





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- <u>Network</u> Preventive Health Care services, services with a <u>copayment</u> , and some <u>prescription drugs</u> are covered before you meet your <u>deductible</u> .	This plan covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this plan covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan ?	\$7,250 Individual/\$14,500 Family	The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit ?	<u>Premiums</u> , <u>balance-billed</u> charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <u>participating providers</u> .	This plan uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's network . You will pay all health care costs if you use an <u>out-of-network provider</u> (except for emergency care), and you will receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your plan pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> 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	\$40 <u>copay</u> per visit	Not Covered	Virtual visits are available with some PCPs.
	<u>Specialist</u> visit	\$65 <u>copay</u> per visit	Not Covered	<u>Referrals</u> not required.
	<u>Preventive care/screening/immunization</u>	No <u>copay</u>	Not Covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	\$125 <u>copay</u> per visit	Not Covered	<u>Preauthorization</u> may be required.
	Imaging (CT/PET scans, MRIs)	\$125 <u>copay</u> per procedure	Not Covered	<u>Preauthorization</u> may be required.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at https://exchange.communityfirstthehealthplans.com/formulary	Generic drugs	\$15 <u>copay</u> per prescription	Not Covered	Limited to a 30-day supply at retail (or a 90-day supply at a <u>network</u> of select retail pharmacies). Up to a 90-day supply at mail order. <u>Specialty drugs</u> 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. <u>Preauthorization</u> may be required.
	Preferred brand drugs	\$25 <u>copay</u> per prescription	Not Covered	
	Non-preferred brand drugs	\$50 <u>copay</u> per prescription	Not Covered	
	<u>Specialty drugs</u>	30% <u>coinsurance</u>	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$125 <u>copay</u> per visit	Not Covered	<u>Preauthorization</u> may also be required. For Outpatient Infusion Therapy, see policy document*.
	Physician/surgeon fees	No <u>copay</u>	Not Covered	
If you need immediate medical attention	<u>Emergency room care</u>	\$250 <u>copay</u> per visit	\$250 <u>copay</u> per visit	<u>Copay</u> waived if admitted.
	<u>Emergency medical transportation</u>	\$250 <u>copay</u> per transport	\$250 <u>copay</u> per transport	<u>Preauthorization</u> may be required for non-emergency transportation; see policy document*.
	<u>Urgent care</u>	\$40 <u>copay</u> 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)	\$800 <u>copay</u> per admission	Not Covered	<u>Preauthorization</u> 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 <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> 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	No <u>copay</u>	Not Covered	<u>Preauthorization</u> required; see policy document*.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$40 <u>copay</u> per visit	Not Covered	<u>Preauthorization</u> required; see policy document*.
	Inpatient services	\$800 <u>copay</u> per admission	Not Covered	<u>Preauthorization</u> required see policy document*.
If you are pregnant	Office visits	\$40 <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	No <u>copay</u>	Not Covered	
	Childbirth/delivery facility services	\$800 <u>copay</u> per visit	Not Covered	
If you need help recovering or have other special health needs	Home health care	\$65 <u>copay</u> per visit	Not Covered	60 visits/year. <u>Preauthorization</u> is required; see policy document*.
	Rehabilitation services	\$125 <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> is required; see policy document*.
	Habilitation services	\$125 <u>copay</u> per visit	Not Covered	
	Skilled nursing care	\$300 <u>copay</u> per day	Not Covered	25 days/year. <u>Preauthorization</u> is required; see policy document*.
	Durable medical equipment	\$65 <u>copay</u>	Not Covered	<u>Preauthorization</u> required.
	Hospice services	\$65 <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	\$40 <u>copay</u> per visit	Not Covered	One visit per year. See policy document* for Pediatric Vision Care Benefits.
	Children's glasses	\$40 <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) | • Dental care (Adult) | • Routine eye care (Adult) |
| • Acupuncture | • Infertility treatment (diagnosis and treatment covered; in vitro not covered) | • 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) |
| • Bariatric surgery | • Long-term care | • Weight loss programs |
| • Cosmetic surgery (except for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors or diseases when <u>medically necessary</u>) | • Non-emergency care when traveling outside the U.S. | |
| | • Private-duty nursing | |

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), \$65 <u>copay</u> per visit. | • Hearing aids (one hearing aid per ear every 36 months), \$65 <u>copay</u> 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	\$65
■ Hospital (facility) copay	\$800
■ Other copays	\$125

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
---------------------------	-----------------

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$1,900
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Peg would pay is	\$1,900

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	\$65
■ Hospital (facility) copay	\$800
■ Other copays	\$40

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
---------------------------	----------------

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$1,500
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$1,500

Mia's Simple Fracture

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

■ The plan's overall deductible	\$0
■ Specialist copay	\$65
■ Hospital (facility) copay	\$800
■ Other copays	\$125

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
---------------------------	----------------

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$1,600
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,600

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