





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 <a href="#">deductible</a> ?	\$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 <a href="#">deductible</a> ?	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 <a href="#">plan</a> 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 <a href="#">plan</a> 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 <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a>
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$2,700 Individual/\$5,400 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 <a href="#">out-of-pocket limit</a> ?	<u>Premiums</u> , <u>balance-billed</u> charges, and health care this <a href="#">plan</a> 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 <a href="#">network provider</a> ?	Yes. See <a href="https://exchange.communityfirsthealthplans.com/network">https://exchange.communityfirsthealthplans.com/network</a> or call 1-888-512-2347 for a list of <u>participating providers</u> .	This <a href="#">plan</a> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <a href="#">plan's network</a> . 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 <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$15 <a href="#">copay</a> per visit	Not Covered	Virtual visits are available with some PCPs.
	<a href="#">Specialist</a> visit	\$30 <a href="#">copay</a> per visit	Not Covered	<a href="#">Referrals</a> not required.
	<a href="#">Preventive care/screening/immunization</a>	No <a href="#">copay</a>	Not Covered	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$75 <a href="#">copay</a> per visit	Not Covered	<a href="#">Preauthorization</a> may be required.
	Imaging (CT/PET scans, MRIs)	\$75 <a href="#">copay</a> per procedure	Not Covered	<a href="#">Preauthorization</a> may be required.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="https://exchange.communityfirstthehealthplans.com/forulary">https://exchange.communityfirstthehealthplans.com/forulary</a>	Generic drugs	\$10 <a href="#">copay</a> per prescription	Not Covered	Limited to a 30-day supply at retail (or a 90-day supply at a <a href="#">network</a> of select retail pharmacies). Up to a 90-day supply at mail order. <a href="#">Specialty drugs</a> 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. <a href="#">Preauthorization</a> may be required.
	Preferred brand drugs	\$20 <a href="#">copay</a> per prescription	Not Covered	
	Non-preferred brand drugs	\$40 <a href="#">copay</a> per prescription	Not Covered	
	<a href="#">Specialty drugs</a>	40% <a href="#">coinsurance</a>	Not Covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$75 <a href="#">copay</a> per visit	Not Covered	<a href="#">Preauthorization</a> may be required. For Outpatient Infusion Therapy, see <a href="#">policy document</a> *.
	Physician/surgeon fees	No <a href="#">copay</a>	Not Covered	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$150 <a href="#">copay</a> per visit	\$150 <a href="#">copay</a> per visit	<a href="#">Copay</a> waived if admitted.
	<a href="#">Emergency medical transportation</a>	\$150 <a href="#">copay</a> per transport	\$150 <a href="#">copay</a> per transport	<a href="#">Preauthorization</a> may be required for non-emergency and air transportation; see <a href="#">policy document</a> *.
	<a href="#">Urgent care</a>	\$15 <a href="#">copay</a> per visit	Not Covered	Outpatient Laboratory and X-Ray Services charges may also apply.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$300 <a href="#">copay</a> per admission	Not Covered	<a href="#">Preauthorization</a> required; see <a href="#">policy document</a> *.

\* 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	No <a href="#">copay</a>	Not Covered	<a href="#">Preauthorization</a> required; see policy document*.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$15 <a href="#">copay</a> per visit	Not Covered	<a href="#">Preauthorization</a> may be required; see policy document*.
	Inpatient services	\$300 <a href="#">copay</a> per admission	Not Covered	<a href="#">Preauthorization</a> required; see policy document*.
<b>If you are pregnant</b>	Office visits	\$15 <a href="#">copay</a> per visit	Not Covered	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . 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 <a href="#">copay</a>	Not Covered	
	Childbirth/delivery facility services	\$300 <a href="#">copay</a> per visit	Not Covered	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	\$30 <a href="#">copay</a> per visit	Not Covered	60 visits/year. <a href="#">Preauthorization</a> required; see policy document*.
	<a href="#">Rehabilitation services</a>	\$75 <a href="#">copay</a> per visit	Not Covered	Separate 35 visit maximum per benefit period for <a href="#">Habilitation</a> and <a href="#">Rehabilitation services</a> . <a href="#">Preauthorization</a> required; see policy document*.
	<a href="#">Habilitation services</a>	\$75 <a href="#">copay</a> per visit	Not Covered	
	<a href="#">Skilled nursing care</a>	\$150 <a href="#">copay</a> per day	Not Covered	25 days/year. <a href="#">Preauthorization</a> required; see policy document*.
	<a href="#">Durable medical equipment</a>	\$30 <a href="#">copay</a>	Not Covered	<a href="#">Preauthorization</a> required.
	<a href="#">Hospice services</a>	\$30 <a href="#">copay</a> per day	Not Covered	<a href="#">Preauthorization</a> may be required.
<b>If your child needs dental or eye care</b>	Children's eye exam	\$15 <a href="#">copay</a> per visit	Not Covered	One visit per year. See policy document* for Pediatric Vision Care Benefits.
	Children's glasses	\$15 <a href="#">copay</a>	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), \$30 copay per visit.
- Hearing aids (one hearing aid per ear every 36 months), \$30 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](http://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](http://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, kwijjigo 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copay</a>	\$30
■ Hospital (facility) <a href="#">copay</a>	\$300
■ Other <a href="#">copays</a>	\$75

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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1,100
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$1,100</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copay</a>	\$30
■ Hospital (facility) <a href="#">copay</a>	\$300
■ Other <a href="#">copays</a>	\$30

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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1,100
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,100</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copay</a>	\$30
■ Hospital (facility) <a href="#">copay</a>	\$300
■ Other <a href="#">copays</a>	\$75

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1,100
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,100</b>

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