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, please contact ACI at 888-585-9038. 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.healthcare.gov/sbc-glossary or call 888-585-9038.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0 In network	There is no deductible when using the first Health Network.
Are there services covered before you meet your deductible?	YES	MEC services are covered at 100% with a First Health network provider.
Are there other deductibles for specific services?	No	No
What is the out-of-pocket limit for this plan?	No Out Of Pocket Limit	
What is not included in the out-of-pocket limit?	N/A	
Will you pay less if you use a network provider?	YES	Yes. See www.firsthealth.com call 1-800-226-2116 for a list of network providers.
Do you need a referral to see a specialist?	NO	You can see the First Health Provider 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 or Specialist visit to treat an injury or illness	$30 Copay 3 visits per year	Not Covered	Lab, Diagnostic Testing, Xray covered under the Office Visit Copay when completed during the visit.
	Preventive care/screening/ immunization	$0	Not Covered	The Plan covers preventive care treatment provided by a First Health Participating provider. Please see https://www.healthcare.gov/coverage/preventive-care-benefits for a list of covered services
If you have need Urgent Care	Urgent Care Office Visit	$50 Copay 1 Visit per year	Not covered	Lab, Diagnostic Testing, Xray covered under the Office Visit Copay when completed during the visit.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.healthcare.gov	ACA Covered RX	$0	Not Covered	Please see https://www.healthcare.gov/coverage/preventive-care-benefits for covered preventive drugs and supplies
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Covered	Not Covered	
	Physician/surgeon fees	Not Covered	Not Covered	
If you need immediate medical attention	Emergency room care	Not Covered	Not Covered	
	Emergency medical transportation	Not Covered	Not Covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	Not Covered	Not Covered	
	Physician/surgeon fees	Not Covered	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not Covered	Not Covered	
	Inpatient services	Not Covered	Not Covered	

* For more information about limitations and exceptions, see the plan or policy document by calling 888-585-9038.

If you are pregnant	Office visits	Not Covered	Not Covered	
	Childbirth/delivery professional services	Not Covered	Not Covered	
	Childbirth/delivery facility services	Not Covered	Not Covered	
If you need help recovering or have other special health needs	Home health care	Not Covered	Not Covered	
	Rehabilitation services	Not Covered	Not Covered	
	Habilitation services	Not Covered	Not Covered	
	Skilled nursing care	Not Covered	Not Covered	
	Durable medical equipment	Not Covered	Not Covered	
	Hospice services	Not Covered	Not Covered	
If your child needs dental or eye care	Children's eye exam	$0	Not Covered	Vision Screening for all children by a First Health participating provider.
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	What is covered: Fluoride chemoprevention supplements for children without fluoride in their water source Fluoride varnish for all infants and children as soon as teeth are present https://www.cdc.gov/oralhealth/basics/childrens-oral-health/index.html

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.)

- Treatment of illness or injury
- Acupuncture
- Bariatric surgery
- Chiropractic care
- Cosmetic surgery
- Out of Network preventive care
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Hospitalization for Injury or Illness
- 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.)

- Smoking Cessation
- FDA Approved Contraception
- Breast Pumps

* For more information about limitations and exceptions, see the plan or policy document by calling 888-585-9038.

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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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: [insert applicable contact information from instructions].

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 888-585-9038.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 888-585-9038.]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码[888-585-9038.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 888-585-9038.]

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

* For more information about limitations and exceptions, see the plan or policy document by calling 888-585-9038.

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]*** **100%**
- **Other *[cost sharing]*** **$50 copay (diagnostic)**

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	$200
Coinsurance	100%
What isn't covered	
Limits or exclusions	$9700
The total Peg would pay is	**$9900**

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]*** **100%**
- **Other *[cost sharing]*** **$50 copay (diagnostic)**

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	$125
Coinsurance	100%
What isn't covered	
Limits or exclusions	$4600
The total Joe would pay is	**$4725**

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]*** **100%**
- **Other *[cost sharing]*** **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	$475
Coinsurance	100%
What isn't covered	
Limits or exclusions (Er, DME, PT)	$2,000
The total Mia would pay is	**$2475**

The plan would **not** be responsible for the other costs of these EXAMPLE covered services.