

 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> ?	<b>In Network:</b> \$0/Individual, \$0/Family <b>Out of Network:</b> Not Covered	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. All covered health services are covered without a deductible	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> ?	<b>In Network:</b> \$3,150/Individual, \$6,300/Family <b>Out of Network:</b> 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 (You will pay the least)	Out of Network (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.	\$45 <a href="#">copayment</a> /visit	Not Covered	None
	<a href="#">Specialist</a> visit	\$90 <a href="#">copayment</a> /visit	Not Covered	None
	<a href="#">Preventive care/screening</a> /immunization	No Charge	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> Blood work: 30% <a href="#">coinsurance</a>	X-ray: Not Covered 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 More information about <a href="#">prescription drug coverage</a> is available at <a href="https://client.formularynavigator.com/Search.aspx?siteCode=8334465244">https://client.formularynavigator.com/Search.aspx?siteCode=8334465244</a>	Generic drugs	\$15 <a href="#">copayment</a> /prescription	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	\$30 <a href="#">copayment</a> /prescription	Not Covered	
	Non-preferred brand drugs	30% <a href="#">coinsurance</a>	Not Covered	
	<a href="#">Specialty drugs</a>	30% <a href="#">coinsurance</a>	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.
	Physician/surgeon fees	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://firstchoicenext/pdf/member/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)	
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>	\$65 <a href="#">copayment</a> /visit	Not Covered	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	\$45 <a href="#">copayment</a> /visit	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	30% <a href="#">coinsurance</a>	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. 60 visits per benefit period

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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)	
If you need help recovering or have other special health needs	<a href="#">Rehabilitation services</a>	30% <a href="#">coinsurance</a>	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>	30% <a href="#">coinsurance</a>	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>	30% <a href="#">coinsurance</a>	Not Covered	Prior authorization may be required. Covered no limit.
	<a href="#">Hospice services</a>	30% <a href="#">coinsurance</a>	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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"><li>• Abortion (except in cases of rape, incest, or when life of mother is endangered)</li><li>• Acupuncture</li><li>• Bariatric surgery</li><li>• Cosmetic surgery</li></ul>	<ul style="list-style-type: none"><li>• Dental care (Adult)</li><li>• Hearing aids</li><li>• Infertility treatment</li><li>• Long-term care</li></ul>	<ul style="list-style-type: none"><li>• Private-duty nursing</li><li>• Routine eye care (Adult)</li><li>• Weight loss programs</li></ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"><li>• Chiropractic care</li></ul>	<ul style="list-style-type: none"><li>• Routine foot care</li></ul>	

**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.*

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

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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](#) \$0
- [Specialist copayment](#) \$90
- 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>	\$0
<a href="#">Copayments</a>	\$50
<a href="#">Coinsurance</a>	\$3,100
What isn't covered	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$3,150</b>

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$90
- 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>	\$0
<a href="#">Copayments</a>	\$1,000
<a href="#">Coinsurance</a>	\$80
What isn't covered	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,080</b>

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$90
- 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>	\$0
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$700
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$900</b>