

 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 1-833-983-7272 (TTY 711). 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 [www.healthcare.gov/sbc-glossary/](http://www.healthcare.gov/sbc-glossary/) or call 1-833-983-7272 (TTY 711) to request a copy.

| Important Questions   | Answers   | Why This Matters:   |
|---|---|---|
| What is the overall <a href="#">deductible</a> ?                                | In Network: \$500/Individual, \$1,000/Family<br>Out of Network: Not Covered   | Generally, you must pay all of the costs from <a href="#">providers</a> 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 plan, 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/screening/immunization</a> , Primary Care, <a href="#">Specialist Care</a> , <a href="#">Urgent Care</a> , <a href="#">Mental/Behavioral Health Outpatient Services</a> , and <a href="#">Substance Abuse Outpatient Services</a> do not apply toward the <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?              | No  | You don't have to meet <a href="#">deductibles</a> for specific services.   |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | In Network: \$3,000/Individual, \$6,000/Family<br>Out of Network: Not Covered   | 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 limit</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, penalties for failure to obtain <a href="#">preauthorization</a> for services and health care this <a href="#">plan</a> does not 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.firstchoicenext.com">www.firstchoicenext.com</a> or call 1-833-983-7272 (TTY 711) for a list of <a href="#">network providers</a> .  | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's 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 <a href="#">provider's</a> 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   |
|---|---|---|---|--|
|   |   | In Network<br>(You will pay the least)  | Out of Network<br>(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.       | \$20 <a href="#">copayment</a> /visit, <a href="#">Deductible</a> does not apply        | Not Covered                                   | None   |
|   | <a href="#">Specialist</a> visit                        | \$40 <a href="#">copayment</a> /visit, <a href="#">Deductible</a> does not apply        | Not Covered                                   | None   |
|   | <a href="#">Preventive care/screening</a> /immunization | 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 needed 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)     | X-ray: 30% <a href="#">coinsurance</a><br>Blood work: 30% <a href="#">coinsurance</a>   | X-ray: Not Covered<br>Blood work: Not Covered | None.  |
|   | Imaging (CT/PET scans, MRIs)                            | 30% <a href="#">coinsurance</a>   | Not Covered                                   | Prior authorization may be required. Covered no limit  |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="https://client.formularynavigator.com/Search.aspx?siteCode=7356865853">https://client.formularynavigator.com/Search.aspx?siteCode=7356865853</a> | Generic drugs   | \$10 <a href="#">copayment</a> /prescription, <a href="#">Deductible</a> does not apply | Not Covered                                   | Prior authorization / step therapy may be required. Covers up to a 30-day supply (retail subscription); 31–90 day supply (mail order prescription). Cost share shown is per retail prescription. Mail order cost share is 2.5 times retail cost. |
|   | Preferred brand drugs                                   | \$20 <a href="#">copayment</a> /prescription, <a href="#">Deductible</a> does not apply | Not Covered                                   |  |
|   | Non-preferred brand drugs                               | \$60 <a href="#">copayment</a> /prescription  | Not Covered                                   |  |
|   | <a href="#">Specialty drugs</a>                         | \$250 <a href="#">copayment</a> /prescription   | Not Covered                                   |  |
| If you have outpatient surgery  | Facility fee (e.g., ambulatory surgery center)          | 30% <a href="#">coinsurance</a>   | Not Covered                                   | Prior authorization may be required. Covered no limit.   |

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://www.firstchoicenext.com/assets/pdf/member/2025/forms/evidence-of-coverage.pdf>

| Common Medical Event  | Services You May Need                            | What You Will Pay  |  | Limitations, Exceptions, & Other Important Information   |
|---|--|--|--|--|
|   |  | In Network (You will pay the least)  | Out of Network (You will pay the most)   |  |
|   | Physician/surgeon fees                           | 30% <a href="#">coinsurance</a>  | Not Covered  | Prior authorization may be required. Covered no limit.   |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | 30% <a href="#">coinsurance</a>  | 30% <a href="#">coinsurance</a>  | You pay the same level as in-network if it is an emergency as defined in your policy, otherwise not covered.   |
|   | <a href="#">Emergency medical transportation</a> | 30% <a href="#">coinsurance</a>  | 30% <a href="#">coinsurance</a>  | None   |
|   | <a href="#">Urgent care</a>                      | \$30 <a href="#">copayment</a> /visit, <a href="#">Deductible</a> does not apply | \$30 <a href="#">copayment</a> /visit, <a href="#">Deductible</a> does not apply | Out-of-network <a href="#">Urgent Care</a> services are covered when <a href="#">network providers</a> are temporarily unavailable or inaccessible and if the services are for an urgent condition as defined in your <a href="#">plan</a> policy, otherwise not covered.                              |
| If you have a hospital stay   | Facility fee (e.g., hospital room)               | 30% <a href="#">coinsurance</a>  | Not Covered  | Prior authorization may be required. Covered no limit.   |
|   | Physician/surgeon fees                           | 30% <a href="#">coinsurance</a>  | Not Covered  | Prior authorization may be required. Covered no limit.   |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | \$20 <a href="#">copayment</a> /visit, <a href="#">Deductible</a> does not apply | Not Covered  | Prior authorization may be required. Covered no limit.   |
|   | Inpatient services                               | 30% <a href="#">coinsurance</a>  | Not Covered  | Prior authorization may be required. Covered no limit.   |
| If you are pregnant   | Office visits                                    | No Charge, <a href="#">Deductible</a> does not apply                             | Not Covered  | Prior authorization may be required. <a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">coinsurance</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
|   | Childbirth/delivery professional services        | 30% <a href="#">coinsurance</a>  | Not Covered  |  |
|   | Childbirth/delivery facility services            | 30% <a href="#">coinsurance</a>  | Not Covered  |  |
|   | <a href="#">Home health care</a>                 | 30% <a href="#">coinsurance</a>  | Not Covered  | Prior authorization may be required.   |

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| Common Medical Event   | Services You May Need                     | What You Will Pay  |   | Limitations, Exceptions, & Other Important Information  |
|--|---|--|---|---|
|  |   | In Network<br>(You will pay the least)   | Out of Network<br>(You will pay the most) |   |
| If you need help recovering or have other special health needs |   |  |   | 60 visits per benefit period  |
|  | <a href="#">Rehabilitation services</a>   | \$20 <a href="#">copayment</a> /visit, <a href="#">Deductible</a> does not apply | Not Covered                               | Prior authorization may be required. 30 visits per benefit period for rehabilitative speech therapy; Combined limit of 30 visits per benefit period for rehabilitative physical and occupational therapy. |
|  | <a href="#">Habilitation services</a>     | \$20 <a href="#">copayment</a> /visit, <a href="#">Deductible</a> does not apply | Not Covered                               | Prior authorization may be required. Covered no limit.  |
|  | <a href="#">Skilled nursing care</a>      | 30% <a href="#">coinsurance</a>  | Not Covered                               | Prior authorization may be required. 60 days per benefit period   |
|  | <a href="#">Durable medical equipment</a> | 50% <a href="#">coinsurance</a>  | Not Covered                               | Prior authorization may be required. Covered no limit.  |
|  | <a href="#">Hospice services</a>          | No Charge  | Not Covered                               | Prior authorization may be required. 6 months per episode   |
| If your child needs dental or eye care                         | Children's eye exam                       | 30% <a href="#">coinsurance</a>  | Not Covered                               | 1 exam per benefit period   |
|  | Children's glasses                        | 30% <a href="#">coinsurance</a>  | Not Covered                               | 1 pair of children's eye glasses (with standard frames and lenses) or contact lenses per benefit period   |
|  | Children's dental check-up                | Not Covered  | Not Covered                               | None  |

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## 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](#).)

- Abortion (except in cases of rape, incest, or when life of mother is endangered)
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- 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
- Routine foot care

**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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov), or South Carolina Consumer Services Division, P.O. Box 100105, Columbia, SC 29202-3105, Phone:1-803-737-6180 or 1-800-768-3467. Other options to continue coverage are 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: visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Does this plan provide Minimum Essential Coverage? Yes**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

**Does this plan meet the Minimum Value Standards? Not Applicable**

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 1-833-983-7272.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-833-983-7272.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-833-983-7272.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-833-983-7272.

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

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## 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](#) \$500
- [Specialist copayment](#) \$40
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

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 | \$12,700 |
|--------------------|----------|

In this example, Peg would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$500          |
| <a href="#">Copayments</a>        | \$0            |
| <a href="#">Coinsurance</a>       | \$2,500        |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Peg would pay is</b> | <b>\$3,000</b> |

### Managing Joe's type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$500
- [Specialist copayment](#) \$40
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

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 | \$5,600 |
|--------------------|---------|

In this example, Joe would pay:

| Cost Sharing                      |              |
|-----------------------------------|--------------|
| <a href="#">Deductibles</a>       | \$100        |
| <a href="#">Copayments</a>        | \$600        |
| <a href="#">Coinsurance</a>       | \$0          |
| What isn't covered                |              |
| Limits or exclusions              | \$0          |
| <b>The total Joe would pay is</b> | <b>\$700</b> |

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$500
- [Specialist copayment](#) \$40
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

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 | \$2,800 |
|--------------------|---------|

In this example, Mia would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$500          |
| <a href="#">Copayments</a>        | \$100          |
| <a href="#">Coinsurance</a>       | \$600          |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,200</b> |