**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 1-855-315-5386 or https://www.communityhealthchoice.org/health-insurance-marketplace/know-the-details-2027/. 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.cciio.cms.gov or call 1-855-315-5386 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $7,500 / individual; $15,000 / family | 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. Preventive care, Urgent Care, Mental/Behavioral Health and Substance Use Disorder services, and generic 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/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?** | $12,000 / individual; $24,000 / family | 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?** | Premiums, balance-billing charges, and health care this plan doesn't 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. See Find A Provider or call 1-855-315-5386 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. |

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 | $50 copay; deductible does not apply | Not covered | None |
| | Specialist visit | $100 copay; deductible does not apply | Not covered | None |
| | Preventive care/screening/ immunization | No charge; deductible does not apply | 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) | 50% coinsurance | Not covered | None |
| | Imaging (CT/PET scans, MRIs) | 50% coinsurance | Not covered | Requires preauthorization for certain services. Failure to obtain an authorization may result in denial of benefits. |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at https://www.communityhealthchoice.org/wp-content/uploads/202606/formulary-select-2027.pdf | Generic drugs | $25 copay/prescription (retail); $62.50 copay/prescription (mail order); deductible does not apply | Not covered | Covers up to 30-day supply (retail). Covers up to 90-day supply (mail order). Please refer to formulary for cost share tiers. Tier 2 includes preferred generics and some lower cost brand products. |
| | Preferred brand drugs | $50 copay/prescription (retail); $125 copay/prescription (mail order) | Not covered | Covers up to 30-day supply (retail). Covers up to 90-day supply (mail order). Preauthorization may be required for a branded medication when the generic equivalent is preferred on the formulary. Failure to obtain preauthorization to show medical necessity may increase your costs. Note: If a generic drug is available and you choose to buy the preferred brand drug, you will pay the generic copay plus the cost difference between the preferred and |

* For more information about limitations and exceptions, see the plan or policy document at https://www.communityhealthchoice.org/wp-content/uploads/2026/06/eoc-deductible-ultra-select-2027.pdf

| 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) | |
| | | | | generic. Tier 3 includes high cost generics and preferred brand. |
| | Non-preferred brand drugs | $100 copay/prescription (retail); $250 copay/prescription (mail order) | Not covered | Covers up to 30-day supply (retail). Covers up to 90-day supply (mail order). Tier 4 includes non-preferred formulary products (can include non-preferred generic products). |
| | Specialty drugs | $500 copay/prescription (retail) | Not covered | Covers up to 30-day supply (retail) Tier 5 includes specialty drugs. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 50% coinsurance | Not covered | Requires preauthorization for certain services, failure to obtain preauthorization may result in denial of benefits. |
| | Physician/surgeon fees | 50% coinsurance | Not covered | None |
| **If you need immediate medical attention** | Emergency room care | 50% coinsurance | 50% coinsurance | None |
| | Emergency medical transportation | $100 copay/transportation | Not covered | Requires preauthorization for certain services such as air transportation, non-emergency ground transportation, facility-to-facility transfers, out-of-network and out of area transfers. |
| | Urgent care | $75 copay/visit; deductible does not apply | Not covered | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 50% coinsurance | Not covered | Requires preauthorization for certain services, failure to obtain preauthorization may result in denial of benefits. |
| | Physician/surgeon fees | 50% coinsurance | Not covered | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $50 copay/office visit; deductible does not apply. 50% coinsurance for other outpatient services | Not covered | Requires preauthorization for certain services, failure to obtain preauthorization may result in denial of benefits. Depending on type of service, a copayment or coinsurance may apply. |

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| 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) | |
| | Inpatient services | 50% coinsurance | Not covered | Requires preauthorization for certain services, failure to obtain preauthorization may result in denial of benefits. |
| **If you are pregnant** | Office visits | $100 copay/occurrence | Not covered | Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. |
| | Childbirth/delivery professional services | 50% coinsurance | Not covered | Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Requires preauthorization for certain services, failure to obtain preauthorization may result in denial of benefits. Depending on the type of services, a copayment or coinsurance may apply. |
| | Childbirth/delivery facility services | 50% coinsurance | Not covered | |
| **If you need help recovering or have other special health needs** | Home health care | $100 copay | Not covered | Requires preauthorization for certain services, failure to obtain preauthorization may result in denial of benefits. Limited to 60 visits per year. |
| | Rehabilitation services | $75 copay/visit; deductible does not apply | Not covered | Requires preauthorization for certain services, failure to obtain preauthorization may result in denial of benefits. |
| | Habilitation services | $50 copay/visit; deductible does not apply | Not covered | Requires preauthorization for certain services, failure to obtain preauthorization may result in denial of benefits. |
| | Skilled nursing care | 50% coinsurance | Not covered | Requires preauthorization for certain services, failure to obtain preauthorization may result in denial of benefits. Limited to 25 days per year. |
| | Durable medical equipment | 30% coinsurance | Not covered | Requires preauthorization for certain services, failure to obtain preauthorization may result in denial of benefits. Limited to |

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| 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) | |
| | | | | plan requirements. |
| | Hospice services | $100 copay/day<br>50% coinsurance in an inpatient setting | Not covered | Depending on the type of services, a copayment or coinsurance may apply. Limited to plan requirements. |
| **If your child needs dental or eye care** | Children's eye exam | $100 copay | Not covered | One routine eye exam annually. |
| | Children's glasses | $100 copay | Not covered | For select frames, standard lenses, and contact lenses only, for children 18 years old and younger. Limited to plan requirements. |
| | 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 with exception of limited services
- Acupuncture
- Bariatric surgery
- Children's dental check-up
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (inpatient)
- Routine eye care (Adult)
- 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.)**

- Chiropractic care (35 visits per year)
- Hearing aids (each ear, every three years)

**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: Texas Department of Insurance, 333 Guadalupe, Austin TX 78701 at 1-800-578-4677 or the issuer at 1-855-315-5386. 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, 333 Guadalupe Austin, TX 78701 or 1-800-578-4677.

* For more information about limitations and exceptions, see the plan or policy document at https://www.communityhealthchoice.org/wp-content/uploads/2026/06/eoc-deductible-ultra-select-2027.pdf

**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? Not Applicable.**
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 Assistance:**
Community Health Choice is committed to providing high-quality, accessible healthcare services to a diverse population. Community Health Choice offers translated materials and interpretation services to ensure clear and effective communication with all members, regardless of their primary language. Community Health Choice trains staff to be mindful of cultural differences in communication styles, body language, and decision-making processes. Community Health Choice provides oral and written notice to consumers with limited English proficiency (LEP) in their preferred language informing them of their right to receive language assistance services and how to get them.

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-315-5386.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-315-5386.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-855-315-5386.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-315-5386.

*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** | **$7,500** |
| **Specialist copayment** | **$100** |
| **Hospital (facility) coinsurance** | **50%** |
| **Other coinsurance** | **50%** |

**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 | $7,500 |
| Copayments | $0 |
| Coinsurance | $2,500 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$10,060** |

### Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| **The plan's overall deductible** | **$7,500** |
| **Specialist copayment** | **$100** |
| **Hospital (facility) coinsurance** | **50%** |
| **Other coinsurance** | **50%** |

**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** | **$5,600** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $4,000 |
| Copayments | $700 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$4,720** |

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

| | |
|---|---|
| **The plan's overall deductible** | **$7,500** |
| **Specialist copayment** | **$100** |
| **Hospital (facility) coinsurance** | **50%** |
| **Other coinsurance** | **50%** |

**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 | $2,100 |
| Copayments | $500 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,600** |

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