**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?** | $7,500 Individual/$15,000 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 Questions | Answers | Why This Matters: | | |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | Important Information |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $60 copay per visit | Not Covered | Virtual visits are available with some PCPs. |
| | Specialist visit | $120 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) | $120 copay per visit | Not Covered | Preauthorization may be required. |
| | Imaging (CT/PET scans, MRIs) | $120 copay per procedure | 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.communityfirsthealthplans.com/formulary | Generic drugs | $40 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. |
| | Preferred brand drugs | $60 copay per prescription | Not Covered | |
| | Non-preferred brand drugs | $120 copay per prescription | Not Covered | |
| | Specialty drugs | 50% coinsurance | Not Covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $120 copay per visit | Not Covered | Preauthorization may be required. For Outpatient Infusion Therapy, see policy document*. |
| | Physician/surgeon fees | No copay | Not Covered | |
| **If you need immediate medical attention** | Emergency room care | $400 copay per visit | $400 copay per visit | Copay waived if admitted. |
| | Emergency medical transportation | $400 copay per transport | $400 copay per transport | Preauthorization may be required for non-emergency and air transportation; see policy document*. |
| | Urgent care | $60 copay per visit | Not Covered | None. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $1,475 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.communityfirsthealthplans.com/plan-documents/

| Important Questions | Answers | Why This Matters: | | |
|---|---|---|---|---|
| | Physician/surgeon fees | No copay | Not Covered | Preauthorization required; see policy document*. |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $60 copay per visit | Not Covered | Preauthorization may be required; see policy document*. |
| | Inpatient services | $1,475 copay per admission | Not Covered | Preauthorization required; see policy document*. |
| **If you are pregnant** | Office visits | $60 copay per visit | Not Covered | Cost sharing does not apply for preventive services. 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 copay | Not Covered | |
| | Childbirth/delivery facility services | $1,475 copay per visit | Not Covered | |
| **If you need help recovering or have other special health needs** | Home health care | $120 copay per visit | Not Covered | 60 visits/year. Preauthorization required; see policy document*. |
| | Rehabilitation services | $120 copay per visit | Not Covered | Separate 35 visit maximum per benefit period for Habilitation and Rehabilitation services. Preauthorization required; see policy document*. |
| | Habilitation services | $120 copay per visit | Not Covered | |
| | Skilled nursing care | $400 copay per day | Not Covered | 25 days/year. Preauthorization required; see policy document*. |
| | Durable medical equipment | $120 copay | Not Covered | Preauthorization required. |
| | Hospice services | $120 copay per day | Not Covered | Preauthorization may be required. |
| **If your child needs dental or eye care** | Children's eye exam | $60 copay per visit | Not Covered | One visit per year. See policy document* for Pediatric Vision Care Benefits. |
| | Children's glasses | $60 copay | 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. |

## 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), $120 copay per visit.
- Hearing aids (one hearing aid per ear every 36 months), $120 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 copaymeet 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, kwiijigo 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 | $120 |
| Hospital (facility) copay | $1,475 |
| Other copays | $100 |

**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 | $2,600 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Peg would pay is** | **$2,600** |

### 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 | $120 |
| Hospital (facility) copay | $1,475 |
| Other copays | $60 |

**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 | $23100 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$2,300** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist copay | $120 |
| Hospital (facility) copay | $1,475 |
| Other copays | $100 |

**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 | $2,100 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,100** |

The plan would be responsible for the other costs of these EXAMPLE covered services.