



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, visit www.fbg.com or call 1-855-495-1190. 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/>.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$0	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your <u>deductible</u> ?	Yes	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other <u>deductibles</u> for specific services?	No	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	Not Applicable	This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Not Applicable	This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses.
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.firsthealthlbp.com or call 1-800-226-5116 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your provider before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No	You can see the <u>specialist</u> you choose without a <u>referral</u> . NOTE: the only services by a specialist that are covered are <u>preventive services</u> .



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	Not Covered	---None---
	Specialist visit	Not Covered	Not Covered	---None---
	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 needed are preventive. Then check what your plan will pay for. Certain age restrictions may apply.
If you have a test	Diagnostic test (x-ray, blood work)	Not Covered	Not Covered	---None---
	Imaging (CT/PET scans, MRIs)	Not Covered	Not Covered	---None---
If you need drugs to treat your illness or condition More information about prescription drug coverage is available by calling 855-495-1190	Generic drugs	Not Covered	Not Covered	FDA approved contraceptive methods as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs).
	Preferred brand drugs	Not Covered	Not Covered	FDA approved contraceptive methods as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs).
	Non-preferred brand drugs	Not Covered	Not Covered	FDA approved contraceptive methods as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs).
	Specialty drugs	Not Covered	Not Covered	---None---
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Not Covered	Not Covered	---None---
	Physician/surgeon fees	Not Covered	Not Covered	---None---
If you need immediate medical attention	Emergency room care	Not Covered	Not Covered	---None---
	Emergency medical transportation	Not Covered	Not Covered	---None---
	Urgent care	Not Covered	Not Covered	---None---
	Facility fee (e.g., hospital room)	Not Covered	Not Covered	---None---

* For more information about limitations and exceptions, see the plan or policy document at www.fbg.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)	
If you have a hospital stay	Physician/surgeon fees	Not Covered	Not Covered	---None---
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not Covered	Not Covered	---None---
	Inpatient services	Not Covered	Not Covered	---None---
If you are pregnant	Office visits	Not Covered	Not Covered	Cost sharing does not apply for <u>preventive services</u>
	Childbirth/delivery professional services	Not Covered	Not Covered	---None---
	Childbirth/delivery facility services	Not Covered	Not Covered	---None---
If you need help recovering or have other special health needs	Home health care	Not Covered	Not Covered	---None---
	Rehabilitation services	Not Covered	Not Covered	---None---
	Habilitation services	Not Covered	Not Covered	---None---
	Skilled nursing care	Not Covered	Not Covered	---None---
	Durable medical equipment	Not Covered	Not Covered	---None---
	Hospice services	Not Covered	Not Covered	---None---
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 .)		
<ul style="list-style-type: none"> Acupuncture Cosmetic surgery Hearing aids Mental Health services Private-duty nursing Weight loss programs 	<ul style="list-style-type: none"> Bariatric surgery Dental care (Adult) Infertility treatment Non-emergency care when traveling outside the U.S. Routine eye care (Adult) 	<ul style="list-style-type: none"> Chiropractic care Habilitation services Long-term care Prescription drugs Routine foot care
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
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* For more information about limitations and exceptions, see the plan or policy document at www.fbg.com.

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-EBSA (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 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-EBSA (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 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 855-495-1190.

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

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](#) \$0
- [Specialist \[cost sharing\]](#) 100%
- [Hospital \(facility\) \[cost sharing\]](#) 100%
- [Other \[cost sharing\]](#) 100%

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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$12,694
The total Peg would pay is	\$12,694

Managing Joe's type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist \[cost sharing\]](#) 100%
- [Hospital \(facility\) \[cost sharing\]](#) 100%
- [Other \[cost sharing\]](#) 100%

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$7,239
The total Joe would pay is	\$7,239

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist \[cost sharing\]](#) 100%
- [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	\$1,925
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$1,925
The total Mia would pay is	\$1,925