





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, visit <https://exchange.communityfirsthealthplans.com/plan-documents/>. 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 [SBC Uniform Glossary | HealthCare.gov](#) or call 1-888-512-2347 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$0 Individual/\$0 Family	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible ?	Yes. In-Network Preventive Health Care services, services with a copayment , and some prescription drugs are covered before you meet your deductible .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible . See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	\$1,000 Individual/\$2,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Premiums , balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. See https://exchange.communityfirsthealthplans.com/network or call 1-888-512-2347 for a list of participating providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay all health care costs if you use an out-of-network provider (except for emergency care), and you will receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral.

 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$5 copay per visit	Not Covered	Virtual visits are available with some PCPs.
	Specialist visit	\$10 copay per visit	Not Covered	Referrals not required.
	Preventive care/screening/immunization	No copay	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay.
If you have a test	Diagnostic test (x-ray, blood work)	\$10 copay per visit	Not Covered	Preauthorization may be required.
	Imaging (CT/PET scans, MRIs)	\$10 copay per visit	Not Covered	Preauthorization may be required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://exchange.communityfirstthehealthplans.com/formulary	Generic drugs	\$5 copay per prescription	Not Covered	Limited to a 30-day supply at retail (or a 90-day supply at a network of select retail pharmacies). Up to a 90-day supply at mail order. Specialty drugs limited to a 30-day supply. Payment of the difference between the cost of a brand name drug and a generic may also be required if a generic drug is available. Preauthorization may be required.
	Preferred brand drugs	\$10 copay per prescription	Not Covered	
	Non-preferred brand drugs	\$20 copay per prescription	Not Covered	
	Specialty drugs	20% coinsurance	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$10 copay per visit	Not Covered	Preauthorization may also be required. For Outpatient Infusion Therapy, see policy document*.
	Physician/surgeon fees	\$100 copay per visit	Not Covered	
If you need immediate medical attention	Emergency room care	\$80 copay per visit	\$80 copay per visit	Copay waived if admitted.
	Emergency medical transportation	\$10 copay per transport	\$10 copay per transport	Preauthorization may be required for non-emergency and air transportation; see policy document*.
	Urgent care	\$5 copay per visit	Not Covered	Outpatient Laboratory and X-Ray Services charges may also apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$120 copay per admission	Not Covered	Preauthorization required; see policy document*.

* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://exchange.communityfirstthehealthplans.com/plan-documents/> Page 2 of 6

 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	\$5 <u>copay</u> per visit	Not Covered	<u>Preauthorization</u> required; see policy document*.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$5 <u>copay</u> per visit	Not Covered	<u>Preauthorization</u> may be required; see policy document*.
	Inpatient services	\$120 <u>copay</u> per admission	Not Covered	<u>Preauthorization</u> required; see policy document*.
If you are pregnant	Office visits	\$5 <u>copay</u> per visit	Not Covered	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Prenatal and Postnatal Visits - After the initial office visit, subsequent office visits are covered in full.
	Childbirth/delivery professional services	\$10 <u>copay</u> per visit	Not Covered	
	Childbirth/delivery facility services	\$120 <u>copay</u> per visit	Not Covered	
If you need help recovering or have other special health needs	Home health care	\$10 <u>copay</u> per visit	Not Covered	60 visits/year. <u>Preauthorization</u> required; see policy document*.
	Rehabilitation services	\$10 <u>copay</u> per visit	Not Covered	Separate 35 visit maximum per benefit period for <u>Habilitation</u> and <u>Rehabilitation services</u> . <u>Preauthorization</u> required; see policy document*.
	Habilitation services	\$10 <u>copay</u> per visit	Not Covered	
	Skilled nursing care	\$80 <u>copay</u> per day	Not Covered	25 days/year. <u>Preauthorization</u> required; see policy document*.
	Durable medical equipment	\$10 <u>copay</u>	Not Covered	<u>Preauthorization</u> required.
	Hospice services	\$10 <u>copay</u> per day	Not Covered	<u>Preauthorization</u> may be required.
If your child needs dental or eye care	Children's eye exam	\$5 <u>copay</u> per visit	Not Covered	One visit per year. See policy document* for Pediatric Vision Care Benefits.
	Children's glasses	\$5 <u>copay</u>	Not Covered	One pair of glasses per year. See policy document* for Pediatric Vision Care Benefits.
	Children's dental check-up	Not Covered	Not Covered	Limited dental services. See policy document* for Pediatric Dental Services.

* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://exchange.communityfirsthealthplans.com/plan-documents/> Page 3 of 6

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- Abortion (except for a pregnancy that, as certified by a physician, places the woman in danger of death or a serious risk of substantial impairment of a major bodily function unless an abortion is performed)
- Acupuncture
- Bariatric surgery
- Cosmetic surgery (except for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors or diseases when [medically necessary](#))
- Dental care (Adult)
- Infertility treatment (diagnosis and treatment covered; in vitro not covered)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care (except in connection with diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Chiropractic care (35 visits per year) \$10 copay per visit.
- Hearing aids (one hearing aid per ear every 36 months), \$10 copay per hearing aid.

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:

Community First Health Plans at 1-888-512-2347 or at <https://exchange.communityfirsthealthplans.com/>.

Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa>.

State consumer assistance program contact information available from <http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/>.

Office of Personnel Management Multi State Plan Program: <https://www.opm.gov/healthcare-insurance/multi-state-plan-program/external-review/>.

Healthcare.gov: www.HealthCare.gov or call 1-800-318-2596 or state health insurance marketplace or SHOP."

Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit 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 on how 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: Texas Department of Insurance at 1-800-578-4677 or visit <https://tdi.texas.gov>.

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 1-888-512-2347.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-512-2347.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-512-2347.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-512-2347.

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

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 copay	\$10
■ Hospital (facility) copay	\$120
■ Other copays	\$10

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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$400
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Peg would pay is	\$400

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 copay	\$10
■ Hospital (facility) copay	\$120
■ Other copays	\$10

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$600
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$600

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$0
■ Specialist copay	\$10
■ Hospital (facility) copay	\$120
■ Other copays	\$10

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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$200
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$200

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.