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?	No deductible	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-Network Preventive care 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 https://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?	Not applicable	This plan does not have an out-of-pocket limit on your expenses.
What is not included in the out-of-pocket limit?	Not applicable	This plan does not have an out-of-pocket limit on your expenses.
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 network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might 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.

(HHS - OMB control number: 0938-1146/Expiration date: 05/31/2026)

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	No charge	Not Covered	Virtual visits are available with some PCPs
	Specialist visit	No charge	Not Covered	Referrals not required.
	Preventive care/screening/ immunization	No charge	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 for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not Covered	Preauthorization may be required.
	Imaging (CT/PET scans, MRIs)	No charge	Not Covered	
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 (Tier 1)	No charge	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 (Tier 2)	No charge	Not Covered	
	Non-preferred brand drugs (Tier 3)	No charge	Not Covered	
	Specialty drugs (Tier 4)	No charge	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not Covered	Preauthorization may be required. For Outpatient Infusion Therapy, see policy document*.
	Physician/surgeon fees	No charge	Not Covered	Preauthorization may be required. For Outpatient Infusion Therapy, see policy document*.
If you need immediate medical attention	Emergency room care	No charge	100% coinsurance after deductible	Emergency room coinsurance waived if admitted. Preauthorization may be required for non-emergency and air transportation; see
	Emergency medical	No charge	100% coinsurance after	

[* For more information about limitations and exceptions, see the plan or policy document at https://exchange.communityfirsthealthplans.com/plan-documents/.]

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)	
	transportation		deductible	policy document*.
	Urgent care	No charge	Not Covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not Covered	Preauthorization is required; see policy document*.
	Physician/surgeon fees	No charge	Not Covered	Preauthorization is required; see policy document*.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	Not Covered	Preauthorization is required; see policy document*.
	Inpatient services	No charge	Not Covered	
If you are pregnant	Office visits	No charge	Not Covered	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply. 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 charge	Not Covered	
	Childbirth/delivery facility services	No charge	Not Covered	
If you need help recovering or have other special health needs	Home health care	No charge	Not Covered	60 visits/year. Preauthorization required; see policy document*.
	Rehabilitation services	No charge	Not Covered	35 visits/year. Preauthorization required; see policy document*.
	Habilitation services	No charge	Not Covered	
	Skilled nursing care	No charge	Not Covered	25 days/year. Preauthorization required; see policy document*.
	Durable medical equipment	No charge	Not Covered	Preauthorization is required.
	Hospice services	No charge	Not Covered	Preauthorization may be required.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Coverage limited to one exam/year. See policy document* for Pediatric Vision Care Benefits.
	Children's glasses	No charge	Not covered	Coverage limited to one pair of glasses/year.

[* For more information about limitations and exceptions, see the plan or policy document at https://exchange.communityfirsthealthplans.com/plan-documents/.]

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
				See policy document* for Pediatric Vision Care Benefits.
	Children's dental check-up	Not covered	Not covered	None

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; invitro not covered)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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), $0 copay per visit.
- Hearing aids (one hearing aid per ear every 36 months), $0 copay per hearing aid
- Accidental Dental

[* For more information about limitations and exceptions, see the plan or policy document at https://exchange.communityfirsthealthplans.com/plan-documents/.]

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/askebsa.

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? No.
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 copayment** **$0**
- **Hospital (facility) coinsurance** **0%**
- **Other copayment** **$0**

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

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 copayment** **$0**
- **Hospital (facility) coinsurance** **0%**
- **Other copayment** **$0**

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	**$0**

In this example, Joe would pay:

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

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$0**
- **Hospital (facility) coinsurance** **0%**
- **Other copayment** **$0**

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

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