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, www.acuity-grp.com or 1-866-569-6092. 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.cciio.cms.gov or call 1-888-866-5311 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network Providers: $2,000/individual or $4,000/family. Non-Network Providers: $4,000/individual or $8,000/family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care and primary 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 deductible specific services.
What is the out-of-pocket limit for this plan?	For network :$6,500 individual / $13,000 family. Non-Network: $13,000 individual / $26,000 family.	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, prior authorization/cost containment penalties, amounts over allowed amount, 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.myfirsthealth.com or call 1-800-226-5116 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	$30 copayment office visit Deductible does not apply.	40% coinsurance	Includes x-rays, tests, inoculations, lad work performed in the provider's office at the time of the appointment. Does not include MRIs, other non-X-ray imaging test, surgery, or chemotherapy.
	Specialist visit	$50 copayment office visit Deductible does not apply.	40% coinsurance	Includes x-rays, tests, inoculations, lab work performed in the provider's office at the time of the appointment. Does not include MRIs, other non-X-ray imaging test, surgery, or chemotherapy.
	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. Frequency limits apply.
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 is required. If you don't get preauthorization, benefits will be reduced to 50% of the total cost of the service.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.truescripts.com	Generic drugs	$25 copayment for up to 30-day supply; $50 copayment for up to 90-day supply through mail order pharmacy		
	Preferred brand drugs	$50 copayment for up to 30-day supply; $100 copayment for up to 90-day supply through mail order pharmacy		
	Non-preferred brand/Compound drugs	$75 copayment for up to 30-day supply; $150 copayment for up to 90-day supply through mail order pharmacy		
	Specialty drugs Tier 1	$75 copayment for up to 30-day supply		Preauthorization is required for Specialty medications

[* For more information about limitations and exceptions, see the plan or policy document at www.acuity-grp.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 Tier 2 Specialty drugs Tier 3 Specialty drugs Tier 4 Specialty drugs Tier 5	20% copayment up to $550.00 maximum 20% copayment up to $2,000.00 maximum 20% copayment 50% copayment		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits will be reduced to 50% of the total cost of the service.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits will be reduced to 50% of the total cost of the service.
If you need immediate medical attention	Emergency room care	$250 copayment, then 20% coinsurance	$250 copayment, then 20% coinsurance	Preauthorization is required within 48 hours, if admitted as an inpatient. If you don't get preauthorization, benefits will be reduced to 50% of the total cost of the service.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Non-emergency transport requires Preauthorization. If you don't get preauthorization, benefits will be reduced to 50% of the total cost of the service. Only covered if a "prudent" layperson would consider usage appropriate.
	Urgent care	$75 copayment	40% coinsurance	Includes routine services (X-rays, surgery, etc.) performed on the same day by same provider. If sent to the ER from Urgent Care, Urgent Care copayment is waived.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copayment, then 20% coinsurance	40% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits will be reduced to 50% of the total cost of the service.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits will be reduced to 50% of the total cost of the service.

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 need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copayment office visit and 20% coinsurance other outpatient services	40% coinsurance	Preauthorization is required. If you don't get and preauthorization, benefits will be reduced to 50% of the total cost of the service.
	Inpatient services	$500 copayment, then 20% coinsurance	40% coinsurance	Preauthorization is required. If you don't get and preauthorization, benefits will be reduced to 50% of the total cost of the service.
If you are pregnant	Office visits	$30 copayment	40% coinsurance	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	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	$500 copayment, then 80% after the Deductible.	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits will be reduced to 50% of the total cost of the service.
	Rehabilitation services	20% coinsurance	40% coinsurance	Preauthorization is required.
	Habilitation services	$50 copayment	40% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits will be reduced to 50% of the total cost of the service. 30 maximum visits per Plan Year.
	Skilled nursing care	20% coinsurance	40% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits will be reduced to 50% of the total cost of the service.
	Durable medical equipment	20% coinsurance	40% coinsurance	Preauthorization is required if charges are greater than $500. If you don't get

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)	
				preauthorization, benefits will be reduced to 50% of the total cost of the service.
	Hospice services	No charge	40% coinsurance	Preauthorization is required. If you don't get preauthorization, benefits will be reduced to 50% of the total cost of the service.
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.)

- Bariatric surgery
- Cometic surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S. if travel is for the sole purpose of obtaining medical service
- Routine eye care (Adult)
- Weight loss programs

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

- Acupuncture
- Chiropractic care
- Infertility treatment
- Private-duty nursing
- 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: 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: 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: the plan sponsor at 1-914-241-4999 or the plan's Claims processor at 1-866-569-6092, or the U. S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

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.

[* For more information about limitations and exceptions, see the plan or policy document at www.acuity-grp.com.]

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 1-866-569-6092.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-569-6092.]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-866-569-6092.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-569-6092.]

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.acuity-grp.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	$2,000
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$2,000
Copayments	$500
Coinsurance	$700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,260**

Managing Joe's Type 2 Diabetes

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

The plan's overall deductible	$2,000
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$900
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,020**

Mia's Simple Fracture

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

The plan's overall deductible	$2,000
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,000
Copayments	$200
Coinsurance	$90
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,290**

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