



# Summary of Benefits & Coverage

**Minimum Value \$0 Deductible  
Copay Silver 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 Silver Plan

Network: First Health PPO	Benefit (In-Network Only)
<p><b>In Network Provider:</b> To search for in-network providers, click <a href="#">here</a>.</p> <p>Select <b>"First Health network"</b></p>	
<p><b>Lifetime Maximum Benefit</b></p>	<p>Unlimited</p>
<p><b>Deductible</b></p> <p>The amount the Covered Person pays each benefit year for Covered Services before Copays Are Eligible.</p> <ul style="list-style-type: none"> <li>. Individual</li> <li>. Family</li> </ul>	<p>\$0</p> <p>\$0</p>
<p><b>Out of Pocket Maximum</b></p> <p>Once reached, the plan pays 100% of covered services for the remainder of the year.</p> <p>Coverage is subject to plan limits and allowable claim amounts. Services not covered or exceeding plan limits may still be your responsibility.</p> <ul style="list-style-type: none"> <li>. Individual</li> <li>. Family</li> </ul>	<p>\$7,000</p> <p>\$14,000</p>
<p><b>Out of Pocket Limit:</b> Please note expenses incurred for non-covered services will not be included in the out of pocket limit.</p>	
<p><b>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</b></p>	
<ul style="list-style-type: none"> <li>• Cosmetic Surgery</li> <li>• Dental Care (Adult)</li> <li>• Infertility Treatment</li> </ul>	<ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Care Provided in Emergency Care</li> <li>• Private Duty Nursing</li> </ul>
<ul style="list-style-type: none"> <li>• Routine Eye Care (Adult)</li> <li>• Routine Foot Care</li> <li>• Hearing Aids</li> </ul>	
<p><b>Important Plan Notes:</b></p> <ul style="list-style-type: none"> <li>• Doctor visits, mental health services, and emergency care are limited to a set number of visits per year</li> <li>• Diagnostic tests and advanced imaging (MRI, CT scans) are limited per year</li> <li>• Hospital and surgical services are limited to a set number of procedures per year</li> <li>• Prescription drug coverage includes monthly maximum limits and does not cover specialty medications</li> <li>• Some services (including specialty medications, DME, and hospice care) are not covered, and coverage is limited to in-network providers only</li> </ul>	
<p><b>This illustration describes the plan in an easily understood manner and is presented as a matter of general information only.</b></p>	
<p><b>Services may require preauthorization. Failure to obtain the required preauthorization may result in denial of benefit coverage.</b></p>	
<p>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.</p>	

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<b>Covered Services - Preventive, Health Care Provider or Clinic</b>		
<b>Primary Care Physician</b> Covered visits per family member, combined with maternity visits	\$35 Copay	6 Visits Per Plan Year
<b>Specialist Office Visit</b> Covered visits per family member, combined with mental health visits	\$50 Copay	6 Visits Per Plan Year
<b>Annual Preventive Care, Screenings, Immunizations</b>	Covered 100%	
<b>24/7 Virtual Care &amp; Telehealth Benefits</b>  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. <ul style="list-style-type: none"> <li>• 24/7 doctor access</li> <li>• Virtual therapy &amp; mental health support</li> <li>• \$0 copay visits</li> <li>• Coverage for your household</li> </ul>	Covered 100%	
<b>Labs and X-Ray</b> (Non-hospital based)	\$50 Copay	4 Services Per Plan Year
<b>Imaging (Preauthorization Required)</b> MRI, MRA, CT/PET Scans	\$500 Copay	2 Service Per Plan Year
<b>Covered Services - Emergency Services, Hospitalization and Surgeries</b>		
<b>Urgent Care</b>	\$50 Copay	3 Visits Per Plan Year
<b>Emergency Room Care</b>	\$500 Copay	1 Visit Per Plan Year
<b>Emergency Medical Transportation</b> Ground transportation only	Covered 100%	1 Occurance Per Plan Year
<b>Outpatient Services (Preauthorization Required)</b> <ul style="list-style-type: none"> <li>• Office Fee</li> <li>• Outpatient Surgical Facility Services</li> </ul>	\$70 Copay \$500 Copay	2 Procedures Per Plan Year
<b>Inpatient Hospital Services (Preauthorization Required)</b> Combined with mental health inpatient hospitalization	\$1,000 Copay	7 Day Limit Per Plan Year
<b>Inpatient Surgical Services (Preauthorization Required)</b>	\$500 Copay	2 Procedures Per Plan Year

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Network: First Health PPO	Benefit (In-Network Only)	Limit
<b>Covered Services - Maternity, Mental Health and Other</b>		
<b>Pregnancy/Maternity (Preauthorization Required)</b> <ul style="list-style-type: none"> <li>Prenatal Office Visits</li> <li>Childbirth/Delivery Facility and Professional Services</li> </ul>	\$35 Copay \$2,300 Copay	6 Office Visits Per Plan Year Combined With Primary Visits
<b>Home Health Care</b>	\$50 Copay	6 Vists Per Plan Year
<b>Rehabilitation / Habilitation Services</b> (Phyiscal Therapy, Occupational Therapy)	\$50 Copay	6 Visits Per Plan Year Combined
<b>Mental Health Treatment (Preauthorization Required)</b> <ul style="list-style-type: none"> <li>Outpatient Services (Combined with specialists visits)</li> <li>Inpatient Services (Combined with impatient services)</li> </ul>	\$50 Copay \$1,000 Copay (Per Admission)	6 Visits Per Plan Year Per Member 7 Days Per Plan Year
<b>Children's Eye Exam</b>	Covered 100%	No Limit
<b>Children's Dental Checkup</b>	Covered 100%	No Limit
<b>Skilled Nursing Care</b>	NOT COVERED	N/A
<b>Hospice Services</b>	NOT COVERED	N/A
<b>Durable Medical Equipment (DME)</b>	NOT COVERED	N/A

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Network: First Health PPO	Tier	Coverages
<b>Covered Services - Prescriptions</b>		
<b>Prescription Deductible</b> 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.		\$250
<b>Retail Pharmacy Copayments</b> Per 30-Day Supply Per Prescription.	ACA Generic Drugs	\$0 Copay
	Formulary Generic Drugs	30% Co-Insurance (Deductible Waived)
	Brand Name Drugs (Preferred)	Deductible, 30% Co-Insurance
	Brand Name Drugs (Non-Preferred)	Deductible, 30% Co-Insurance
	Specialty Drugs	NOT COVERED
<b>Mail Order Pharmacy Copayments</b> Available Up to 90-Day Supply Per Prescription	ACA Generic Drugs	\$0 Copay
	Formulary Generic Drugs	30% Co-Insurance (Deductible Waived)
	Brand Name Drugs (Preferred)	Deductible, 30% Co-Insurance
	Brand Name Drugs (Non-Preferred)	Deductible, 30% Co-Insurance
	Specialty Drugs	NOT COVERED
<b>Prescription Benefit Highlights</b>		
RX Company		ServeYou Rx
Formulary		<a href="#">Prescription Formulary</a>
<b>Supplemental Plan Information</b>		
Plan SPD		<a href="#">SPD</a>



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