

























Plan Benefits	FirstCare Prime Silver HMO 003	FirstCare Prime Silver HMO 003 - CSR 73% AV* FPL (201%-250%)	FirstCare Prime Silver HMO 003 - CSR 87% AV* FPL (151%-200%)	FirstCare Prime Silver HMO 003 - CSR 94% AV* FPL (100%-150%)
Medical Deductible <i>Single/Family</i>	\$4,000 / \$8,000	\$1,600 / \$3,200	\$350 / \$700	\$0 / \$0
Medication Deductible <i>Single/Family</i>	ACA Preventive Drugs and Tier 1: \$0 Tier 2-4 and preferred diabetic test strips for blood glucose monitors: Integrated with Medical	ACA Preventive Drugs and Tier 1: \$0 Tier 2-4 and preferred diabetic test strips for blood glucose monitors: Integrated with Medical	ACA Preventive Drugs and Tier 1: \$0 Tier 2-4 and preferred diabetic test strips for blood glucose monitors: Integrated with Medical	ACA Preventive Drugs and Tier 1: \$0 Tier 2-4 and preferred diabetic test strips for blood glucose monitors: Integrated with Medical
Preventive Care Copay	No Charge	No Charge	No Charge	No Charge
Adult Primary Care Visit Copay	\$30	\$20	\$10	\$5
Pediatric Primary Care Visit Copay (Ages 0-18)	\$0	\$0	\$0	\$0
Specialty Care Visit Copay	\$60	\$50	\$20	\$10
Inpatient Copay	\$2,500 per stay plus 40% ¹	\$1,500 per stay plus 40% ¹	\$700 per stay plus 20% ¹	20%
Outpatient Copay	\$600 per visit plus 40% ¹	\$600 per visit plus 40% ¹	\$300 per visit plus 20% ¹	20%
Emergency Room Copay	\$750 per visit plus 40% ¹	\$750 per visit plus 40% ¹	\$500 per visit plus 20% ¹	\$250 per visit plus 20%
Urgent Care Copay	\$60	\$50	\$20	\$10
Routine Lab/X-Ray Copay	40% ¹	40% ¹	20% ¹	20%
Imaging (MRI, CT, Scans) Copay	40% ¹	40% ¹	20% ¹	20%
Telehealth <i>Coverage to include FirstCare Virtual Care powered by MDLIVE and MyBSWHealth</i>	No Charge	No Charge	No Charge	No Charge
Medication Copays:				
<i>ACA Preventative Drugs</i>	\$0	\$0	\$0	\$0
<i>Tier I</i>	\$15	\$15	\$10	\$10
<i>Tier II</i>	\$55 ¹	\$55 ¹	\$55 ¹	\$55
<i>Tier III</i>	\$150 ¹	\$150 ¹	\$150 ¹	\$150
<i>Tier IV</i>	\$500 ¹	\$500 ¹	\$500 ¹	\$500
Formulary	Click here	Click here	Click here	Click here
Compare Medication Costs	Click here	Click here	Click here	Click here
Maximum Out-of-Pocket <i>Single/Family</i>	\$8,700 / \$17,400	\$6,950 / \$13,900	\$2,900 / \$5,800	\$1,300 / \$2,600
Plan ID	26539TX0140003-00	26539TX0140003-04	26539TX0140003-05	26539TX0140003-06
Summary of Benefits & Coverage (SBC)				
Plan Documents				

*These plans offer lower cost sharing, based on percentage of Federal Poverty Level (FPL) – 26539TX0140003-04 (201-250%), 26539TX0140003-05 (151-200%), 26539TX0140003-06 (100-150%),
¹After Medical Deductible





Plan Benefits	FirstCare Prime Silver HMO 008	FirstCare Prime Silver HMO 008 - CSR 73% AV* FPL (201%-250%)	FirstCare Prime Silver HMO 008 - CSR 87% AV* FPL (151%-200%)	FirstCare Prime Silver HMO 008 - CSR 94% AV* FPL (100%-150%)
Medical Deductible <i>Single/Family</i>	\$8,550 / \$17,100	\$5,900 / \$11,800	\$1,800 / \$3,600	\$600 / \$1,200
Medication Deductible <i>Single/Family</i>	ACA Preventive Drugs and Tier 1: \$0 Tier 2-4 and preferred diabetic test strips for blood glucose monitors: Integrated with Medical	ACA Preventive Drugs and Tier 1: \$0 Tier 2-4 and preferred diabetic test strips for blood glucose monitors: Integrated with Medical	ACA Preventive Drugs and Tier 1: \$0 Tier 2-4 and preferred diabetic test strips for blood glucose monitors: Integrated with Medical	ACA Preventive Drugs and Tier 1: \$0 Tier 2-4 and preferred diabetic test strips for blood glucose monitors: Integrated with Medical
Preventive Care Copay	No Charge	No Charge	No Charge	No Charge
Adult Primary Care Visit Copay	\$35	\$15	\$10	\$10
Pediatric Primary Care Visit Copay (Ages 0-18)	\$0	\$0	\$0	\$0
Specialty Care Visit Copay	\$70	\$50	\$30	\$30
Inpatient Copay	0% ¹	0% ¹	0% ¹	0% ¹
Outpatient Copay	0% ¹	0% ¹	0% ¹	0% ¹
Emergency Room Copay	0% ¹	0% ¹	0% ¹	0% ¹
Urgent Care Copay	\$70	\$50	\$30	\$30
Routine Lab/X-Ray Copay	0% ¹	0% ¹	0% ¹	0% ¹
Imaging (MRI, CT, Scans) Copay	0% ¹	0% ¹	0% ¹	0% ¹
Telehealth <i>Coverage to include FirstCare Virtual Care powered by MDLIVE and MyBSWHealth</i>	0% ¹	0% ¹	0% ¹	0% ¹
Medication Copays:				
ACA Preventative Drugs	\$0	\$0	\$0	\$0
Tier I	\$15	\$15	\$15	\$10
Tier II	0% ¹	0% ¹	0% ¹	0% ¹
Tier III	0% ¹	0% ¹	0% ¹	0% ¹
Tier IV	0% ¹	0% ¹	0% ¹	0% ¹
Formulary	Click here	Click here	Click here	Click here
Compare Medication Costs	Click here	Click here	Click here	Click here
Maximum Out-of-Pocket <i>Single/Family</i>	\$8,550 / \$17,100	\$5,900 / \$11,800	\$1,800 / \$3,600	\$600 / \$1,200
Plan ID	26539TX0140008-00	26539TX0140008-04	26539TX0140008-05	26539TX0140008-06
Summary of Benefits & Coverage (SBC)				
Plan Documents				

*These plans offer lower cost sharing, based on percentage of Federal Poverty Level (FPL) – 26539TX0140008-04 (201-250%), 26539TX0140008-05 (151-200%), 26539TX0140008-06 (100-150%)
¹After Medical Deductible

Plan Benefits	FirstCare Prime Silver HMO 012	FirstCare Prime Silver HMO 012 - CSR 73% AV* FPL (201%-250%)	FirstCare Prime Silver HMO 012 - CSR 87% AV* FPL (151%-200%)	FirstCare Prime Silver HMO 012 - CSR 94% AV* FPL (100%-150%)
Medical Deductible <i>Single/Family</i>	\$0 / \$0	\$0 / \$0	\$0 / \$0	\$0 / \$0
Medication Deductible <i>Single/Family</i>	\$0	\$0	\$0	\$0
Preventive Care Copay	No Charge	No Charge	No Charge	No Charge
Adult Primary Care Visit Copay	\$40	\$40	\$15	\$0
Pediatric Primary Care Visit Copay (Ages 0-18)	\$0	\$0	\$0	\$0
Specialty Care Visit Copay	\$80	\$75	\$30	\$10
Inpatient Copay	\$2,500 per stay	\$1,500 per stay	\$500 per stay	\$300 per stay
Outpatient Copay	\$500	\$500	\$500	\$200
Emergency Room Copay	\$750	\$750	\$750	\$200
Urgent Care Copay	\$80	\$75	\$30	\$10
Routine Lab/X-Ray Copay	\$125 for X-rays, \$50 for Labs	\$125 for X-rays, \$50 for Labs	\$75 for X-rays, \$50 for Labs	\$35 for X-rays, \$25 for Labs
Imaging (MRI, CT, Scans) Copay	\$250	\$250	\$250	\$75
Telehealth <i>Coverage to include FirstCare Virtual Care powered by MDLIVE and MyBSWHealth</i>	No Charge	No Charge	No Charge	No Charge
Medication Copays:				
<i>ACA Preventative Drugs</i>	\$0	\$0	\$0	\$0
<i>Tier I</i>	\$15	\$15	\$10	\$10
<i>Tier II</i>	\$55	\$55	\$55	\$55
<i>Tier III</i>	\$150	\$150	\$150	\$150
<i>Tier IV</i>	\$500	\$500	\$500	\$500
Formulary	Click here	Click here	Click here	Click here
Compare Medication Costs	Click here	Click here	Click here	Click here
Maximum Out-of-Pocket <i>Single/Family</i>	\$8,700 / \$17,400	\$6,950 / \$13,900	\$2,250 / \$4,500	\$800 / \$1,600
Plan ID	26539TX0140012-00	26539TX0140012-04	26539TX0140012-05	26539TX0140012-06
Summary of Benefits & Coverage (SBC)				
Plan Documents				

*These plans offer lower cost sharing, based on percentage of Federal Poverty Level (FPL) – 26539TX0140012-04 (201-250%), 26539TX0140012-05 (151-200%), 26539TX0140012-06 (100-150%)
¹After Medical Deductible

Off-Exchange Plans

Plan Benefits	FirstCare Prime Silver HMO 010	FirstCare Prime Silver HMO 011
Medical Deductible <i>Single/Family</i>	\$4,950 / \$9,900	\$0/ \$0
Medication Deductible <i>Single/Family</i>	\$0 / \$0	\$0
Preventive Care Copay	No Charge	No Charge
Adult Primary Care Visit Copay	\$30	\$40
Pediatric Primary Care Visit Copay <i>(Ages 0-18)</i>	\$0	\$0
Specialty Care Visit Copay	\$60	\$80
Inpatient Copay	20% ¹	\$2,500 per stay
Outpatient Copay	20% ¹	\$600 per visit
Emergency Room Copay	\$750 ¹	\$750
Urgent Care Copay	\$60	\$80
Routine Lab/X-Ray Copay	20% ¹	\$125 for X-rays, \$50 for Labs
Imaging (MRI, CT, Scans) Copay	20% ¹	\$250
Telehealth <i>Coverage to include FirstCare Virtual Care powered by MDLIVE and MyBSWHealth</i>	No Charge	No Charge
Medication Copays:		
<i>ACA Preventative Drugs</i>	\$0	\$0
<i>Tier I</i>	\$15	\$15
<i>Tier II</i>	\$55	\$55
<i>Tier III</i>	\$150	\$150
<i>Tier IV</i>	\$500	\$500
Formulary	Click here	Click here
Compare Medication Costs	Click here	Click here
Maximum Out-of-Pocket <i>Single/Family</i>	\$8,700 / \$17,400	\$8,700 / \$17,400
Plan ID	26539TX0140010-00	26539TX0140014-00
Summary of Benefits & Coverage (SBC)		
Plan Documents		

¹After Medical Deductible