




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> ?	\$3,000 individual or \$6,000 family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. In-Network <a href="#">Preventive care</a> services with a <a href="#">copayment</a> , and some prescription drugs are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://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 <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$6,400 individual / \$12,800 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
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 <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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	\$40 <a href="#">copay</a> per visit	Not Covered	Virtual visits are available with some PCPs
	<a href="#">Specialist</a> visit	\$80 <a href="#">copay</a> per visit	Not Covered	<a href="#">Referrals</a> not required.
	<a href="#">Preventive care/screening/immunization</a>	No charge	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 for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	40% <a href="#">coinsurance</a> after <a href="#">deductible</a> per test	Not Covered	<a href="#">Preauthorization may be required.</a>
	Imaging (CT/PET scans, MRIs)	40% <a href="#">coinsurance</a> after <a href="#">deductible</a> per test	Not Covered	
<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.communityfirsthealthplans.com/formulary">https://exchange.communityfirsthealthplans.com/formulary</a>	Generic drugs (Tier 1)	\$20 <a href="#">copay</a> /30-day supply	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)	\$40 <a href="#">copay</a> /30-day supply	Not Covered	
	Non-preferred brand drugs (Tier 3)	\$80 <a href="#">copay</a> after <a href="#">deductible</a> /30-day supply	Not Covered	
	<a href="#">Specialty drugs</a> (Tier 4)	\$350 <a href="#">copay</a> after <a href="#">deductible</a> /30-day supply	Not Covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	40% <a href="#">coinsurance</a> after <a href="#">deductible</a> per visit	Not Covered	<a href="#">Preauthorization</a> may be required. For Outpatient Infusion Therapy, see policy document*.
	Physician/surgeon fees	40% <a href="#">coinsurance</a>	Not Covered	<a href="#">Preauthorization</a> may be required. For Outpatient Infusion Therapy, see policy document*.
<b>If you need immediate</b>	<a href="#">Emergency room care</a>	40% <a href="#">coinsurance</a> after	40% <a href="#">coinsurance</a>	Emergency room coinsurance waived if

[\* For more information about limitations and exceptions, see the [plan](#) or policy document at [https://exchange.communityfirsthealthplans.com/plan-documents/.](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)	
medical attention		<a href="#">deductible</a>		admitted. <a href="#">Preauthorization may be required for non-emergency and air transportation; see policy document*</a> .
	<a href="#">Emergency medical transportation</a>	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	40% <a href="#">coinsurance</a>	
	<a href="#">Urgent care</a>	\$60 <a href="#">copay</a> per visit	Not Covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	<a href="#">Preauthorization</a> is required; see policy document*.
	Physician/surgeon fees	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	<a href="#">Preauthorization</a> is required; see policy document*.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$40 <a href="#">copay</a> per visit	Not Covered	<a href="#">Preauthorization</a> is required; see policy document*.
	Inpatient services	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	
If you are pregnant	Office visits	\$40 <a href="#">copay</a>	Not Covered	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">coinsurance</a> 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 copay	Not Covered	
	Childbirth/delivery facility services	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	\$80 <a href="#">copay</a>	Not Covered	60 visits/year. <a href="#">Preauthorization required; see policy document*</a> .
	<a href="#">Rehabilitation services</a>	\$40 copay	Not Covered	35 visits/year. <a href="#">Preauthorization required; see policy document*</a> .
	<a href="#">Habilitation services</a>	\$40 <a href="#">copay</a>	Not Covered	
	<a href="#">Skilled nursing care</a>	40% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not Covered	25 days/year. <a href="#">Preauthorization required; see policy document*</a> .
	<a href="#">Durable medical equipment</a>	\$80 <a href="#">copay</a>	Not Covered	<a href="#">Preauthorization</a> is required.
	<a href="#">Hospice services</a>	\$80 <a href="#">copay</a>	Not Covered	<a href="#">Preauthorization</a> may be required.
If your child needs	Children's eye exam	\$40 <a href="#">copay</a> per visit	Not covered	Coverage limited to one exam/year. See policy document* for Pediatric Vision Care

[\* 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)	
dental or eye care				Benefits.
	Children's glasses	\$40 copay	Not covered	Coverage limited to one pair of glasses/year. 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), \$80 copay per visit.
- Hearing aids (one hearing aid per ear every 36 months), \$80 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](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? 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, 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.*

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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](#) \$3,000
- [Specialist copayment](#) \$80
- Hospital (facility) [coinsurance](#) 40%
- Other [copayment](#) \$40

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:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$3,000
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$2,800
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$6,000</b>

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$3,000
- [Specialist copayment](#) \$80
- Hospital (facility) [coinsurance](#) 40%
- Other [copayment](#) \$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*)

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

<i>Cost Sharing</i>	
<a href="#">Deductibles*</a>	\$100
<a href="#">Copayments</a>	\$1,600
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,700</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$3,000
- [Specialist copayment](#) \$80
- Hospital (facility) [coinsurance](#) 40%
- Other [copayment](#) \$40

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:

<i>Cost Sharing</i>	
<a href="#">Deductibles*</a>	\$1,500
<a href="#">Copayments</a>	\$700
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,200</b>

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