





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 <u>deductible</u> ?	\$1,500 Individual/\$3,000 Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	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 <u>plan</u> 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 <u>plan</u> 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 <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$8,700 Individual/\$17,400 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 <u>plan</u> , 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 <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billed</u> charges, and health care this <u>plan</u> 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 <u>network provider</u> ?	Yes. See https://exchange.communityfirsthealthplans.com/network or call 1-888-512-2347 for a list of <u>participating providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . 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 <u>referral</u> to see a <u>specialist</u> ?	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)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$30 copay per visit	Not Covered	Virtual visits are available with some PCPs.
	Specialist visit	\$60 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)	25% coinsurance per test, after deductible	Not Covered	Preauthorization may be required.
	Imaging (CT/PET scans, MRIs)	25% coinsurance per test, after deductible	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	\$15 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	\$30 copay per prescription	Not Covered	
	Non-preferred brand drugs	\$60 copay per prescription	Not Covered	
	Specialty drugs	\$250 copay per prescription	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance per visit, after deductible	Not Covered	Preauthorization may also 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	25% coinsurance per visit, after deductible	25% coinsurance per visit, after deductible	Waived if admitted.
	Emergency medical transportation	25% coinsurance after deductible	25% coinsurance after deductible	Preauthorization may be required for non-emergency and air transportation; see policy document*.
	Urgent care	\$45 copay per visit	Not Covered	Outpatient Laboratory and X-Ray Services charges may also apply.
If you have a hospital	Facility fee (e.g., hospital)	25% coinsurance per	Not Covered	Preauthorization required; see policy

* 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)	
stay	room)	stay, after <u>deductible</u>		document*.
	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	\$30 <u>copay</u> per visit	Not Covered	<u>Preauthorization</u> may be required; see policy document*.
	Inpatient services	25% <u>coinsurance</u> per stay, after <u>deductible</u>	Not Covered	<u>Preauthorization</u> required; see policy document*.
If you are pregnant	Office visits	\$30 <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	25% <u>coinsurance</u> per stay, after <u>deductible</u>	Not Covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	\$60 <u>copay</u> per visit	Not Covered	60 visits/year. <u>Preauthorization</u> is required; see policy document*.
	<u>Rehabilitation services</u>	\$30 <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*.
	<u>Habilitation services</u>	\$30 <u>copay</u> per visit	Not Covered	
	<u>Skilled nursing care</u>	25% <u>coinsurance</u> per visit, after <u>deductible</u>	Not Covered	25 days/year. <u>Preauthorization</u> is required; see policy document*.
	<u>Durable medical equipment</u>	\$60 <u>copay</u>	Not Covered	<u>Preauthorization</u> required.
	<u>Hospice services</u>	\$60 <u>copay</u> per visit	Not Covered	<u>Preauthorization</u> may be required.
If your child needs dental or eye care	Children's eye exam	\$30 <u>copay</u> per visit	Not Covered	One visit per year. See benefit booklet* for Pediatric Vision Care Benefits.
	Children's glasses	\$30 <u>copay</u>	Not Covered	One pair of glasses per year. See benefit booklet* 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 .)		
<ul style="list-style-type: none">• 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 <u>medically necessary</u>)	<ul style="list-style-type: none">• 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	<ul style="list-style-type: none">• 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*.)		
<ul style="list-style-type: none">• Chiropractic care (35 visits per year), \$60 <u>copay</u> per visit.	<ul style="list-style-type: none">• Hearing aids (one hearing aid per ear every 36 months), \$60 <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	\$1,000
■ Specialist copay	\$60
■ 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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$100
Coinsurance	\$2,100
What isn't covered	
Limits or exclusions	\$0
The total Peg would pay is	\$3,700

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$1,000
■ Specialist copay	\$60
■ 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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$100
Copayments	\$1,300
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$1,400

Mia's Simple Fracture

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

■ The plan's overall deductible	\$1,000
■ Specialist copay	\$60
■ 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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$500
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,000

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