FirstCare™ HEALTH PLANS

FirstCare *mySeries*

Benefits Summary
SelectHC V

An Embedded Deductible, High Deductible Health Plan (HDHP)

This chart only summarizes covered benefits.
Please refer to the Policy for coverage details including exclusions and limitations.

COVERED SERVICE	PREFERRED PROVIDER (In-Network Benefits)	NON-PREFERRED PROVIDER (Out-of-Network Benefits)
POLICY YEAR: CALENDAR		
DEDUCTIBLE[1] (Applies toward Out-of-Pocket Maximum)	$5,000 per Insured $10,000 per Family	$10,000 per Insured $20,000 per Family
OUT-OF-POCKET MAXIMUM[2]	$5,000 per Insured $10,000 per Family	$20,000 per Insured $40,000 per Family
AGGREGATE LIFETIME MAXIMUM	$2,000,000	
PRE-AUTHORIZATION PENALTY	Failure to Pre-authorize reduces benefits by 50% or $500, whichever is less.	
INPATIENT SERVICES Inpatient Services include: • Semi-Private Room and Board Charges • Surgical Procedures • Pre-Admission Testing • Physician Hospital Visits • Intensive Care & Coronary Care Units • Operating/Recovering Room • Acquired Brain Injury • Laboratory Tests and X-ray • Reconstructive Surgery • Observation Unit • Physician Services • Skilled Nursing Facility - *Limited to a combined 30 In-/Out-of-Network days per Policy Year*	100% after Deductible	70% after Deductible
OUTPATIENT SERVICES Outpatient Services/Surgery include: • Facility Charges • Surgical Procedures • Physician Services	100% after Deductible	70% after Deductible
Laboratory Tests and X-ray in an Outpatient Setting	100% after Deductible	70% after Deductible
MRI, CT Scans, Sleep Study, Nuclear Stress Tests and PET Scan	100% after Deductible	70% after Deductible

[1] ***Embedded Deductible*** *is when the Individual Deductible amount must be met by every Insured covered, each Policy Year. If Dependents are covered, all charges applied to the Individual Deductible amount will be applied towards the Family Deductible amount. When the Family Deductible is reached, no further Individual Deductibles will have to be met for the remainder of that Policy Year. No Insured will contribute more than the Individual Deductible amount to the Family Deductible amount.*

[2] ***Out-of-Pocket Maximum*** *is the total amount that must be paid each Policy Year before benefits are covered at 100%, up to the Usual, Customary and Reasonable (UCR) amount. Coinsurance amounts count towards the Out-of-Pocket Maximum. Deductibles do count towards the Out-of-Pocket Maximum.*

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COVERED SERVICE	PREFERRED PROVIDER (In-Network Benefits)	NON-PREFERRED PROVIDER (Out-of-Network Benefits)
PHYSICIAN OFFICE SERVICES		
Physician Office Services Include: • Physician Office Visits • Medications, supplies and materials administered in the office • Second Surgical Opinion	100% after Deductible	70% after Deductible
Laboratory Tests and X-Ray	100% after Deductible	70% after Deductible
MRI, CT Scans, Sleep Study, Nuclear Stress Tests and PET Scan performed in the Physician's office	100% after Deductible	70% after Deductible
Allergy Services: • Office Visit • Allergy Testing • Serum • Injection Administration	100% after Deductible	70% after Deductible
Surgical Procedures performed in the Physician's Office	100% after Deductible	70% after Deductible
PREVENTIVE SERVICES ***Limited to a combined $500 In-/Out-of-Network benefit per Insured per Policy Year.*** Preventive Services include*: • Annual Routine Physicals* • Well Baby and Well Child Care* • Routine Eye, Speech and Hearing Screenings for Children when performed during an office visit* • Routine Labs and X-Rays* • Routine Immunizations (ages 6 and older)* • Examinations and testing for the detection of Prostate Cancer* • Well Woman Exam including Routine Annual Physicals and low-dose mammography screenings*	$40 Copayment - Deductible waived	70% after Deductible
Immunizations for Newborns *(birth to 6-years of age)*	Covered in full	Covered in full
Newborn Child Hearing Screenings *(birth to 30-days old)*	$40 Copayment - Deductible waived	70% after Deductible
Preventive Diagnostics and Testing: • Non-routine mammograms including Digital, X-ray and Ultrasound • Screening for the detection of Colorectal Cancer *(If other procedures are done during screening, additional copays, deductibles, and/or coinsurance will apply)* • Bone Mass Measurement	$40 Copayment - Deductible waived	70% after Deductible

COVERED SERVICE	PREFERRED PROVIDER (In-Network Benefits)	NON-PREFERRED PROVIDER (Out-of-Network Benefits)
FAMILY PLANNING		
Family Planning and Counseling	100% after Deductible	70% after Deductible
Contraceptive Devices, Implants and Injections including: • Diaphragm • IUD • Subdermal Contraceptive Implants & Removal • Depo-Provera™ Injections	100% after Deductible	70% after Deductible
Sterilization Procedures: (Vasectomy & Tubal Ligation) • When performed in an Outpatient Facility • When performed in the Physician's Office • When performed in an Inpatient Facility	100% after Deductible	70% after Deductible
DIABETIC SERVICES		
Diabetic Self-Management Education	100% after Deductible	70% after Deductible
Insulin and Diabetic Medication: • 30-day Supply • Mail Order (up to 90-day supply)	100% after Deductible 100% after Deductible	70% after Deductible 70% after Deductible
Test Strips: • Level 1 Strips • Level 2 Strips	100% after Deductible	70% after Deductible
Other Diabetic Supplies and Equipment (30-day Supply)	100% after Deductible	70% after Deductible
OUTPATIENT PHARMACY *Limited to a combined $4,000 In-/Out-of-Network, Policy Year Maximum* 30-Day Supply Mail Order (up to 90-Day Supply)	100% after Deductible 100% after Deductible	The claim is paid at 70% of the actual charges, after they are first reduced by the sum of the applicable In-Network pharmacy Copayment and any required difference in the cost between a Brand Name medication and a Generic medication.
SPECIALTY SERVICES/PHARMACY Specialty Services/Pharmacy includes: • Medical Injectable Drugs *(excluding Depo-Provera™ injectables)* • Defined Hybrid Injectables • Radiation Therapy • Transplant Anti-Rejection Therapy • Specified Cancer Chemotherapy • Defined Associated Agents	• When Covered Service cost is $500 or less: No additional Coinsurance taken after Deductible. *See the office visit, outpatient surgery or inpatient hospital section(s) for applicable charges.* • When Covered Service cost is more than $500: 30% coinsurance after Deductible, not to exceed $3,000 Out-of-Pocket Maximum for these specific	70% after Deductible 70% after Deductible

COVERED SERVICE	PREFERRED PROVIDER (In-Network Benefits)	NON-PREFERRED PROVIDER (Out-of-Network Benefits)
	services. *See Section 3 - How Benefits Are Paid in Your Certificate of Insurance.*	
Home Infusion Therapy *(excluding "self-injectable" drugs)*	100% after Deductible	70% after Deductible
EMERGENCY ROOM SERVICES		
Emergency Room	100% after Deductible	
Minor Emergency/Urgent Care Facilities	100% after Deductible	70% after Deductible
Ambulance	100% after Deductible	70% after Deductible
OTHER HEALTH CARE SERVCES		
Limited Accidental Dental Care and Medically Related Oral Surgeries – *$1,000 combined In-/Out-of Network Maximum Benefit per Policy Year.*	100% after Deductible	70% after Deductible
Therapy Services: • Rehabilitation Therapy, Occupational Therapy, & Physical Therapy *(Limited to a combined 20 In-/Out-of-Network visits per Policy Year)* • Speech Therapy *(Limited to 20 In-/Out-of-Network visits per Policy Year)*	100% after Deductible	70% after Deductible
Hospice Care – *Limited to a combined $10,000 In-/Out-of-Network Lifetime Maximum Benefit.*	100% after Deductible	70% after Deductible
Spinal Manipulation – *Limited to a combined 10 In-/Out-of-Network visits per Policy Year.*	100% after Deductible	70% after Deductible
Pain Management Services	100% after Deductible	70% after Deductible
Durable Medical Equipment (DME) – *Limited to a combined $2,000 In-/Out-of-Network Maximum Benefit per Policy Year. This limit applies to both Outpatient & Home Health Care services. DME used in the treatment of diabetes, oxygen and monitoring devices are not included in the $2,000 maximum.*	100% after Deductible	70% after Deductible
Medical Supplies	100% after Deductible	70% after Deductible
Prosthetics: External Devices: *Combined In-/Out-of-Network Lifetime Maximum of $4,000 per Device/Limb*	100% after Deductible	70% after Deductible
Orthotics	100% after Deductible	70% after Deductible
Internal Implantable Devices	100% after Deductible	70% after Deductible
Dialysis Services *(Inpatient & Outpatient)*	100% after Deductible	70% after Deductible

COVERED SERVICE	PREFERRED PROVIDER (In-Network Benefits)	NON-PREFERRED PROVIDER (Out-of-Network Benefits)
Organ Transplant Services *(Inpatient & Outpatient) – Limited to a combined $300,000 In-/-Out of Network Lifetime Maximum*	100% after Deductible	70% after Deductible
Home Health Care Services include: *Limited to a combined 20 In-/Out-of-Network visits per Covered Service per Policy Year* • Skilled nursing services provided by a registered nurse or vocational nurse; supervised by one registered nurse and one physician • Home health aide services; supervised by a registered nurse • Medical equipment/supplies other than drugs and medicines: *Limited to the combined dollar amount listed under Durable Medical Equipment (DME) for both Outpatient & Home Health DME services.*	100% after Deductible	70% after Deductible
ALL OTHER COVERED SERVICES	100% after Deductible	70% after Deductible