
 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 1-800-884-4901 or visit us at [www.firstcare.com](http://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 1-800-884-4901 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$750 member/ \$2,250 family	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> , <a href="#">urgent care</a> , and office visits are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits">https://www.healthcare.gov/coverage/preventive-care-benefits</a> .
Are there other <a href="#">deductibles</a> for specific services?	Yes. \$100 member/\$300 family for <a href="#">prescription drug coverage</a> .	You must pay all of the costs for these services up to the specific <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay for these services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$6,000 member/ \$12,000 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.firstcare.com">www.firstcare.com</a> or call 1-800-884-4901 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a provider <a href="#">network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	Adult: \$20 <a href="#">copay</a> /visit Pediatric: \$0 <a href="#">copay</a> /visit (Ages 0-19) <a href="#">Deductible</a> does not apply.	Not covered	None
	<a href="#">Specialist</a> visit	\$60 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply.	Not covered	
	<a href="#">Preventive care/screening/immunization</a>	No charge <a href="#">Deductible</a> does not apply.	Not covered	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	\$250 <a href="#">copay</a> /test	Not covered	Services that are not <a href="#">preauthorized</a> will be denied.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="http://www.firstcare.com">prescription drug coverage</a> is available at <a href="http://www.firstcare.com">www.firstcare.com</a>	<i>Tier 1:</i> Preferred generic drugs	\$0/\$0 <a href="#">copay</a> /prescription (retail & mail order) <a href="#">Deductible</a> does not apply.	Not covered	Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription).
	<i>Tier 2:</i> Generic drugs	\$15/\$45 <a href="#">copay</a> /prescription (retail & mail order) <a href="#">Deductible</a> does not apply.	Not covered	
	<i>Tier 3:</i> Preferred brand/generic drugs	\$40/\$120 <a href="#">copay</a> /prescription (retail & mail order)	Not covered	
	<i>Tier 4:</i> Non-preferred brand/generic drugs	\$100/\$300 <a href="#">copay</a> /prescription (retail & mail order)	Not covered	
	<i>Tier 5:</i> <a href="#">Specialty drugs</a>	20% <a href="#">coinsurance</a>	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	25% <a href="#">coinsurance</a>	Not covered	Some services that are not <a href="#">preauthorized</a> will be denied. Refer to <a href="http://www.firstcare.com">www.firstcare.com</a> or Customer Service at 1-800-884-4901.
	Physician/surgeon fees	25% <a href="#">coinsurance</a>	Not covered	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$500 <a href="#">copay</a> /visit	\$500 <a href="#">copay</a> /visit	If services are obtained inside the service area from an <a href="#">out-of-network provider</a> , or if the <a href="#">provider</a> is not an <a href="#">Out-of-Area Wrap Network contracted provider</a> , then the Member may be billed for the balance between billed charges and Non-Participating Provider Reimbursement (NPPR) if payment is made at NPPR.
	<a href="#">Emergency medical transportation</a>	25% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a>	
	<a href="#">Urgent care</a>	\$75 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply.	\$75 <a href="#">copay</a> /visit, if outside service area. Not covered, if inside service area.	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	25% <a href="#">coinsurance</a>	Not covered	Services that are not <a href="#">preauthorized</a> will be denied.
	Physician/surgeon fees	25% <a href="#">coinsurance</a>	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <a href="#">copay</a> /office visit. <a href="#">Deductible</a> does not apply to office visit. 25% <a href="#">coinsurance</a> for all other services.	Not covered	Some services that are not <a href="#">preauthorized</a> will be denied. Refer to <a href="http://www.firstcare.com">www.firstcare.com</a> or Customer Service at 1-800-884-4901.  Services that are not <a href="#">preauthorized</a> will be denied.
	Inpatient services	25% <a href="#">coinsurance</a>	Not covered	
If you are pregnant	Office visits	\$25 <a href="#">copay</a> /visit <a href="#">Deductible</a> does not apply.	Not covered	None
	Childbirth/delivery professional services	25% <a href="#">coinsurance</a>	Not covered	Some services that are not <a href="#">preauthorized</a> will be denied. Refer to <a href="http://www.firstcare.com">www.firstcare.com</a> or Customer Service at 1-800-884-4901.
	Childbirth/delivery facility services	25% <a href="#">coinsurance</a>	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	25% <a href="#">coinsurance</a>	Not covered	Limited to 60 visits per <a href="#">plan</a> year. Services that are not <a href="#">preauthorized</a> will be denied.
	<a href="#">Rehabilitation services</a>	25% <a href="#">coinsurance</a>	Not covered	Limited to 35 visits per <a href="#">plan</a> year for each service. Includes physical therapy, speech therapy, and occupational therapy. Services that are not <a href="#">preauthorized</a> will be denied.
	<a href="#">Habilitation services</a>	25% <a href="#">coinsurance</a>	Not covered	
	<a href="#">Skilled nursing care</a>	25% <a href="#">coinsurance</a>	Not covered	Limited to 30 days per <a href="#">plan</a> year. Services that are not <a href="#">preauthorized</a> will be denied.
	<a href="#">Durable medical equipment</a>	25% <a href="#">coinsurance</a>	Not covered	Services that are not <a href="#">preauthorized</a> will be denied.
	<a href="#">Hospice services</a>	25% <a href="#">coinsurance</a>	Not covered	Some services that are not <a href="#">preauthorized</a> will be denied. Refer to <a href="http://www.firstcare.com">www.firstcare.com</a> or Customer Service at 1-800-884-4901.
<b>If your child needs dental or eye care</b>	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)
- Hearing aids
- 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 10 visits per plan year)
- 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 1-800-884-4901 or [www.firstcare.com](http://www.firstcare.com), Texas Department of Insurance at 1-800-578-4677 or <http://www.tdi.texas.gov/index.html>, Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://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](http://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 1-800-884-4901 or [www.firstcare.com](http://www.firstcare.com), Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), Texas Department of Insurance Texas Health Options at 1-800-252-3439 or [www.texashealthoptions.com](http://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 1-800-884-4901.

—————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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$750
■ <a href="#">Specialist copayment</a>	\$60
■ Hospital (facility) <a href="#">coinsurance</a>	25%
■ Other <a href="#">coinsurance</a>	25%

#### 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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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#### In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$750
Copayments	\$400
Coinsurance	\$2,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,410</b>

### Managing Joe's type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$750
■ <a href="#">Specialist copayment</a>	\$60
■ Hospital (facility) <a href="#">coinsurance</a>	25%
■ Other <a href="#">coinsurance</a>	25%

#### 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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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#### In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$750
Copayments	\$1,300
Coinsurance	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$2,510</b>

### Mia's Simple Fracture

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

The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$750
■ <a href="#">Specialist copayment</a>	\$60
■ Hospital (facility) <a href="#">coinsurance</a>	25%
■ Other <a href="#">coinsurance</a>	25%

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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#### In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$750
Copayments	\$200
Coinsurance	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,350</b>



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/TTD 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/TTD 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/TTD 1.800.562.5259).

**Chinese:** 如果您，或是您正在協助的對象，有關於[插入項目的名稱 FirstCare Health Plans 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 1.855.572.7238 (TTY/TTD 1.800.562.5259)。

**Korean:** 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 FirstCare Health Plans 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1.855.572.7238 (TTY/TTD 1.800.562.5259) 로 전화하십시오.

**Arabic:** 1.855.572.7238 نإنا ناك دل ياك وأألد صخش دأستة ةلأسا وصخبص FirstCare Health Plans ، لنلكي قحلا نيال لوصح لعى ةدأسملا لعملا وومات ضلارروية كئغلب نم نود باة لألكة. لتحت عم نمرمج نأصل ب (TTY/TTD 1.800.562.5259)

**Urdu:** 1.855.572.7238 (TTY/TTD 1.800.562.5259) نو فر كپي رگا اپ يسكو ك مدد ے د ہرے ميں روا اپ نو نو دو كو سال ے FirstCare Health Plans ے كراب ے یم، وٹ اپ نو نو نو ك پانی نابز 1.800.562.5259) نیم فہت مدد روا امولاعمت احصل ے نو كا ك فح - ے نر نامج س ے بت رك ے ك ے ے،

**Tagalog:** Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa FirstCare Health Plans, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalín, tumawag sa 1.855.572.7238 (TTY/TTD 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/TTD 1.800.562.5259).

**Hindi:** यदि आपके ,या आप द्वारा सहायता ककए जा रहे ककसी व्यक्तत के de FirstCare Health Plans के बारे में प्रश्न हैं ,तो आपके पास अपनी भाषा में मुफ्त में सहायता और सूचना प्राप्त करने का अधिकार है। ककसी िभाषण से बात करने के लिए ,1.855.572.7238 (TTY/TTD 1.800.562.5259) पर कॉि करें।

**Persian-Farsi:** 1.855.572.7238 (TTY/TTD 1.800.562.5259) اطاعلا ته بز ناب دوخ راه ب طور گ بار نأ فآوردت ان ید. شادته دبشا ب قح نأ ار رادید که کمک

**German:** Falls Sie oder jemand, dem Sie helfen, Fragen zum 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/TTD 1.800.562.5259) an.

**Gujarati:** જો તમે અથવા તમે કોઇને મદદ કરી રહ્યાં છો તેમ આંથી કોઇને FirstCare Health Plans વિશે પ્રશ્નો હોય તો તમને મદદ અને મ હક્તી મેળિ ની અવિક ર છે. તે અર્થ વિન તમ રી ભ ષ મ ં પુ પ્ત કરી શક ય છે. દુભ વષયો િ ત કરિ મ ટે,આ 1.855.572.7238 (TTY/TTD 1.800.562.5259) પર કોલ કરો.

**Russian:** Если у вас или лица, которому вы помогаете, имеются вопросы по поводу FirstCare Health Plans, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1.855.572.7238 (TTY/TTD 1.800.562.5259).

**Japanese:** ご本人様、またはお客様の身の回りの方でも、FirstCare Health Plansについてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入力したりすることができます。料金はかかりません。通訳とお話される場合、1.855.572.7238 (TTY/TTD 1.800.562.5259) までお電話ください。

**Laotian:** ຖ້າທ່ານ, ຫຼື ຄົນທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ, ມີ ຄຳຖາມກ່ຽວກັບ FirstCare Health Plans, ທ່ານມີ ສິດທິ ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອ ຕາມພາສາຂອງທ່ານ ບໍ່ມີ ຄ່າໃຊ້ຈ່າຍ. ການໂອ້ນລັກກັບພາສາລາວ, ໃຫ້ໂທຫາ 1.855.572.7238 (TTY/TTD 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 /TTD: 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  
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