



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.cfhp.com or by calling 1-888-512-2347.

Important Questions	Answers	Why this Matters:
What is the overall deductible ?	\$ 1,500 individual; \$ 3,000 family Does not apply to preventive care and preventive drugs.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. \$6,000 family unit	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit ?	Premiums, copayments for prescription drugs and infertility testing and treatment are not applicable to any annual out-of-pocket maximums.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers ?	Yes. See www.cfhp.com or call 1-888-512-2347 for a list of participating providers.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a specialist ?	No.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about excluded services .

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- Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$25 copay	Not covered	_____none_____
	Specialist visit	\$50 copay	Not covered	_____none_____
	Other practitioner office visit	\$25 copay	Not covered	_____none_____
	Preventive care/screening/immunization	No charge	Not covered	_____none_____
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance	Not covered	_____none_____
	Imaging (CT/PET scans, MRIs)	15% coinsurance	Not covered	_____none_____

Community First Health Plans: CommunityFirst Premier Coverage Period: Beg on/after 01/01/2014

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual & Family | **Plan Type:** HMO

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
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	\$20 copay/prescription (retail); \$40 copay/prescription (mail order)	Not covered	_____none_____
	Preferred brand drugs	\$40 copay/prescription (retail); \$80 copay/prescription (mail order)	Not covered	_____none_____
	Non-preferred brand drugs	\$60 copay/prescription (retail); \$180 copay/prescription (mail order)	Not covered	_____none_____
	Specialty drugs	40% coinsurance	Not covered	_____none_____
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	Not covered	_____none_____
	Physician/surgeon fees	15% coinsurance	Not covered	_____none_____
If you need immediate medical attention	Emergency room services	\$150 copay	\$150 copay	_____none_____
	Emergency medical transportation	15% coinsurance	15% coinsurance after deductible	_____none_____
	Urgent care	\$50 copay	Not covered	_____none_____
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	Not covered	_____none_____
	Physician/surgeon fee	15% coinsurance	Not covered	_____none_____

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Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual & Family | **Plan Type:** HMO

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$50 copay	Not covered	_____none_____
	Mental/Behavioral health inpatient services	15% coinsurance	Not covered	_____none_____
	Substance use disorder outpatient services	\$50 copay	Not covered	_____none_____
	Substance use disorder inpatient services	15% coinsurance	Not covered	_____none_____
If you are pregnant	Prenatal and postnatal care	\$50 first visit	Not covered	No charge after first visit.
	Delivery and all inpatient services	15% coinsurance	Not covered	_____none_____
If you need help recovering or have other special health needs	Home health care	15% coinsurance	Not covered	60 visits per year.
	Rehabilitation services	15% coinsurance	Not covered	35 visits per year.
	Habilitation services	15% coinsurance	Not covered	35 visits per year.
	Skilled nursing care	15% coinsurance	Not covered	25 visits per year.
	Durable medical equipment	15% coinsurance	Not covered	_____none_____
	Hospice service	15% coinsurance	Not covered	_____none_____
If your child needs dental or eye care	Eye exam	15% coinsurance	Not covered	One per year.
	Glasses	15% coinsurance	Not covered	One pair per year.
	Dental check-up	Not covered	Not covered	_____none_____

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn’t a complete list. Check your policy or plan document for other excluded services.)

- | | | |
|-----------------------|--|----------------------------|
| • Acupuncture | • Long-term care | • Routine eye care (Adult) |
| • Bariatric surgery | • Non-emergency care when traveling outside the U.S. | • Weight loss programs |
| • Dental care (Adult) | • Private-duty nursing | |

Other Covered Services (This isn’t a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- | | | |
|---------------------|--|---|
| • Chiropractic care | • Infertility treatment (diagnosis only covered) | • Except in the case of a true emergency, coverage provided outside the United States is not available. |
| • Cosmetic surgery | • Routine foot care | |
| • Hearing Aids | | |

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-512-2347. You may also contact your state insurance department, 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.

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Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact:

Member Services
Community First Health Plans
12238 Silicon Drive, Suite 100
San Antonio, TX 78249

You may contact the Texas Department of
Insurance to obtain information on companies,
Coverages, rights or complaints at 1-800-252-3439

You may write the Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104
Fax (512) 475-1771
Web: <http://www.tdi.state.tx.us> E-Mail: ConsumerProtection@tdi.state.tx.us

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-512-2347.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$5,084
- Patient pays \$2,456

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$1,500
Copays	\$50
Coinsurance	\$906
Limits or exclusions	\$3,000
Total	\$2,456

Note: These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your cost may be higher. For more information, please contact: Preventive Health Unit at 1-888-512-2347

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$3,220
- Patient pays \$2,180

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$1,500
Copays	\$200
Coinsurance	\$480
Limits or exclusions	\$3,000
Total	\$2,180

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact: Preventive Health Unit at 1-888-512-2347

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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