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. 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 deductible?	$750 member/ $2,250 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, urgent care, and office visits 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?	Yes. $100 member/$300 family for prescription drug coverage.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	$7,350 member/ $14,700 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, 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 or call 1-800-884-4901 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
		Participating Provider (You will pay the least)	Non-Participating 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: $20 copay/visit Pediatric: $0 copay/visit (Ages 0-19) Deductible does not apply.	Not covered	None
	Specialist visit	$60 copay/visit Deductible does not apply.	Not covered	
	Preventive care/screening/ immunization	No charge Deductible does not apply.	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	Not covered	None
	Imaging (CT/PET scans, MRIs)	$250 copay/test	Not covered	Services that are not preauthorized 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)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.firstcare.com	*Tier 1:* Preferred generic drugs	$0/$0 copay/prescription (retail & mail order) Deductible does not apply.	Not covered	Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription).
	Tier 2: Generic drugs	$15/$45 copay/prescription (retail & mail order) Deductible does not apply.	Not covered	
	Tier 3: Preferred brand/generic drugs	$40/$120 copay/prescription (retail & mail order)	Not covered	
	Tier 4: Non-preferred brand/generic drugs	$100/$300 copay/prescription (retail & mail order)	Not covered	
	Tier 5: Specialty drugs	20% coinsurance	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	Not covered	Some services that are not preauthorized will be denied. Refer to www.firstcare.com or Customer Service at 1-800-884-4901.
	Physician/surgeon fees	25% coinsurance	Not covered	
If you need immediate medical attention	Emergency room care	$500 copay/visit	$500 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	25% coinsurance	25% coinsurance	
	Urgent care	$75 copay/visit Deductible does not apply.	$75 copay/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% coinsurance	Not covered	Services that are not preauthorized will be denied.
	Physician/surgeon fees	25% coinsurance	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/office visit. Deductible does not apply to office visit. 25% coinsurance for all other services.	Not covered	Some services that are not preauthorized will be denied. Refer to www.firstcare.com or Customer Service at 1-800-884-4901.
	Inpatient services	25% coinsurance	Not covered	Services that are not preauthorized will be denied.
If you are pregnant	Office visits	$25 copay/visit Deductible does not apply.	Not covered	None
	Childbirth/delivery professional services	25% coinsurance	Not covered	Some services that are not preauthorized will be denied. Refer to www.firstcare.com or Customer Service at 1-800-884-4901.
	Childbirth/delivery facility services	25% coinsurance	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)	
If you need help recovering or have other special health needs	Home health care	25% coinsurance	Not covered	Limited to 60 visits per plan year. Services that are not preauthorized will be denied.
	Rehabilitation services	25% coinsurance	Not covered	Limited to 35 visits per plan year for each service. Includes physical therapy, speech therapy, and occupational therapy. Services that are not preauthorized will be denied.
	Habilitation services	25% coinsurance	Not covered	
	Skilled nursing care	25% coinsurance	Not covered	Limited to 30 days per plan year. Services that are not preauthorized will be denied.
	Durable medical equipment	25% coinsurance	Not covered	Services that are not preauthorized will be denied.
	Hospice services	25% coinsurance	Not covered	Some services that are not preauthorized will be denied. Refer to www.firstcare.com or Customer Service at 1-800-884-4901.
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)
- 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, 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, Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 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 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, 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 1-800-884-4901.

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 plan's overall deductible	$750
Specialist copayment	$60
Hospital (facility) coinsurance	25%
Other coinsurance	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)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

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

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

The plan's overall deductible	$750
Specialist copayment	$60
Hospital (facility) coinsurance	25%
Other coinsurance	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)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

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

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

The plan's overall deductible	$750
Specialist copayment	$60
Hospital (facility) coinsurance	25%
Other coinsurance	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)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$750
Copayments	$200
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,350**

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

FirstCare™
HEALTH PLANS

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 사람이FirstCare 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: ن ا ِ ذاكدليك وأ لد ِ د صخش دعاسته ةلئسأ صوصخب FirstCare Health Plans ، لديك قحلا ني الول صح لعى ةدعاسملا لعملاوومات 1.855.572.7238 (TTY/TTD 1.800.562.5259) ضلارروية كتغلب نم نود ياة فلكة. للتحث عم تمرجم ناصل ب

Urdu: 1.855.572.7238اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کر رہے ہیں، FirstCare Health Plans کے بارے میں سوالات ہیں، تو آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ کسی ترجمان سے بات کرنے کے لیے، (TTY/TTD 1.800.562.5259)

Tagalog: Kung ikaw, o ang iyong tinutulangan, 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 tagasalin, 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 िुभाषषए से बात करने के लिए ,1.855.572.7238 (TTY/TTD 1.800.562.5259) पर कॉि करें।

Persian-Farsi: اگر شما، یا کسی که شما به او کمک می کنید، سوال در مورد FirstCare Health Plans ، داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. 1.855.572.7238 (TTY/TTD 1.800.562.5259).

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.

Guajarati: જો તમે અથવા તમે કોઇને મદદ કરી રહ્ાાં તેમ ાંથી કોઇને FirstCare Health Plans વિશે પ્રશ્નો હોય તો તમને મદદ અને મ હહતી મેળિિ નો અવિક ર છે. તે ખર્ચ વિન તમ રી ભ ષ મ ાં પ્ર 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、情報を入手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, ຫ ຼືຄົນທ ່ທ່ານກໍາລັງຊ່ວຍເຫ ຼືອ, ມ ຄໍາຖາມກ່ຽວກັບ FirstCare Health Plans, ທ່ານມ ສິດທ ່ຈະໄດ້ຮັບການຊ່ວຍເຫ ຼືອແລະຂໍ້ມູນຂ່າວສານທ ່ເປັນພາສາຂອງທ່ານບໍ່ມ ຄ່າໃຊ້ຈ່າຍ. ການໂອ້ລົມກັບນາຍພາສາ, ໃຫ້ໂທຫາ 1.855.572.7238 (TTY/TTD 1.800.562.5259).

FirstCare
HEALTH PLANS

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
TTY/TTD: 1.800.537.7697

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