covered unless mandated by ACA preventive services. Initial visit $10 copayment; plan pays up to $70 per visit.	Not covered	Initial visit combines with 3 visit maximum for Primary Care & Specialist visits. Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	Not covered	Not covered	
	Childbirth/delivery facility services	Day 1: plan pays up to $1,500. Day 2-5: plan pays up to $1,000 per day.	Not covered	
If you need help recovering or have other special health needs	Home health care	Not covered	Not covered	Only Preventive Care / Routine Services are covered
	Rehabilitation services	Not covered	Not covered	Only Preventive Care / Routine Services are covered
	Habilitation services	Not covered	Not covered	
	Skilled nursing care	Not covered	Not covered	Only Preventive Care / Routine Services are covered
	Durable medical equipment	Not covered	Not covered	Only Preventive Care / Routine Services are covered
	Hospice services	Not covered	Not covered	Only Preventive Care / Routine Services are covered
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	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
- Allergy Testing
- Bariatric Surgery
- Chiropractic Care
- Cosmetic Surgery
- Hearing Aids
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Orthotics / Prosthetics
- Private Duty Nursing
- Routine eye care (Adult)
- Routine Foot Care
- Transplants
- Weight Loss Programs

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

This Plan covers Preventive Care / Wellness Services in compliance with the Affordable Care Act (ACA) and other limited services outlined in this SBC up to the maximum benefit specified under each medical service.

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-(EBSA)4272 or 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 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 Preferred Benefit Administrators at 1-888-524-2777.

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? No.
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 1-888-524-2777

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-524-2777

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-888-524-2777

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-524-2777

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	**$0**
Specialist copayment	**$10**
Hospital (facility) coinsurance	**100%**
Other coinsurance	**100%**

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	$0
Copayments	$40
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10,000
The total Peg would pay is	**$10,040**

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

The plan's overall deductible	**$0**
Specialist copayment	**$10**
Hospital (facility) coinsurance	**100%**
Other coinsurance	**100%**

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	$0
Copayments	$70
Coinsurance	$0
What isn't covered	
Limits or exclusions	$4,900
The total Joe would pay is	**$4,970**

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

The plan's overall deductible	**$0**
Specialist copayment	**$10**
Hospital (facility) coinsurance	**100%**
Other coinsurance	**100%**

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	$0
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$1,600
The total Mia would pay is	**$1,610**

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