

 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, call 1-877-698-7032 or visit members.cfhp.com. 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 www.cfhp.com or call 1-877-698-7032 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$0 individual / \$0 family	See the chart starting on page 2 for your costs for services this plan covers.
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> services 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.
Are there other <u>deductibles</u> for specific services?	Yes. \$50 per person for prescription drug expenses. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$6,750 person / \$13,500 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>Copayments</u> for certain services, <u>premiums</u> , <u>balance billing</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 www.cfhp.com or call 1-877-698-7032 for a list of <u>network providers</u> .	This <u>plan</u> uses a provider <u>network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> 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> .

Questions: Call (877) 698-7032 for Customer Service or visit us at members.cfhp.com. If you aren't clear about any of the underlined or bolded terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or www.cciio.cms.gov or call 1-877-698-7032 to request a copy.

 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	\$25 <u>copayment</u> /visit	Not Covered	-----None-----
	<u>Specialist</u> visit	\$40 <u>copayment</u> /visit	Not Covered	-----None-----
	<u>Preventive care/screening/immunization</u>	No Charge	Not Covered	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u> /test	Not Covered	-----None-----
	Imaging (CT/PET scans, MRIs)	\$100 <u>copayment</u> plus 20% <u>coinsurance</u> /test	Not Covered	<u>Preauthorization</u> may be required. Failure to obtain <u>preauthorization</u> may increase your cost.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.cfhp.com	Generic drugs	\$10 <u>copayment</u> /prescription (maintenance) \$10 <u>copayment</u> /prescription (non-maintenance) \$30 <u>copayment</u> /prescription (mail order or extended day supply)	Not Covered	<u>Preauthorization</u> may be required. Failure to obtain <u>preauthorization</u> may increase your cost.
	Preferred brand drugs	\$35 <u>copayment</u> /prescription (non-maintenance) \$45 <u>copayment</u> /prescription (maintenance) \$105 <u>copayment</u> /prescription (mail order or extended day supply)	Not Covered	<u>Preauthorization</u> may be required. Failure to obtain <u>preauthorization</u> may increase your cost. Note: If a generic drug is available and you choose to buy the preferred brand drug, you will pay the generic <u>copayment</u> plus the cost difference between the preferred brand drug and the generic drug.
	Non-preferred brand drugs	\$60 <u>copay</u> (non-maintenance) \$75 <u>copay</u> (maintenance) \$180 <u>copay</u> (mail order)	Not Covered	<u>Preauthorization</u> may be required. Failure to obtain <u>preauthorization</u> may increase your cost. Note: If a generic drug is available and you choose to buy the preferred brand drug, you will pay the generic <u>copayment</u> plus the cost

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)	
		or extended day supply)		difference between the preferred brand drug and the generic drug.
	<u>Specialty drugs</u>	If purchased through a pharmacy, the pharmacy benefit applies, otherwise, covered as a medical benefit	Not Covered	<u>Preauthorization</u> may be required. Failure to obtain <u>preauthorization</u> may increase your cost.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$100 <u>copayment</u> plus 20% <u>coinsurance</u>	Not Covered	<u>Preauthorization</u> may be required. Failure to obtain <u>preauthorization</u> may increase your cost.
	Physician/surgeon fees	20% <u>coinsurance</u>	Not Covered	-----None-----
If you need immediate medical attention	<u>Emergency room care</u>	\$150 <u>copayment</u> plus 20% <u>coinsurance</u>	\$150 <u>copayment</u> plus 20% <u>coinsurance</u>	If admitted, <u>copayment</u> is applied to inpatient hospital <u>copay</u> .
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	-----None-----
	<u>Urgent care</u>	\$50 <u>copayment</u> plus 20% <u>coinsurance</u>	Not Covered	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	\$150/day <u>copayment</u> per admission plus 20% <u>coinsurance</u>	Not Covered	\$750 <u>copayment</u> max per admission. \$2,250 <u>copay</u> max per plan year per person. <u>Preauthorization</u> may be required. Failure to obtain <u>preauthorization</u> may increase your cost.
	Physician/surgeon fees	20% <u>coinsurance</u>	Not Covered	-----None-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <u>copayment</u> /visit	Not Covered	-----None-----
	Inpatient services	\$150/day <u>copayment</u> per admission plus 20% <u>coinsurance</u>	Not Covered	\$750 <u>copayment</u> max per admission. \$2,250 <u>copay</u> max per plan year per person. <u>Preauthorization</u> may be required. Failure to obtain <u>preauthorization</u> may increase your cost.
If you are pregnant	Office visits	Prenatal: No Charge Postnatal: \$25 PCP <u>copayment</u> ; \$40 specialist <u>copayment</u>	Not Covered	No charge for network prenatal office visits or obstetrician delivery.
	Childbirth/delivery professional services	No Charge	Not Covered	-----None-----
	Childbirth/delivery facility services	\$150/day <u>copayment</u> per admission plus 20%	Not Covered	\$750 <u>copayment</u> max per admission. \$2,250 <u>copay</u> max per plan year per person. <u>Preauthorization</u>

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)	
		<u>coinsurance</u>		may be required. Failure to obtain <u>preauthorization</u> increase your cost.
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u>	Not Covered	<u>Preauthorization</u> may be required. Failure to obtain <u>preauthorization</u> may increase your cost.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u> without office visit, \$40 plus 20% <u>coinsurance</u> with office visit	Not Covered	<u>Preauthorization</u> may be required. Failure to obtain <u>preauthorization</u> may increase your cost.
	<u>Habilitation services</u>	20% <u>coinsurance</u>	Not Covered	-----None-----
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	Not Covered	<u>Preauthorization</u> may be required. Failure to obtain <u>preauthorization</u> may increase your cost.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	Not Covered	<u>Preauthorization</u> may be required. Failure to obtain <u>preauthorization</u> may increase your cost.
	<u>Hospice services</u>	20% <u>coinsurance</u>	Not Covered	<u>Preauthorization</u> may be required. Failure to obtain <u>preauthorization</u> may increase your cost.
If your child needs dental or eye care	Children's eye exam	\$40 <u>copayment</u> /visit	Not Covered	Limit of one routine exam per plan year per person. One <u>preventive</u> care visual acuity screening covered with no <u>copayment</u> at <u>network</u> provider.
	Children's glasses	Varies, \$125 allowance	Not Covered	Limit of one pair per every 24 months per person.
	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.)

- | | | |
|---|--|---|
| <ul style="list-style-type: none"> • Acupuncture • Artificial insemination • Bariatric surgery • Cosmetic surgery | <ul style="list-style-type: none"> • Dental check-up • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none"> • Personal comfort items • Routine foot care • Weight loss programs |
|---|--|---|

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

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|--|--|---|
| <ul style="list-style-type: none"> • Chiropractic care • Hearing aids (limited to \$1,000 per ear per 36-month period) Eligible minors 18 and under are not subject to \$1,000 hearing aid maximum | <ul style="list-style-type: none"> • Private duty nursing | <ul style="list-style-type: none"> • Routine eye exams |
|--|--|---|

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 1-877-698-7032, or members.cfhp.com; the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272, or www.dol.gov/ebsa; or the U.S. Department of Health and Human Services at 1-877-267-2323 X61565, or www.cciio.cms.gov. 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 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

P.O. Box 149104

Austin, TX 78714-9104

Fax 1-512-475-1771

Web: <http://www.tdi.state.tx.us>

E-Mail: ConsumerProtection@tdi.state.tx.us.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

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 1-877-698-7032.

Vietnamese (Tiếng Việt): Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. 1-877-698-7032

Korean (한국어): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-698-7032 번으로 전화해 주십시오.

Arabic (العربية): 1-877-698-7032 برقم اتصالات مجاني لتوافر الخدمات المساعدة لخدمات فإن اللغة، كراذت تحدث كنت إذا ملحوظة 1-877-698-7032

Urdu (اُردُو): 1-877-698-7032 کال۔ پین دس تیاں میں مفت خدمات کی مدد کی زبان کو آپتو دہیں، بولتے اردو آپ اگر بخ بردار (اُردُو)

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-698-7032

French (Français): Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-698-7032

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-877-698-7032

Hindi (हिंदी): ध्यान दें: यदि आप हठी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-698-7032

Farsi (فارسی): 1-877-698-7032 شما برای رایگان به صورت زبانی تسهیلات کنید، میگویند فارسی زبان به اگر بوجه: (فارسی)

German (Deutsch): Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer 1-877-698-7032

Gujarati (ગુજરાતી): યુના: જો તમેજરાતી બોલતા હો, તો નિ:લઙ્કુ ભાષા સહાય સેવાઓ તમારા માટેઉપલબ્ધ છ. ફોન કરો 1-877-698-7032

Russian (Русский): Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-698-7032

Japanese (日本語): 注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。1-877-698-7032

Lao (ພາສາລາວ): ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ມັນມີຮ່ວມໃຫ້ທ່ານ. ໂທ 1-877-698-7032

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 \$40
- Hospital (facility) copayment and coinsurance \$150/day copay + 20% coinsurance
- Other coinsurance 20%

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	\$10,284
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$340
Coinsurance	\$2,000
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Peg would pay is	\$2,340

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 \$40
- Hospital (facility) copayment and coinsurance \$150/day copay + 20% coinsurance
- Other coinsurance 20%

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	\$5,877
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$50
Copayments	\$1,000
Coinsurance	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$1,510

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

- The plan's overall deductible \$0
- Specialist copayment \$40
- Hospital (facility) copayment and coinsurance \$150/day copay + 20% coinsurance
- Other coinsurance 20%

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	\$1,447
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$30
Copayments	\$200
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$430