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, call 1-800-240-3270 or visit us at www.FirstCare.com. 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 1-800-240-3270 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$2,500 person/ $5,000 family for a preferred provider and $5,000 person/ $10,000 family for a non-preferred provider.	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, urgent care, office visits and prescription drugs by a preferred provider 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?	$5,500 person/ $11,000 family for a preferred provider and $15,000 person/ $30,000 family for a non-preferred provider	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, 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.FirstCare.com/FindAProvider or call 1-800-240-3270 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
		Preferred Provider (You will pay the least)	Non-Preferred 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	Adult: $25 copay/visit Pediatric: No Charge (Ages 0-19) Deductible does not apply.	50% coinsurance	None
	Specialist visit	$55 copay/visit Deductible does not apply.	50% coinsurance	
	Preventive care/screening/ immunization	No charge Deductible does not apply.	50% coinsurance No charge for child immunizations through the 6th birthday	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.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	$250 copay/test	50% coinsurance	Failure to preauthorize services reduces benefits by 50%.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://www.firstcare.com/en/Employers/Pharmacy-Drugs/Drug-Lists-Benefit-Forms	*Tier I:* Preferred generic drugs	$0/$0 copay/prescription (retail & mail order) Deductible does not apply.	30% coinsurance	Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription).
	Tier II: Generic drugs	$10/$30 copay/prescription (retail & mail order) Deductible does not apply.	30% coinsurance	
	Tier III: Preferred brand/generic drugs	$50/$150 copay/prescription (retail & mail order) Deductible does not apply.	30% coinsurance	
	Tier IV: Non-preferred brand/generic drugs	$100/$300 copay/prescription (retail & mail order) Deductible does not apply.	30% coinsurance	
	Tier V: Specialty drugs	20% coinsurance Deductible does not apply.	30% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Failure to preauthorize some outpatient services reduces benefits by $500.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	$400 copay/visit	$400 copay/visit	If services are obtained inside the service area from an out-of-network provider, or if the provider is not an Out-of-Area Wrap Network contracted provider, then the Member may be billed for the balance between billed charges and Non-Participating Provider Reimbursement (NPPR) if payment is made at NPPR.
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	$50 copay/visit Deductible does not apply.	50% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Failure to preauthorize services reduces benefits by $500.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/office visit. Deductible does not apply to office visit. 20% coinsurance for all other services.	50% coinsurance	Failure to preauthorize services reduces benefits by 50%.
	Inpatient services	20% coinsurance	50% coinsurance	Failure to preauthorize services reduces benefits by $500.
If you are pregnant	Office visits	$25 copay/visit Deductible does not apply.	50% coinsurance	None
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	Failure to preauthorize services reduces benefits by $500.
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Non-Preferred Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	Limited to 60 visits per plan year. Failure to preauthorize services reduces benefits by 50%.
	Rehabilitation services	20% coinsurance	50% coinsurance	Limited to 35 visits per plan year for each service. Includes physical therapy, speech therapy, and occupational therapy. Failure to preauthorize services reduces benefits by 50%.
	Habilitation services	20% coinsurance	50% coinsurance	
	Skilled nursing care	20% coinsurance	50% coinsurance	Limited to 25 days per plan year. Failure to preauthorize services reduces benefits by $500.
	Durable medical equipment	20% coinsurance	50% coinsurance	Failure to preauthorize services reduces benefits by 50%.
	Hospice services	20% coinsurance	50% coinsurance	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	
	Children's dental check-up	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 (Adult and Child)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult and Child)
- 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 (Limited to 35 visits per plan year)
- Hearing aids (Limited to one device per ear every 3 years)
- Private-duty nursing (Limited to Home Health Care Services)

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: Customer Service at 1-800-240-3270 or www.FirstCare.com, 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: Customer Service at 1-800-240-3270 or www.FirstCare.com, Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, Texas Department of Insurance Texas Health Options at 1-800-252-3439 or www.texashealthoptions.com.

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? **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 1-800-240-3270.

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	$2,500
Specialist copayment	$55
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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$500
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,860**

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

The plan's overall deductible	$2,500
Specialist copayment	$55
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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,400
Copayments	$1,300
Coinsurance	$300
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$3,060**

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

The plan's overall deductible	$2,500
Specialist copayment	$55
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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,300
Copayments	$200
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,800**

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

If you, or someone you're helping, has questions about FirstCare Health Plans, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-855-572-7238 (TTY/TDD 1.800.562.5259).

Spanish: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de FirstCare Health Plans, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-855-572-7238 (TTY/TDD 1-800-562-5259).

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về FirstCare Health Plans, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-855-572-7238 (TTY/TDD 1-800-562-5259).

Chinese: 如果您或您正在帮助的人士对第一救护健康计划 (FirstCare Health Plans) 有疑问，您有权免费获取对应您母语的帮助及信息。联系口译员请拨打1-855-572-7238 (TTY/TDD 1-800-562-5259)。

Korean: 귀하 또는 귀하가 돕는 있는 사람이 FirstCare Health Plans에 문의할 사항이 있는 경우, 귀하의 언어도 무료 지원 및 정보를 받을 권리가 있습니다. 통역사와 통화하시려면 1-855-572-7238 (TTY/TDD 1-800-562-5259) 번으로 전화해 주십시오.

Arabic:
لك الحق، أو لدى اي شخص آخر تساعده، في الحصول على المساعدة والمعلومات أو اي أسئلة بخصوص FirstCare Health Plans. للتحدث مع مترجم بلغتك بدون تكلفة اتصل بالرقم (TTY/TDD 1-800-562-5259) 1-855-572-7238

Urdu:
اگر آپ یا آپ کسی کی مدد کر رہے ہیں, اور سوالات ہیں" FirstCare Health Plans " کے بارے میں, تو یہ آپ کا حق ہے مدد حاصل کرنا اور معلومات حاصل کرنا اپنی زبان میں بغیر کسی قیمت کے. کسی ترجمان سے بات کرنے کے لئے کال کریں.1-855-572-7238 (TTY/TDD 1-800-562-5259)

Tagalog: Kung mayroon kang, o sinumang tinutulungan mo, mga katanungan tungkol sa FirstCare Health Plans, mayroon kang karapatang humingi ng tulong at impormasyon nang walang bayad. Upang makipag-usap sa isang tagapagsalin, tumawag sa 1-855-572-7238 (TTY/TDD 1-800-562-5259)

French: Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de FirstCare Health Plans, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-855-572-7238 (TTY/TDD 1-800-562-5259).

Hindi: यदि आपके, या आप जिन्हें सहायता कर रहे हैं उनके पास FirstCare Health Plans से संबंधित कोई प्रश्न हैं तो आपको अपनी भाषा में बिना किसी शुल्क के सहायता और जानकारी पाने का अधिकार है। किसी अनुवादक से बात करने के लिए यहां कॉल करें 1-855-572-7238 (TTY/TDD 1-800-562-5259)

Persian-Farsi:
اگر شما یا شخصی که به او کمک می‌کنید سوالی درباره FirstCare Health Plans داشتید، این حق را دارید تا کمک و اطلاعات را به زبان خود و بدون هیچ هزینه‌ای دریافت کنید. برای صحبت با یک مترجم با شماره 1-855-572-7238 (TTY/TDD 1-800-562-5259) تماس حاصل فرمایید.

German: Falls Sie oder jemand, dem Sie helfen, Fragen zu FirstCare Health Plans haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-855-572-7238 (TTY/TDD 1-800-562-5259) an.

Gujarati: જો તમને, અથવા કોઈકને તમે મદદ કરી રહ્યાં છો, તેને FirstCare Health Plans વિશે પ્રશ્નો હોય તો, તમને નિશુલ્ક તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો અધિકાર છે.

દુભાષિયા સાથે વાત કરવા કોલ કરોઃ 1-855-572-7238 (TTY/TDD 1-800-562-5259).

Russian: Если вам или лицу, которому вы помогаете, возникнет вопросы по FirstCare Health Plans, то вы имеете право на бесплатную помощь и информацию на вашем языке. Для разговора с переводчиком позвоните по телефону 1-855-572-7238 (TTY/TDD 1-800-562-5259).

Japanese: FirstCare Health Plan についてご質問の場合は、無料でご自分の言語のサポートと情報を得ることができます。1-855-572-7238 （テレタイプライター/聴覚障害者用通信機器 1-800-562-5259） にお電話いただき、通訳者とお話しください。

Laotian: ຖ້າທ່ານ ຫຼື ຄົນທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ ມີຄຳຖາມກ່ຽວກັບ FirstCare Health Plans, ທ່ານມີສິດໄດ້ຮັບຄວາມຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ເພື່ອໂອ້ລົມ ກັບລ່າມແປພາສາ, ກະລຸນາໂທ 1-855-572-7238 (TTY/TDD 1-800-562-5259).

Non-Discrimination Notice

FirstCare Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. FirstCare does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

We provide free communication aids and services to people with disabilities. We also provide language assistance to people whose primary language is not English.

To receive language or communication assistance please call 1-855-572-7238.

If you believe that we have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, please contact us to file a grievance:

SHA, LLC dba FirstCare
ATTN: Complaints and Appeals
12940 N. HWY 183
Austin, TX 78750
Phone: 1-855-572-7238 *(Mon. - Fri., 8 a.m. - 5 p.m. CT)*
TTY /TDD: 1-800-562-5259

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F
HHH Building, Washington, DC 20201
Phone: 1-800-368-1019
TTY/TDD: 1-800-537-7697

Complaint forms are available at: http://www.hhs.gov/ocr/filing-with-ocr/index.html

Language/Non-Discrimination_Notice
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