1099WORKERS.COM

# Summary of Benefits & Coverage

## Minimum Value $0 Deductible Copay Bronze Plan

**First Health PPO In-Network**

**Rates effective as of January 1, 2026**

*This plan is underwritten by Magna Insurance Company, and not First Health.

# Summary of Benefits and Coverage

## Minimum Value Plan Copay Bronze Plan

| Network: First Health PPO | Benefit (In-Network Only) |
|---|---|
| **In Network Provider: To search for in-network providers, click *here*.**<br><br>***Select "First Health network"*** | |
| **Lifetime Maximum Benefit** | Unlimited |
| **Deductible**<br><br>The amount the Covered Person pays each benefit year for Covered Services before Copays Are Eligible.<br><br>. Individual<br>. Family | <br><br><br><br>$0<br>$0 |
| **Out of Pocket Maximum**<br><br>Once reached, the plan pays 100% of covered services for the remainder of the year.<br><br>Coverage is subject to plan limits and allowable claim amounts. Services not covered or exceeding plan limits may still be your responsibility.<br><br>. Individual<br>. Family | <br><br><br><br><br><br>$8,000<br>$16,000 |
| **Out of Pocket Limit: Please note expenses incurred for non-covered services will not be included in the out of pocket limit.** | |
| **Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)** | |

| | | |
|---|---|---|
| • Cosmetic Surgery<br>• Dental Care (Adult)<br>• Infertility Treatment<br>• Maternity | • Long-term care<br>• Care Provided in Emergency Care<br>• Private Duty Nursing | • Routine Eye Care (Adult)<br>• Routine Foot Care<br>• Hearing Aids |

**Important Plan Notes:**

- Doctor visits, mental health services, and emergency care are limited to a set number of visits per year
- Diagnostic tests and advanced imaging (MRI, CT scans) are limited per year
- Hospital and surgical services are limited to a set number of procedures per year
- Prescription drug coverage includes monthly maximum limits and does not cover specialty medications
- Some services (including specialty medications, DME, and hospice care) are not covered, and coverage is limited to in-network providers only

**This illustration describes the plan in an easily understood manner and is presented as a matter of general information only.**

**Services may require preauthorization. Failure to obtain the required preauthorization may result in denial of benefit coverage.**

**The contents are not to be accepted or construed as a substitute for the provisions of the plan document or summary plan description, which contains more exact terms and detailed provisions of the plan, and it is not to be considered a policy of insurance.**

# Summary of Benefits and Coverage

## Minimum Value Plan Copay Bronze Plan

| Network: First Health PPO | Benefit (In-Network Only) | Limit |
|---|---|---|
| **Covered Services - Preventive, Health Care Provider or Clinic** | | |
| **Primary Care Physician**<br>Covered visits per family member<br><br>**Specialist Office Visit**<br>Covered visits per family member, combined with mental health visits | $50 Copay<br><br>$75 Copay | 4 Visits Per Plan Year<br><br>4 Visits Per Plan Year |
| **Annual Preventive Care, Screenings, Immunizations** | Covered 100% | |
| **24/7 Virtual Care & Telehealth Benefits**<br><br>Access care anytime, anywhere with 24/7 virtual healthcare included in your plan. Speak with a doctor or licensed therapist by phone or video — with no copays or visit limits.<br><br>• 24/7 doctor access<br>• Virtual therapy & mental health support<br>• $0 copay visits<br>• Coverage for your household | Covered 100% | |
| **Labs and X-Ray**<br>(Non-hospital based)<br><br>**Imaging (Preauthoirzation Required)**<br>MRI, MRA, CT/PET Scans | $75 Copay<br><br>$750 Copay | 3 Services Per Plan Year<br><br>1 Service Per Plan Year |
| **Covered Services - Emergency Services, Hospitalization and Surgeries** | | |
| **Urgent Care**<br><br>**Emergency Room Care**<br><br>**Emergency Medical Transportation**<br>Ground transporation only | $75 Copay<br><br>$750 Copay<br><br>Covered 100% | 2 Visits Per Plan Year<br><br>1 Visit Per Plan Year<br><br>1 Occurance Per Plan Year |
| **Outpatient Services (Preauthorization Required)**<br><br>• Office Fee<br><br>• Outpatient Surgical Facility Services | $100 Copay<br><br>$750 Copay | 1 Procedure Per Plan Year |
| **Inpatient Hospital Services (Preauthorization Required)**<br>Combined with mental health inpatient hospitalization<br><br>**Inpatient Surgical Services (Preauthorization Required)** | $1,500 Copay<br><br>$750 Copay | 5 Day Limit Per Plan Year<br><br>2 Procedures Per Plan Year |

# Summary of Benefits and Coverage

## Minimum Value Plan Copay Bronze Plan

| Network: First Health PPO | Benefit (In-Network Only) | Limit |
|---|---|---|
| **Covered Services - Maternity, Mental Health and Other** | | |
| **Pregnancy/Maternity** | NOT COVERED | N/A |
| **Home Health Care** | $75 Copay | 6 Vists Per Plan Year |
| **Rehabilitation / Habilitation Services** (Physcial Therapy, Occupational Therapy) | $75 Copay | 4 Visits Per Plan Year Combined |
| **Mental Health Treatment (Preauthorization Required)**<br>• Outpatient Services (Combined with specialists visits)<br>• Inpatient Services (Combined with impatient services) | $75 Copay<br>$1,500 Copay (Per Admission) | 4 Visits Per Plan Year Per Member<br>5 Days Per Plan Year |
| **Children's Eye Exam** | Covered 100% | No Limit |
| **Children's Dental Checkup** | Covered 100% | No Limit |
| **Skilled Nursing Care** | NOT COVERED | N/A |
| **Hospice Services** | NOT COVERED | N/A |
| **Durable Medical Equipment (DME)** | NOT COVERED | N/A |

# Summary of Benefits and Coverage

## Minimum Value Plan Copay Bronze Plan

| Network: First Health PPO | Tier | Coverages |
|---|---|---|
| **Covered Services - Prescriptions** | | |
| **Prescription Deductible**<br>The amount the Covered Person pays each benefit year before plan begins to cover prescription services.<br>Prescription drugs regardless of tier will be limited to a $500 per month benefit for any 30-day fill and $1,500 for a 90-day supply. | | $500 |
| **Retail Pharmacy Copayments**<br>Per 30-Day Supply Per Prescription. | ACA Generic Drugs | $0 Copay |
| | Formulary Generic Drugs | 40% Co-Insurance<br>(Deductible Waived) |
| | Brand Name Drugs (Preferred) | Deductible, 40% Co-Insurance |
| | Brand Name Drugs (Non-Preferred) | Deductible, 40% Co-Insurance |
| | Specialty Drugs | NOT COVERED |
| **Mail Order Pharmacy Copayments**<br>Available Up to 90-Day Supply Per Prescription | ACA Generic Drugs | $0 Copay |
| | Formulary Generic Drugs | 40% Co-Insurance<br>(Deductible Waived) |
| | Brand Name Drugs (Preferred) | Deductible, 40% Co-Insurance |
| | Brand Name Drugs (Non-Preferred) | Deductible, 40% Co-Insurance |
| | Specialty Drugs | NOT COVERED |
| **Prescription Benefit Highlights** | | |
| **RX Company** | | ServeYou Rx |
| **Formulary** | | Prescription Formulary |
| **Supplemental Plan Information** | | |
| **Plan SPD** | | SPD |


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