NETWORK- FIRST HEALTH NETWORK

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, [insert contact information]. 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.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Uniform-Glossary-12-19-14-FINAL.pdf or call 1-888-741-2673 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$500** person **/$1,500** family. Does not apply to in-network or out-of-network preventive care.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there services covered before you meet your deductible?	Yes	This **plan** covers some items and services even if you haven't yet met the **deductible** amount. But a **copayment** or **coinsurance** may apply. See your plan document for a list of covered **payment provisions**.
Are there other deductibles for specific services?	Yes. **$500** for Out-of-Network Facility per admission deductible.	You must pay all 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 in-network providers **$5,000** person **/$15,000** family. For out-of-network providers **$10,000** person **/ $30,000** family.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, health care this plan doesn't cover, and penalties for failure to obtain pre-authorization for services.	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. For a list of In-Network providers, see https://providerlocator.firsthealth.com/LocateProvider/LocateProviderSearch/ **or call First Health at** 1-800-226-5116.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do you need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146 Released on April 6, 2016

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	$25 copay/visit and 20% coinsurance	40% coinsurance	——————none——————
	Specialist visit	$25 copay/visit and 20% coinsurance	40% coinsurance	
	Preventive care/screening/ immunization	see limitations	see limitations	Plan pays 100% of eligible expenses up to $500; eligible expenses exceeding $500; 20% coinsurance for in-network or 40% coinsurance for out-of-network., after the deductible has been met.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible (if not performed at health care provider's office or clinic)	40% coinsurance after deductible (if not performed at health care provider's office or clinic)	If performed during a visit to a health care provider, see above for benefit. Penalty for failure of preauthorization is $500/In-network and $1,000/Out-of-network.
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.corehealthbenefits.com	Generic drugs	**Retail**: $10 co-pay **OR** 20% cost of drug/prescription. **Mail order**: $20 co-pay **OR** 20% cost of drug/ prescription.	N/A	Copayment is the greater of the flat-dollar copayment or coinsurance. Retail pharmacy– 30-day supply only; Mail order– 90-day supply.
	Preferred brand drugs	**Retail**: $20 co-pay **OR** 20% cost of drug/ prescription. **Mail order**: $40 co-pay **OR** 20% cost of drug/prescription.		
	Non-preferred brand drugs	**Retail**: $35 co-pay **OR** 20% cost of drug/ prescription. **Mail order**: $70 co-pay **OR**		

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)	
		20% cost of drug/prescription.		
	Specialty drugs	N/A		N/A
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	40% coinsurance after deductible	Penalty for failure of preauthorization is $500/In-network and $1,000/Out-of-network.
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	Penalty for failure of preauthorization is $500/In-network and $1,000/Out-of-network.
If you need immediate medical attention	Emergency room care	$150 copayment per visit then 20% coinsurance	$150 copayment per visit then 40% coinsurance	Copayment is waived if an accident, or admitted within 24 hours, or true emergency.
	Emergency medical transportation	20% coinsurance after deductible	40% coinsurance after deductible	————————none————————
	Urgent care			
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	40% coinsurance after deductible	Penalty for failure of preauthorization is $500/In-network and $1,000/Out-of-network.
	Physician/surgeon fees			
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance after deductible	50% coinsurance after deductible	None
	Inpatient services	20% coinsurance after deductible	40% coinsurance after deductible	Penalty for failure of preauthorization is $500/In-network and $1,000/Out-of-network.
If you are pregnant	Office visits	$25 copay/visit and 20% coinsurance	40% coinsurance	————————none————————
	Childbirth/delivery professional services	20% coinsurance after deductible	40% coinsurance after deductible	Available for Employee and Spouse **ONLY**. Preauthorization required for any maternity hospital stay longer than 48 hours (vaginal delivery) or 96 hours (cesarean).
	Childbirth/delivery facility services			
If you need help recovering or have	Home health care	20% coinsurance after deductible	40% coinsurance after deductible	Must be reviewed and approved every 30 days.

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)	
other special health needs	Rehabilitation services	20% coinsurance after deductible	40% coinsurance after deductible	Preauthorization required for occupational therapy, pulmonary therapy, pulmonary rehabilitation and speech therapy. Limit 25 visits. Inpatient Rehabilitative Facility (IRF) limit is 15 days.
	Habilitation services			
	Skilled nursing care	20% coinsurance after deductible	40% coinsurance after deductible	Maximum 30 days per calendar year
	Durable medical equipment	20% coinsurance after deductible	40% coinsurance after deductible	All DME in excess of $500 require preauthorization by CORE.
	Hospice services	20% coinsurance after deductible	40% coinsurance after deductible	Must be reviewed and approved every 60 days
If your child needs dental or eye care	Children's eye exam	See Limitations	See Limitations	Maximum allowable for Eye Exam is $100 which is included in the Wellness Benefit of $500.
	Children's glasses	Not Covered	Not Covered	n/a
	Children's dental check-up	Not Covered	Not Covered	See Dental Plan

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
- Hearing aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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		
• Dental care (Adult) for accidental injury, removal of tumors, removal of unerupted/impacted teeth, or correction of congenital abnormalities	• Private-duty nursing Routine eye care (Adult)	• Routine foot care

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: Your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 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: 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: 1-888-741-2673.

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 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 1-888-741-2673.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-741-2673.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-888-741-2673.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-741-2673.

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	$500
Specialist *[cost sharing]*	$25
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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	**$12800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$275
Coinsurance	$2405
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3180**

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

The plan's overall deductible	$500
Specialist *[cost sharing]*	$25
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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	**$7400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$1100
Coinsurance	$1160
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2760**

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

The plan's overall deductible	$500
Specialist *[cost sharing]*	$25
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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	**$1900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$215
Coinsurance	$237
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$952**

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