NETWORK- (Inside of GA): First Health Network/ (Outside of GA): 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, 1-888-741-2673. 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?	**$700**/person In-Network/ **$1,400**/person Out-of-Network Doesn't apply to In-Network Routine Annual Exam.	Generally, you must pay all of 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?	**No.**	You don't have to meet **deductibles** for specific services. See the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	For In-Network providers **$4,000**/person /**$12,000** family For Out-of-Network Providers **Unlimited person**	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, 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. For a list of In-Network providers, see https://providerlocator.firsthealth.com/LocateProvider/LocateProviderSearch/ **or call First Health at** 1-800-226-5116.	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 don't need a referral to see a specialist.	You can see a **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	20% coinsurance	40% coinsurance	————————none————————
	Specialist visit	20% coinsurance	40% coinsurance	————————none————————
	Preventive care/screening/ immunization	No charge. See Limitations & Exceptions	40% coinsurance.	First $300 is paid at 100%, charges incurred for Routine Annual Exam in excess of $300 are payable at 80%, waiving the deductible.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	————————none————————
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Preauthorization required, $200 penalty for noncompliance.
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)-$20 copay **OR** greater of 20% coinsurance (Max $100)/(Mail order)-$40 copay **OR** greater of 20% coinsurance (Max $200)	None	Co-payment is the greater of the flat-dollar co-payment or coinsurance**. Total costs not to exceed $300 for any 30-day supply/ $600 for any mail order 90-day supply.** Retail pharmacy – 30, 60, 90-day supply. Mail order – 90-day supply.
	Brand Name Drugs (**No Generic Available**)	(Retail)-$50 copay **OR** greater of 25% coinsurance (Max $200)/(Mail order)-$100 copay **OR** greater of 25% coinsurance (Max $400)	None	
	Brand Name (**By Preference**)	(Retail)-$75 co-pay **OR** greater of 30% coinsurance (Max $300)/(Mail order)-$150 copay **OR** greater of 30% coinsurance(Max $600) ****Plan will pay the cost of available generic****	None	

*For more information about limitations and exceptions, see the plan or policy document at www.corehealthbenefits.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)	
	Specialty drugs	n/a	n/a	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Preauthorization required within 2 business days prior to admission, $200 penalty for noncompliance.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	20% coinsurance	40% coinsurance	Preauthorization required within 2 days after admission, $200 penalty for noncompliance. Non-accident, non-emergency services $25 co-payment, waived if admitted.
	Emergency medical transportation	20% coinsurance	40% coinsurance	————————none————————
	Urgent care	20% coinsurance	40% coinsurance	Preauthorization required within 2 business days prior to admission, $200 penalty for noncompliance.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization required within 2 business days prior to admission, $200 penalty for noncompliance.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	
	Inpatient services	20% coinsurance	40% coinsurance	
If you are pregnant	Office visits	20% coinsurance	40% coinsurance	Preauthorization required for any maternity hospital stay longer than 48 hours (vaginal delivery) or 96 hours (cesarean), $200 penalty for noncompliance.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Preauthorization required, $200 penalty for noncompliance. Must be reviewed and approved every 60 days. Maximum 120 days per calendar year.
	Rehabilitation services	20% coinsurance	40% coinsurance	Preauthorization required for pulmonary rehabilitation and speech therapy, $200 penalty for noncompliance. Limit 25 visits
	Habilitation services	20% coinsurance	40% coinsurance	Preauthorization required, $200 penalty for noncompliance.
	Skilled nursing care	20% coinsurance	40% coinsurance	Preauthorization required, $200 penalty for noncompliance. Must be reviewed and

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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)	
				approved every 60 days. Maximum 120 days per calendar year.
	Durable medical equipment	20% coinsurance	40% coinsurance	Preauthorization required for all DME in excess of $500, penalty for noncompliance $200.
	Hospice services	20% coinsurance	40% coinsurance	Preauthorization required, penalty for noncompliance is $200. Must be reviewed and approved every 60 days. Maximum lifetime benefit is $20,000.
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	Not covered under Medical Plan; 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.
- 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.)

- Chiropractic care
- Dental care - for accidental injury, removal of tumors, removal of unerupted/impacted teeth, or correction of congenital abnormalities
- Private-Duty nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. You may contact your state insurance department, the 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 x61565 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: 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.

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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.

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

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	$600
Specialist *[cost sharing]*	20%
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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$600
Copayments	$0
Coinsurance	$2,440
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,040**

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

The plan's overall deductible	$600
Specialist *[cost sharing]*	20%
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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$600
Copayments	$0
Coinsurance	$1,360
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,960**

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

The plan's overall deductible	$600
Specialist *[cost sharing]*	20%
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	**$2,500**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$600
Copayments	$0
Coinsurance	$380
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$980**

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