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 visit www.communityhealthchoice.org/en-us/plans-benefits/marketplace/know-the-details-2019/. 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.healthcare.gov/sbc-glossary or call 1-855-315-5386 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes, Preventive Services and Generic Drugs	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 www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes, $400 per person | $800 per family for prescription drug coverage. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	$6,300 per person | $12,600 per 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, healthcare this plan doesn't cover and out-of-network services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.The out-of-pocket limit is the most you could pay in a year for covered services.
Will you pay less if you use a network provider?	Yes. See https://providersearch.communityhealthchoice.org or call 1-855-315-5386 for a list of Preventive Services and Generic Drugs	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?	Yes	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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: Participating Provider (You will pay the least)	What You Will Pay: Non-Participating Provider (You will pay the most)	Limitation, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$40 Copay/visit	Not Covered	-----None-----
	Specialist visit	$75 Copay/visit	Not Covered	-----None-----
	Preventive care/ screening/ immunization	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$40 Copay/visit	Not Covered	-----None-----
	Imaging (CT/PET scans, MRIs)	$500 Copay/test	Not Covered	Preauthorization is required. Failure to obtain an authorization may result in reduction of denial of benefits.

Common Medical Event	Services You May Need	What You Will Pay		Limitation, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://www.communityhealthchoice.org/media/2173/formulary-2019.pdf	Generic drugs	$30 Copay/prescription(retail) $75 Copay/prescription(mail order)	Not covered	Covers up to 30 day supply (retail). Covers up to 90 day supply (mail order). Pharmacy deductible does not apply.
	Preferred brand drugs	$105 Copay after deductible/prescription(retail) $262.50 Copay after deductible/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 generic.
	Non-preferred brand drugs	$120 Copay after deductible/prescription(retail) $300 Copay after deductible/prescription(mail order)	Not covered	Covers up to 30 day supply (retail). Covers up to 90 day supply (mail order)
	Specialty drugs	50% Coinsurance after deductible/prescription(retail)	Not covered	Covers up to 30 day supply (retail)

Common Medical Event	Services You May Need	What You Will Pay		Limitation, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$600 Copay/visit	Not Covered	Requires preauthorization for certain services, failure to obtain preauthorization may result in reduction or denial of benefits.
	Physician/surgeon fees	$600 Copay/visit	Not Covered	-----None-----
If you need immediate medical attention	Emergency room care	$800 Copay/visit	$800 Copay/visit	Copayment waived if admitted to hospital. Inpatient copay applies up to 5 days.
	Emergency Medical transportation	$75 Copay/transportation	$75 Copay/transportation	-----None-----
	Urgent Care	$75 Copay/visit	Not Covered	-----None-----
If you have a hospital stay	Facility fee (e.g., hospital room)	$800 Copay/day	Not Covered	Requires preauthorization for certain services, failure to obtain preauthorization may result in reduction or denial of benefits. Copayment applies per day up to 5 days of inpatient stay
	Physician/surgeon fees	$0 Copay	Not Covered	-----None-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$40 Copay/office visit and $600 Copay/visit for other outpatient services	Not Covered	Requires preauthorization for certain services, failure to obtain preauthorization may result in reduction or denial of benefits.
	Inpatient services	$800 Copay/day	Not Covered	Copayment applies per day up to 5 days of inpatient stay.

Common Medical Event	Services You May Need	What You Will Pay: Participating Provider (You will pay the least)	What You Will Pay: Non-Participating Provider (You will pay the most)	Limitation, Exceptions, & Other Important Information
If you are pregnant	Office visits	$75 Copay/occurrence	Not Covered	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment may apply. *See section 3(i)
	Childbirth/delivery professional services	$0 Copay	Not Covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery facility services	$800 Copay/day	Not Covered	Depending on the type of services, a copayment or coinsurance may apply. Copay applies per day up to 5 days of inpatient stay.

Common Medical Event	Services You May Need	What You Will Pay		Limitation, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	$75 Copay/visit	Not Covered	Requires preauthorization for certain services, failure to obtain preauthorization may result in reduction or denial of benefits. Limited to 60 visits per year.
	Rehabilitation services	$75 Copay/visit	Not Covered	Requires preauthorization for certain services, failure to obtain preauthorization may result in reduction or denial of benefits.
	Habilitation services	$75 Copay/visit	Not Covered	Requires preauthorization for certain services, failure to obtain preauthorization may result in reduction or denial of benefits.
	Skilled nursing care	$800 Copay/day	Not Covered	Requires preauthorization for certain services, failure to obtain preauthorization may result in reduction or denial of benefits.* See section 3(r).
	Durable medical equipment	20% Coinsurance	Not Covered	Requires preauthorization for certain services, failure to obtain preauthorization may result in reduction or denial of benefits Limited to plan requirements* See section 3e.
	Hospice services	$75 Copay/day $800 Copay/day in inpatient setting	Not Covered	Requires preauthorization for certain services, failure to obtain preauthorization may result in reduction or denial of benefits. Inpatient copayment applies per day up to 5 days. Limited to plan requirements.* See section 3(j).
If your child needs dental or eye care	Children's eye exam	$75 Copay/visit	Not Covered	One routine eye exam annually.
	Children's glasses	$75 Copay/pair	Not Covered	For select frames, standard lenses, and contact lenses only, for children 18 (until child turns 19) and under.* See Section 3(w)
	Children's dental check-up	Not covered	Not covered	-----None-----

*For more information about limitations and exceptions, see the plan or policy document at www.communityhealthchoice.org/en-us/plans-benefits/marketplace/know-the-details-2019/

Excluded Services & Other Covered Services

Services your Plan Generally Does NOT cover (Check your policy or plan documentation for more information and a list of any other excluded services.)		
• Abortion with the Exception of Limited Services	• Acupuncture	• Bariatric surgery
• Infertility treatment	• Cosmetic surgery	• Dental care (Adult)
• Routine eye care (Adult)	• Long-term care	• Non-emergency care when traveling outside of U.S.
	• 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 visit per year)	• Hearing aids (each ear, every three years)	• Private duty nursing (inpatient)
• Routine Foot Care (limited to plan requirements)		

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 74701 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 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 74701 or Community Health Choice, Inc. 2636 South Loop West Suite 125 Houston Texas 77054 or 1-855-315-5386.

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 1-855-315-5386

——————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 prenatal care and a hospital delivery)

The plan's overall deductible	$400
Specialist copayment	$75
Hospital (facility) copayment	$800
Other coinsurance	20%

This EXAMPLE even includes services like:
Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery facility Services
Diagnostic test (ultrasounds and blood work)
Specialist visit (anesthesia)

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$3,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	**$3,000**

Managing Joe's type 2 Diabetes

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

The plan's overall deductible	$400
Specialist copayment	$75
Hospital (facility) copayment	$800
Other coinsurance	20%

This EXAMPLE even includes services like:
Primary care physician office visits (includes disease education)
Diagnostic tests (blood work)
Prescription Drugs
Durable medical equipment (glucose meter)

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$400
Copayments	$3,600
Coinsurance	$400
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$4,500**

Mia's Simple Fracture

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

The plan's overall deductible	$400
Specialist copayment	$75
Hospital (facility) copayment	$800
Other coinsurance	20%

This EXAMPLE even includes services like:
Emergency room care (including medical supplies)
Diagnostic test (x-ray)
Durable medical equipment (crutches)
Rehabilitation services (Physical therapy)

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,600
Coinsurance	$10
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,600**

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

LANGUAGE ASSISTANCE

Community Health Choice, Inc. is required by federal law to provide the following information.

NON-DISCRIMINATION STATEMENT

Community Health Choice, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Community Health Choice, Inc. does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Community Health Choice, Inc. provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, written information in other formats (large print, audio, accessible electronic formats, other formats). Community Health Choice, Inc. provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Community Health Choice, Inc. Customer Service Care Center at 1.855.315.5386. If you believe that Community Health Choice, Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance.

You can file a grievance in person or by mail, fax or email:

Service Improvement Department
2636 South Loop West, Suite 125
Houston, Texas 77054

Phone: 713.295.6704
Email: ServiceImprovement@CommunityHealthChoice.org

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Arabic

يتضمن هذا الإشعار معلومات مهمة. وتتعلق هذه المعلومات الهامة في الإشعار بخصوص طلبك أو التغطية تحت التأمين الصحي Community Health Choice. ابحث عن التواريخ الهامة في هذا الإشعار. قد تحتاج لاتخاذ إجراءات قبل مواعيد محددة للحفاظ على تأمينك الصحي أو مساعدتك في دفع التكاليف. لديك الحق في الحصول على هذه المعلومات والمساعدة بلغتك دون أي تكلفة. اتصل على 1.855.315.5386.

English

This Notice has Important Information. This notice has important information about your application or coverage through Community Health Choice. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 1.855.315.5386.

German

Diese Mitteilung enthält wichtige Informationen. Diese Mitteilung enthält wichtige Informationen zu Ihrem Antrag auf Krankenversicherung bzw. Ihren Versicherungsschutz mit Community Health Choice. Achten Sie auf wichtige Termine in dieser Mitteilung. Eventuell müssen Sie zu bestimmten Stichtagen Maßnahmen ergreifen, um die Beibehaltung Ihres Versicherungsschutzes bzw. finanzieller Unterstützung zu gewährleisten. Sie haben ein Recht auf die kostenfreie Bereitstellung dieser Informationen und weiterer Unterstützung in Ihrer Sprache. Rufen Sie an unter 1.855.315.5386.

Hindi

इस सूचनामें महत्वपूर्ण जानकारी है। इस सूचनामें आपके आवेदन या Community Health Choice द्वारा कवरेज के बारे में महत्वपूर्ण जानकारी है। इस सूचना मे महत्वपूर्ण तारीखो केलिए खोजिये। आप अपने स्वास्थ्यके कवरेज रखने केलिए या लागत के मदद केलिए निश्चित समय सीमासे कार्रवाई करना जरूरत हो सकती है। आपको अपनी भाषा मे इस जानकारी और सहायता निःशुल्क प्राप्त करने का अधिकार है। 1.855.315.5386 बुलाइये।

Korean

이 통지서는 중요한 정보를 담고 있습니다. 이 통지서는 Community Health Choice를 통한 귀하의 신청이나 보험보장에 대해 중요한 정보를 담고 있습니다.. 이 통지서에서 주요 날짜를 확인하십시오. 귀하의 건강보험 보장을 유지하거나 비용에서 도움을 받기 위해서는 일정한 마감일까지 조치를 취해야 할 수 있습니다. 귀하에게는, 이러한 정보를 받고 무료로 귀하의 언어로 도움을 받을 권리가 있습니다. 1.855.315.5386로 연락하십시오.

Persian

این اطلاعیه حاوی اطلاعات مهمی می باشد. این اطلاعیه حاوی نکات مهمی درباره تقاضانامه و پوشش بیمه ای شما توسط Community Health Choice می باشد. به تاریخ های ذکر شده در این اطلاعیه توجه نمایید. به منظور برقرار نگهداشتن پوشش بیمه ای یا دریافت کمک هزینه، ممکن است نیاز باشد که تا مهلت های مقرر، اقداماتی را انجام دهید. حق شماست که این اطلاعات و کمک را بطور رایگان به زبان خودتان دریافت نمایید. با شماره تلفن 1.855.315.5386 تماس بگیرید.

Spanish or Spanish Creole

Este aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través de Community Health Choice. Preste atención a las fechas clave que se incluyen en este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al teléfono 1.855.315.5386.

Urdu

اس نوٹس میں اہم معلومات ہیں۔ اس نوٹس میں Community Health Choice کے ذریعے آپ کی درخواست یا بیمے کے تحفظ سے متعلق اہم معلومات ہیں۔ اس نوٹس میں اہم تاریخوں کو دیکھیے۔ اپنی صحت کے بیمے کے تحفظ کو برقرار رکھنے یا اخراجات میں مدد کے لیے آپ کو کچھ خاص تاریخوں تک کارروائی کرنے کی ضرورت ہوسکتی ہے۔ آپ کو ان معلومات اور مدد کو اپنی زبان میں مفت حاصل کرنے کا حق حاصل ہے۔ 1.855.315.5386 پر رابطہ کریں۔

Chinese

本通知有重要信息。本通知包含關于您透過Community Health Choice提交的申請或保險的重要訊息。請留意本通知內的重要日期。您可能需要在截止日期之前采取行動，以保留您的健康保險或費用補貼。您有權免費以您的母語得到本訊息和幫助。請撥電話 1.855.315.5386.

French

Cet avis contient d'importantes informations. Cet avis contient d'importantes informations concernant votre demande ou votre couverture avec Community Health Choice. Consultez les dates figurant dans le présent avis car il est possible que vous ayez à prendre certaines mesures avant ces dates pour conserver votre assurance santé ou profiter de meilleurs coûts. Vous êtes en droit de recevoir ces informations et de bénéficier gratuitement d'une aide dans votre langue. Appelez le 1.855.315.5386.

Gujarati

આ નોટિસમાં મહત્વની માહિતી છે. આ નોટિસમાં Community Health Choice દ્વારા તમારી અરજી અથવા કવરેજ વિશે મહત્વની જાણકારી છે. આ નોટિસમાં મહત્વની તારીખો માટે જુઓ. તમારા આરોગ્ય કવરેજને રાખવા અથવા ખર્ચ બાબતે મદદ કરવા માટે અમુક ચોક્કસ મુદત સુધી પગલાં લેવાની તમારે જરૂર પડી શકે છે. તમને કોઈ પણ ખર્ચ વિના તમારી ભાષામાં આ જાણકારી અને મદદ મેળવવાનો અધિકાર છે. 1.855.315.5386 પર કૉલ કરો.

Japanese

この通知には必要な情報が含まれています。この通知にはCommunity Health Choice の申請または補償範囲に関する重要な情報が含まれています。この通知に記載されている重要な日付をご確認ください。健康保険や有料サポートを維持するには、特定の期日までに行動を取らなければならない場合があります。ご希望の言語による情報とサポートが無料で提供されます。1.855.315.5386 までお電話ください。

Laotian

ໜັງສືແຈ້ງການນີ້ມີຂໍ້ມູນທີ່ສຳຄັນ. ໜັງສືແຈ້ງການນີ້ມີຂໍ້ມູນທີ່ສຳຄັນກ່ຽວກັບໃບສະໝັກຫຼືການຄຸ້ມຄອງຂອງທ່ານໂດຍຜ່ານ Community Health Choice. ໃຫ້ຊອກຫາຂໍ້ມູນວັນທີທີ່ສຳຄັນໃນໜັງສືແຈ້ງການນີ້. ທ່ານອາດຈະຕ້ອງປະຕິບັດພາຍໃນກຳນົດເວລາເພື່ອທີ່ຈະຮັກສາການຄຸ້ມຄອງສຸຂະພາບຂອງທ່ານຫຼືການຊ່ວຍເຫຼືອໃນເລື່ອງຄ່າໃຊ້ຈ່າຍ. ມັນເປັນສິດທິຂອງທ່ານທີ່ຈະໄດ້ຮັບຂໍ້ມູນຂ່າວສານນີ້ແລະການຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທລະສັບ 1.855.315.5386.

Russian

Настоящее уведомление содержит важную информацию. Настоящее уведомление содержит важную информацию о вашем заявлении или страховом покрытии, предоставляемым Community Health Choice. Обратите внимание на основные даты, указанные в настоящем уведомлении. Возможно, будет необходимо предпринять действия до наступления конечного срока для сохранения страхового полиса или для получения помощи в оплате расходов. Вы имеете право на бесплатное получение этой информации и помощи на вашем языке. Звоните по телефону: 1.855.315.5386.

Tagalog

Ang Notisyang ito ay naglalaman ng Importanteng Impormasyon. Maayroon itong importanteng impormasyon tungkol sa inyong aplikasyon o pagpapaseguro sa pamamagitan Community Health Choice. Hanapin ang mga importanteng petsa sa notisyang ito. Maaaring may kailangan kayong gawin bago ang mga itinakdang deadline para manatiling nakaseguro o para matulungan kayo sa mga kailangang babayaran. Kayo ay may karapatang makatanggap nitong impormasyon at makatanggap ng pagsasalin sa inyong wika na wala kayong babayaran. Tawagan ang 1.855.315.5386.

Vietnamese

Thông báo này có Thông Tin Quan Trọng. Thông báo này có thông tin quan trong về mẫu đơn của bạn hoặc bảo hiểm qua chương trình Community Health Choice. Xem những ngày quan trọng trong thông báo này. Bạn có thể cần phải thực hiện trong thời hạn nhất định để giữ bảo hiểm sức khỏe của bạn hay giúp đỡ chi phí. Bạn có quyền được thông tin này và giúp đỡ trong ngôn ngữ của bạn miễn phí. Xin gọi 1.855.315.5386.