1099WORKERS.COM

Summary of Benefits & Coverage

Minimum Value $0 Deductible Copay Gold 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 Gold Plan

Network: First Health PPO	**Benefit (In-Network Only)**
In Network Provider: To search for in-network providers, click *here*. ***Select "First Health network"***	
Lifetime Maximum Benefit	Unlimited
Deductible The amount the Covered Person pays each benefit year for Covered Services before Copays Are Eligible. . Individual . Family	 $0 $0
Out of Pocket Maximum Once reached, the plan pays 100% of covered services for the remainder of the year. Coverage is subject to plan limits and allowable claim amounts. Services not covered or exceeding plan limits may still be your responsibility. . Individual . Family	 $6,000 $12,000

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
- Dental Care (Adult)
- Infertility Treatment
- Long-term care
- Care Provided in Emergency Care
- Private Duty Nursing
- Routine Eye Care (Adult)
- Routine Foot Care
- 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.

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Minimum Value Plan Copay Gold Plan

Network: First Health PPO	Benefit (In-Network Only)	Limit
Covered Services - Preventive, Health Care Provider or Clinic		
Primary Care Physician Covered visits per family member, combined with maternity visits	$25 Copay	8 Visits Per Plan Year
Specialist Office Visit Covered visits per family member, combined with mental health visits	$35 Copay	8 Visits Per Plan Year
Annual Preventive Care, Screenings, Immunizations	Covered 100%	
24/7 Virtual Care & Telehealth Benefits 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. • 24/7 doctor access • Virtual therapy & mental health support • $0 copay visits • Coverage for your household	Covered 100%	
Labs and X-Ray (Non-hospital based)	$35 Copay	5 Services Per Plan Year
Imaging (Preauthoirzation Required) MRI, MRA, CT/PET Scans	$375 Copay	3 Services Per Plan Year
Covered Services - Emergency Services, Hospitalization and Surgeries		
Urgent Care	$35 Copay	4 Visits Per Plan Year
Emergency Room Care	$375 Copay	2 Visits Per Plan Year
Emergency Medical Transportation Ground transporation only	Covered 100%	1 Occurance Per Plan Year
Outpatient Services (Preauthorization Required) • Office Fee • Outpatient Surgical Facility Services	$50 Copay $375 Copay	3 Procedures Per Plan Year
Inpatient Hospital Services (Preauthorization Required) Combined with mental health inpatient hospitalization	$750 Copay	10 Day Limit Per Plan Year
Inpatient Surgical Services (Preauthorization Required)	$375 Copay	3 Procedures Per Plan Year

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Network: First Health PPO	Benefit (In-Network Only)	Limit
Covered Services - Maternity, Mental Health and Other		
Pregnancy/Maternity (Preauthorization Required) • Prenatal Office Visits • Childbirth/Delivery Facility and Professional Services	$25 Copay $1,700 Copay	8 Office VIsits Per Plan Year Combined With Primary Visits
Home Health Care	$35 Copay	10 Vists Per Plan Year
Rehabilitation / Habilitation Services (Physcial Therapy, Occupational Therapy)	$35 Copay	8 Visits Per Plan Year Combined
Mental Health Treatment (Preauthorization Required) • Outpatient Services (Combined with specialists visits) • Inpatient Services (Combined with impatient services)	$35 Copay $750 Copay (Per Admission)	8 Visits Per Plan Year Per Member 10 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

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Network: First Health PPO	Tier	Coverages
Covered Services - Prescriptions		
Prescription Deductible The amount the Covered Person pays each benefit year before plan begins to cover prescription services. 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 Per 30-Day Supply Per Prescription.	ACA Generic Drugs	$0 Copay
	Formulary Generic Drugs	20% Co-Insurance
	Brand Name Drugs (Preferred)	20% Co-Insurance
	Brand Name Drugs (Non-Preferred)	20% Co-Insurance
	Specialty Drugs	NOT COVERED
Mail Order Pharmacy Copayments Available Up to 90-Day Supply Per Prescription	ACA Generic Drugs	$0 Copay
	Formulary Generic Drugs	20% Co-Insurance
	Brand Name Drugs (Preferred)	20% Co-Insurance
	Brand Name Drugs (Non-Preferred)	20% 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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