



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 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. https://www.healthcare.gov/sbc-glossary](https://www.healthcare.gov/sbc-glossary) or call 1-800-964-7096 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$0	There is no deductible with this Preventive Care Plan.
Are there services covered before you meet your deductible ?	YES	This plan covers preventive services without cost sharing. 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 ?	\$0	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit ?	Not Applicable	This plan does not have an out-of-pocket limit on your expenses.
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 for preventive treatment 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	Not Covered – 100%	Not Covered – 100%	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
	Specialist visit	Not Covered – 100%	Not Covered – 100%	
	Preventive care/screening/immunization	\$0	Not Covered – 100%	
If you have a test	Diagnostic test (x-ray, blood work)	Not Covered – 100%	Not Covered – 100%	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
	Imaging (CT/PET scans, MRIs)	Not Covered – 100%	Not Covered – 100%	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at healthcare.gov	Generic drugs	Not Covered – 100%	Not Covered – 100%	
	Preferred brand drugs	Not Covered – 100%	Not Covered – 100%	
	Non-preferred brand drugs	Not Covered – 100%	Not Covered – 100%	
	Specialty drugs	Not Covered – 100%	Not Covered – 100%	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Covered – 100%	Not Covered – 100%	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
	Physician/surgeon fees	Not Covered – 100%	Not Covered – 100%	
If you need immediate medical attention	Emergency room care	Not Covered – 100%	Not Covered – 100%	
	Emergency medical transportation	Not Covered – 100%	Not Covered – 100%	
	Urgent care	Not Covered – 100%	Not Covered – 100%	
If you have a hospital stay	Facility fee (e.g., hospital room)	Not Covered – 100%	Not Covered – 100%	
	Physician/surgeon fees	Not Covered – 100%	Not Covered – 100%	
If you need mental	Outpatient services	Not Covered – 100%	Not Covered – 100%	

* For more information about limitations and exceptions, see the [plan](#) or policy document at myternian.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)	
health, behavioral health, or substance abuse services	Inpatient services	Not Covered – 100%	Not Covered – 100%	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 are pregnant	Office visits	Not Covered – 100%	Not Covered – 100%	
	Childbirth/delivery professional services	Not Covered – 100%	Not Covered – 100%	
	Childbirth/delivery facility services	Not Covered – 100%	Not Covered – 100%	
If you need help recovering or have other special health needs	Home health care	Not Covered – 100%	Not Covered – 100%	
	Rehabilitation services	Not Covered – 100%	Not Covered – 100%	
	Habilitation services	Not Covered – 100%	Not Covered – 100%	
	Skilled nursing care	Not Covered – 100%	Not Covered – 100%	
	Durable medical equipment	Not Covered – 100%	Not Covered – 100%	
	Hospice services	Not Covered – 100%	Not Covered – 100%	
If your child needs dental or eye care	Children's eye exam	\$0	Not Covered – 100%	Eye Exams are included in the preventive care visit.
	Children's glasses	Not Covered – 100%	Not Covered – 100%	
	Children's dental check-up	Not Covered – 100%	Not Covered – 100%	

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	Dental care	Non-emergency care or emergency care when traveling outside the U.S.
Bariatric surgery	Hearing aids	Private-duty nursing
Chiropractic care	Infertility treatment	Routine eye care (Adult)
Cosmetic surgery	Long-term 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.)		
• Smoking Cessation	• FDA Approved Contraception	•

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: Benefits Coordinator 1-800-964-7096 or you may also contact your state insurance department, the U.S Department of Labor's Employee Benefit Security Administration 1-866-EBSA or www.dol.gov/ebsa. 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: Benefits Coordinator 1-800-964-7096 or Department of Labor's Employee Benefit Security Administration 1-866-EBSA.

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:

<http://cciio.cms.gov/programs/consumer/summaryandglossary/index.html>.

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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	\$
■ Specialist [cost sharing]	\$
■ Hospital (facility) [cost sharing]	%
■ Other [cost sharing]	%

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$12,700
The total Peg would pay is	\$12,700

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$
■ Specialist [cost sharing]	\$
■ Hospital (facility) [cost sharing]	%
■ Other [cost sharing]	%

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$5,600
The total Joe would pay is	\$5,600

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$
■ Specialist [cost sharing]	\$
■ Hospital (facility) [cost sharing]	%
■ Other [cost sharing]	%

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$2,800
The total Mia would pay is	\$2,800