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 210-358-6090 or visit https://commercial.communityfirsthealthplans.com / For general definitions of common terms, such as allowed amount, balance billing, co-insurance, co-payment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://commercial.communityfirsthealthplans.com / or call 210-358-6090 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$0** UH Network; **$625** Individual/**$1,250** Family First Health Network, now available Nationwide	See the chart starting on page 2 for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No.	You will have to meet the deductible before the plan pays for any services. UH Network does not have a deductible.
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?	**$0** UH Network; **$5,000**/Individual, **$10,000**/Family First Health Network	The out-of-pocket limit 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 out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Co-payments for certain services, premiums, balance-billing charges, and for health care this plan does not cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. Utilizing a UH Network provider eliminates co-insurance & deductibles compared to utilizing the First Health Network. See https://commercial.communityfirsthealthplans.com / or call 1- 800-434-2347 for a list of providers.	You will pay more if you use a First Health Network provider, as you are subject to balance billing which is the difference between the providers' charge and what the plan pays. Be advised, your First Health Network Provider might use an out-of-network provider for some services such as lab work. Check with your provider before obtaining services.
Do you need a referral to see a specialist?	The UH Network requires a referral from your PCP. A referral is not needed to see an OBGYN, Mental Health or Behavioral Health Provider. You do not need a referral for the First Health Network.	The UH Network will pay some or all of the costs to see a specialist for covered services if a referral is obtained by their PCP prior to the service.

Some co-payments and co-insurances in the chart below will require you to meet the deductible first

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		UH Network Provider	First Health Network Provider	
If you visit a health care provider's office or clinic:	Primary care visit to treat an injury or illness	$15 co-payment /visit	30% co-insurance after deductible	----------None----------
	Specialist visit	$15 co-payment /visit	30% co-insurance after deductible	----------None----------
	Preventive care/screening/ immunization	No charge	30% co-insurance after deductible	----------None----------
If you have a test:	Diagnostic test (x-ray, blood work)	No charge	30% co-insurance after deductible	Outpatient only.
	Imaging (CT/PET scans, MRIs)	No charge	30% co-insurance after deductible	Outpatient only.
If you need drugs to treat your illness or condition, more information about **prescription drug coverage** is available at https://commercial.communityfirsthealthplans.com /	Generic drugs – Tier 1	No co-payment	$20 co-payment per prescription (retail); 30 day $40 co-payment per prescription (mail order); 90 day	Co-payment waived if prescription is filled at a University Health Pharmacy or qualifies under Mail Order.
	Preferred brand drugs - Tier 2	No co-payment	$40 co-payment per prescription (retail); 30 day $60 co-payment per prescription (mail order); 90 day	Co-payment waived if prescription is filled at a University Health Pharmacy or qualifies under Mail Order.
	Non-Preferred brand drugs or Specialty drugs – Tier 3	No co-payment	$60 co-payment per prescription (retail); 30 day $100 co-payment per prescription (mail order); 90 day	Co-payment waived if prescription is filled at a University Health Pharmacy or qualifies under Mail Order.
If you have outpatient surgery:	Facility fee (e.g., ambulatory surgery center) Physician/surgeon fees	$100 co-payment/ visit No charge	30% co-insurance after deductible 30% co-insurance after deductible	Pre-authorization required if outside of UH. Pre-authorization required if non-UH physician.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		UH Network Provider	First Health Network Provider	
If you need immediate medical attention:	Emergency room care	$100 co-payment/visit	30% co-insurance after deductible	Emergency Room co-pay is waived under UH Family Network, if admitted.
	Emergency medical transportation	Plan will pay up to $1,500 of the Usual and Customary	Plan will pay up to $1,500 of the Usual and Customary	Community First will pay for Emergency Transportation services performed by non-participating Providers at the negotiated or usual and customary rate. Member may be responsible for balance of billed charges, if any.
	Urgent care	$20 co-payment/ incident	30% co-insurance after deductible	UH Express Med Clinics are the only urgent care facilities covered under the UH Network.
If you have a hospital stay:	Facility fee (e.g., hospital room)	$100 co-payment/day	30% co-insurance after deductible	Pre-authorization required if outside UH. Co-payment required for each day with a $500 maximum for each confinement under the UH Network.
	Physician/surgeon fees	No charge	30% co-insurance after deductible	----------None----------
If you need mental health, behavioral health, or substance abuse services:	Outpatient services	$15 co-payment/visit	30% co-insurance after deductible	----------None----------
	Inpatient services	$100 co-payment/day	30% co-insurance after deductible	Co-payment required for each day with a $500 maximum for each admission under the UH Network.
If you are pregnant:	Office visits	$15 co-payment/first visit	30% co-insurance after deductible	No charge after first visit.
	Childbirth/delivery professional services	No charge	30% co-insurance after deductible	----------None----------
	Childbirth/delivery facility services	$100 co-payment/day	30% co-insurance after deductible	Pre-authorization required $500 maximum per confinement for UH Network.
If you need help recovering or have other special health needs:	Home health care	No charge	30% co-insurance after deductible	60 day maximum per year. Lifetime maximum $10,000.
	Rehabilitation services	$15 co-payment/visit	30% co-insurance after deductible	Physical therapy 60 visits/year; Occupational therapy 60 visits/year; Speech and hearing therapy 60 visits/year; Pulmonary therapy 20 visits/year; Cardiac rehabilitation therapy 36 visits/year.
	Habilitation services	Not covered	Not covered	----------None----------
	Skilled nursing care	$15 co-payment/day	30% co-insurance after deductible	Up to 60 days per condition/year including semi-private room, lab and X-ray.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		UH Network Provider	First Health Network Provider	
	Durable medical equipment	No charge	30% co-insurance after deductible	Prostheses, $10,000 limit/occurrence; Cochlear implant, $500/occurrence.
	Hospice services	No charge	30% co-insurance after deductible	Lifetime maximum $10,000.
If you need dental or eye care:	Eye exam	$10 co-payment/visit	Not covered	One per year.
	Glasses	Varies, $125 allowance	Not covered	One pair per every 24 months.
	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.)

- Acupuncture
- Artificial insemination
- Cosmetic surgery
- Dental care (Adult)
- In vitro fertilization
- Non-emergency care when traveling Nationwide
- Private-duty nursing
- Weight loss programs
- Weight loss programs

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

- Bariatric surgery
- Hearing aids
- Chiropractic Care
- Infertility treatment
- Long-term care
- Routine eye care
- Routine foot care

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 the agencies are Community First Health Plans at 1-800-434-2347, or https://commercial.communityfirsthealthplans.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 Complaint and Appeals Rights: If you have a complaint, call the health plan. Your plan documents also provide complete information to submit a claim, appeal, or a complaint for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

Community First Health Plans
Member Services & Resolution Unit
12238 Silicon Drive, Suite 100
San Antonio, Texas 78249
Phone: 210.358.6090
Web: https://commercial.communityfirsthealthplans.com /

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 1-800-434-2347.
Vietnamese (Tiếng Việt): Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.1-800-434-2347
Korean (한국어): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-434-2347 번으로 전화해 주십시오.
1- Arabic (العربية): 1-800-434-2347 ملحوظة: إذا تتحدث كنت اللغة اذكر، فإن اللغوية المساعدة خدمات تتوافر لك بالمجان. برقم اتصل
1-800- Urdu (اُردُو): 800-434-2347 کال ۔ ہیں دستیاب میں مفت خدمات کی مدد کی زبان کو آپ تو ،ہیں بولتے اردو آپ اگر :خبردار
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 434-2347
French (Français): Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-434-2347
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-434-2347
Hindi (हिंदी): ध्यान द: यद आप हद बोलते ह तो आपके लए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह। 1-800-434-2347 Farsi (فارسی): توجه: اگر بهزبان شما برای رایگان بصورت زبانی تسهیلات، کنید می گفتگو فارسی 1-800-434-2347
German (Deutsch): Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer 1-800-434-2347
Gujarati (ગુજરાતી): ધ્ય: જો તમેગુજરાતી બોલતા હો, તો ન:લ્ુ ભાષા સહાય સેવાઓ તમારા માટઉપલબ્ધ છ. ફોન કરો 1-800-434-2347
Russian (Русский): Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.Звоните 1-800-434-2347
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。1-800-434-2347
Lao (ພາສາລາວ): ໂປດຊາບ: ຖ້າ ທ່ ານ ເວ້ົ າພາສາ ລາວ, ການບໍ ລກການຊ່ ວຍເຫ ຼ ອດ້ ານພາສາ, ໂດຍບ ໍ ເສ ັ ສ ຽ ຄ່ າ, ມ ່ ນມ ີ ພ ້ ອມໃຫ ້ ທ ່ ານ. ໂທ1-800-434-2347

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, co-payments and co-insurance) 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 co-payment:** **$15**
- **Hospital co-payment:** **$100/day**
- **Other co-insurance:** **$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:	**$7,540**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Co-payments	$200
Co-insurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is:	**$260**

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 co-payment:** **$15**
- **Hospital co-payment:** **$100/day**
- **Other co-insurance:** **$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:	**$5,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Co-payments	$600
Co-insurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is:	**$660**

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

- **The plan's overall deductible:** **$0**
- **Specialist co-payment:** **$15**
- **Hospital co-payment:** **$100/day**
- **Other co-insurance:** **$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:	**$1,720**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Co-payments	$300
Co-insurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is:	**$300**

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