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, contact Clearwater Member Services at 877-405-2926. 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.healthcare.gov/sbc-glossary/ or call 1-877-405-2926 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Tier 1: $0 / $0 Tier 2: In-network providers: $3,500/Individual or $7,000/family; Tier 3: Out of network providers: $3,500/Individual or $7,000/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 some services that charge a copayment, such as primary care, specialty care, prescription drugs 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 deductibles for specific services.
What is the out-of-pocket limit for this plan?	Tier 1 & 2: In-network providers: $7,000/Individual or $14,000/Family; Tier 3: Out of network providers: $14,000/Individual or $28,000/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?	Penalties for non-compliance with plan provisions; premiums, 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 https://providerlocator.firsthealth.com/LocateProvider/SelectNetworkType or call 1-877-405-2926 for a list of network providers.	You pay the least if you use Tier 1 providers to whom you are referred by your Care Coordination Team. You pay more if you use a Tier 2 In-Network provider. 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). Non-compliance with using recommended providers subject to precertification will result in a benefit reduction of 25% on covered procedures.
Do you need a referral to see a specialist?	No, but it is highly recommended.	If you use a specialist recommended by the Care Coordination Team, your quality of care may be increased and your out of pocket cost will be reduced.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies. If the deductible does not apply, neither does coinsurance.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 (Preferred)	Tier 2 (In-Network Provider)	Tier 3 (Out-of-Network)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Not applicable. See Tier 2 benefit.	$25 copay/office visit for services up to $500; deductible applies to costs over $500.	50% coinsurance	
	Specialist visit	No charge	$45 copay/visit for services up to $500; deductible applies to costs over $500. 30% coinsurance (outpatient hospital)	50% coinsurance	
	Preventive care/screening/ immunization	No charge	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.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	$50 copay/visit for services up to $500; deductible applies to costs over $500. (independent lab) 30% coinsurance (outpatient hospital)	50% coinsurance	
	Imaging (CT/PET scans, MRIs)	No charge	30% coinsurance	50% coinsurance	$500 penalty for failure to obtain prior authorization, which will

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 (Preferred)	Tier 2 (In-Network Provider)	Tier 3 (Out-of-Network)	
					"not" be approved until the medical management team speaks with the member, or their healthcare proxy. If non-recommended providers/facilities are used on non-emergency services a 25% benefit payment reduction penalty will apply.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.ehimrx.com **or call 800-311-3446.**	Formulary Generic drugs	Not applicable. See Tier 2 benefit.	$0 copay/ prescription (30-day) $0 copay/prescription (90-day); deductible does not apply	Not covered, except in emergencies	Covers up to a 30-day supply (retail); 90-day supply (retail/mail order). Step therapy applies - includes the use of therapeutic alternatives. *Members must call EHIM at 800-311-3446 to determine eligibility criteria and benefit options.
	Formulary brand drugs	Not applicable. See Tier 2 benefit.	$35 copay/ prescription (30-day) $75 copay/prescription (90-day); deductible does not apply	Not covered, except in emergencies	
	Non-formulary brand drugs	Not applicable. See Tier 2 benefit.	$70 copay/ prescription (30-day) $150 copay/ prescription (90-day); deductible does not apply	Not covered, except in emergencies	
	Specialty drugs	Not applicable. See Tier 2 benefit.	*Call EHIM at 800-311-3446 to determine benefit options.	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	30% coinsurance	50% coinsurance	$500 penalty for failure to obtain prior authorization, which will "not" be approved until the

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 (Preferred)	Tier 2 (In-Network Provider)	Tier 3 (Out-of-Network)	
	Physician/surgeon fees	No charge	30% coinsurance	50% coinsurance	medical management team speaks with the member, or their healthcare proxy. If non-recommended providers/facilities are used on non-emergency services, a 25% benefit payment reduction penalty will apply
If you need immediate medical attention	Emergency room care	Not applicable. See Tier 2 benefit.	30% coinsurance	50% coinsurance	$1,000 penalty for non-emergency visits. Notification is required within 48 hours or as soon as reasonably possible, and coinsurance is waived if admitted as inpatient.
	Emergency medical transportation	Not applicable. See Tier 2 benefit.	30% coinsurance	50% coinsurance	
	Urgent care	No charge	$65 copay/office visit; deductible does not apply (standalone clinic) 30% coinsurance (outpatient hospital)	50% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	30% coinsurance	50% coinsurance	$500 penalty for failure to obtain prior authorization, which will "not" be approved until the medical management team speaks with the member, or their healthcare proxy. If non-
	Physician/surgeon fees	No charge	30% coinsurance	50% coinsurance	

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 (Preferred)	Tier 2 (In-Network Provider)	Tier 3 (Out-of-Network)	
					recommended providers/facilities are used on non-emergency services, a 25% benefit payment reduction penalty will apply.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	$45 copay/office visit; deductible does not apply (provider's office) 30% coinsurance (outpatient hospital)	50% coinsurance	Inpatient Services: $500 penalty for failure to obtain prior authorization, which will "not" be approved until the medical management team speaks with the member, or their healthcare proxy. If non-recommended providers/facilities are used on non-emergency services, a 25% benefit payment reduction penalty will apply.
	Inpatient services	No charge	30% coinsurance	50% coinsurance	
If you are pregnant	Office visits	No charge	Initial visit: $45 copay/visit; deductible does not apply Subsequent visits: No charge	Not covered	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Prior authorization may be required for stays exceeding 48 hours (vaginal deliveries) or 96 hours (caesarian deliveries). $500 penalty for failure to obtain prior authorization, which will
	Childbirth/delivery professional services	No charge	30% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	No charge	30% coinsurance	50% coinsurance	

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 (Preferred)	Tier 2 (In-Network Provider)	Tier 3 (Out-of-Network)	
					"not" be approved until the medical management team speaks with the member, or their healthcare proxy. If non-recommended providers/facilities are used on non-emergency services, a 25% benefit payment reduction penalty will apply.
If you need help recovering or have other special health needs	Home health care	No charge	30% coinsurance	50% coinsurance	180 days/calendar year limit. $500 penalty for failure to obtain prior authorization, which will "not" be approved until the medical management team speaks with the member, or their healthcare proxy. If non-recommended providers/facilities are used on non-emergency services, a 25% benefit payment reduction penalty will apply.
	Chiropractic Care	Not applicable. See Tier 2 benefit.	$45 copay/visit for services up to $500; deductible applies to costs over $500.	50% coinsurance	Chiropractic services limited to 12 visits per calendar year.
	Rehabilitation services	No charge	$45 copay, deductible does not apply	50% coinsurance	$500 penalty for failure to obtain prior authorization, which will "not" be approved until the medical management team

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 (Preferred)	Tier 2 (In-Network Provider)	Tier 3 (Out-of-Network)	
	Habilitation services				speaks with the member, or their healthcare proxy. If non-recommended providers/facilities are used on non-emergency services, a 25% benefit payment reduction penalty will apply Rehabilitation & Habilitation: combined limit of 30 days per calendar year. Skilled Nursing: limit of 30 days per calendar year.
	Skilled nursing care	No charge	30% coinsurance	50% coinsurance	
	Durable medical equipment	No charge	30% coinsurance	Not covered	Prior authorization required when costs exceed $750 or rental exceeds 4 months. $500 penalty for failure to obtain prior authorization, which will "not" be approved until the medical management team speaks with the member, or their healthcare proxy. If non-recommended providers/facilities are used on non-emergency services, a 25% benefit payment reduction penalty will apply
	Hospice services	No charge	30% coinsurance	Not covered	Benefits are limited to 30 days per calendar year. $500 penalty for failure to obtain prior authorization, which will "not" be approved until the

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 (Preferred)	Tier 2 (In-Network Provider)	Tier 3 (Out-of-Network)	
					medical management team speaks with the member, or their healthcare proxy. If non-recommended providers/facilities are used on non-emergency services, a 25% benefit payment reduction penalty will apply
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Not covered	
	Children's glasses	Not covered	Not covered	Not covered	
	Children's dental check-up	Not covered	Not covered	Not covered	

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
- Dental Care (except for treatment to sound natural teeth required when due to injury.)
- Hearing Aids,
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine Eye Exam (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.)

- Chiropractic Care
- Dialysis
- Routing Hearing Exam
- Specialty Drugs

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: Department of Labor's 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: 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

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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: Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

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 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 1-877-405-2926.

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

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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	$3,500
Specialist copayment	$45
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	$3,500
Copayments	$600
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,240**

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

The plan's overall deductible	$3,500
Specialist copayment	$45
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	$800
Copayments	$900
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,720**

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

The plan's overall deductible	$3,500
Specialist copayment	$45
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,400**

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