



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-2023/>. 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](http://www.cciio.cms.gov) or call 1-855-315-5386 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$0/ Individual   \$0/family	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes.	For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$9,100/individual / \$18,200/family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and healthcare this <a href="#">plan</a> does not cover.	Even though you pay these expenses, they don't count towards the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="https://providersearch.communityhealthchoice.org">https://providersearch.communityhealthchoice.org</a> or call 1-855-315-5386 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware our <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab works). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$30 <a href="#">copay</a> /visit	Not Covered	None
	<a href="#">Specialist</a> visit	\$65 <a href="#">copay</a> /visit	Not Covered	None
	<a href="#">Preventive care/screening/immunization</a>	No Charge	Not Covered	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$30 <a href="#">copay</a> /visit	Not Covered	None
	Imaging (CT/PET scans, MRIs)	\$500 <a href="#">copay</a> /test	Not Covered	Requires <a href="#">preauthorization</a> for certain services. Failure to obtain an authorization may result in denial of benefits. *See Section 3(g)
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="https://www.communityhealthchoice.org/wp-content/uploads/2022/04/formulary-2023.pdf">https://www.communityhealthchoice.org/wp-content/uploads/2022/04/formulary-2023.pdf</a>	Generic drugs	\$20 <a href="#">copay</a> /prescription (retail) \$50 <a href="#">copay</a> /prescription (mail order)	Not Covered	Covers up to 30 day supply (retail). Covers up to 90 day supply (mail order). Please refer to <a href="#">formulary</a> for cost share tiers. Tier 1 includes preferred generics and some lower cost brand products. *See Section 3(n).
	Preferred brand drugs	\$40 <a href="#">copay</a> /prescription (retail) \$100 <a href="#">copay</a> /prescription (mail order)	Not Covered	Covers up to 30 day supply (retail). Covers up to 90 day supply (mail order). <a href="#">Preauthorization</a> may be required for a branded medication when the generic equivalent is preferred on the <a href="#">formulary</a> . Failure to obtain <a href="#">preauthorization</a> to show medical necessity may increase your costs.

\* For more information about limitations and exceptions, see the [plan](#) or policy document <https://www.communityhealthchoice.org/wp-content/uploads/2022/05/eoc-gold-copay-2023.pdf>

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
				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. Tier 2 includes high cost generics and preferred brand.
	Non-preferred brand drugs	\$80 <a href="#">copay</a> /prescription (retail) \$200 <a href="#">copay</a> /prescription (mail order)	Not Covered	Covers up to 30 day supply (retail). Covers up to 90 day supply (mail order). Tier 3 includes non-preferred <a href="#">formulary</a> products (can include non-preferred generic products).
	<a href="#">Specialty drugs</a>	30% <a href="#">coinsurance</a> /prescription (retail)	Not Covered	Covers up to 30 day supply (retail) Tier 4 includes <a href="#">specialty drugs</a> .
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$300 <a href="#">copay</a> /visit	Not Covered	Requires <a href="#">preauthorization</a> for certain services, failure to obtain <a href="#">preauthorization</a> may result in denial of benefits.
	Physician/surgeon fees	\$300 <a href="#">copay</a> /visit	Not Covered	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$800 <a href="#">copay</a> /visit	\$800 <a href="#">copay</a> /visit	None
	<a href="#">Emergency medical transportation</a>	\$65 <a href="#">copay</a> /transportation	\$65 <a href="#">copay</a> /transportation	Requires <a href="#">preauthorization</a> for certain services such as air transportation, non-emergency ground transportation, facility-to-facility transfers, <a href="#">out-of-network</a> and out of area transfers.
	<a href="#">Urgent care</a>	\$65 <a href="#">copay</a> /visit	Not Covered	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$800 <a href="#">copay</a> /day	Not Covered	Requires <a href="#">preauthorization</a> for certain services, failure to obtain <a href="#">preauthorization</a> may result in denial of benefits. Inpatient copay applies per day up to 5 days

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
	Physician/surgeon fees	\$0 <a href="#">copay</a> /visit	Not Covered	None
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$30 <a href="#">copay</a> /office visit and \$300 <a href="#">copay</a> /visit for other outpatient services/visit	Not Covered	Requires <a href="#">preauthorization</a> for certain services, failure to obtain <a href="#">preauthorization</a> may result in denial of benefits.
	Inpatient services	\$800 <a href="#">copay</a> /per day	Not Covered	Requires <a href="#">preauthorization</a> for certain services, failure to obtain <a href="#">preauthorization</a> may result in denial of benefits. Inpatient copay applies per day up to 5 days.
<b>If you are pregnant</b>	Office visits	\$65 <a href="#">copay</a> /occurrence	Not Covered	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . *See section 3(I)
	Childbirth/delivery professional services	\$0 <a href="#">copay</a>	Not Covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	\$800 <a href="#">copay</a> /visit	Not Covered	Requires <a href="#">preauthorization</a> for certain services, failure to obtain <a href="#">preauthorization</a> may result in denial of benefits. Inpatient copay applies per day up to 5 days
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	\$65 <a href="#">copay</a> /visit	Not Covered	Requires <a href="#">preauthorization</a> for certain services, failure to obtain <a href="#">preauthorization</a> may result in denial of benefits. Limited to 60 visits per year.
	<a href="#">Rehabilitation services</a>	\$65 <a href="#">copay</a> /visit	Not Covered	Requires <a href="#">preauthorization</a> for certain services, failure to obtain <a href="#">preauthorization</a> may result in denial of benefits.
	<a href="#">Habilitation services</a>	\$65 <a href="#">copay</a> /visit	Not Covered	Requires <a href="#">preauthorization</a> for certain services, failure to obtain <a href="#">preauthorization</a> may result in denial of benefits.
	<a href="#">Skilled nursing care</a>	\$800 <a href="#">copay</a> /visit	Not Covered	Requires <a href="#">preauthorization</a> for certain services, failure to obtain <a href="#">preauthorization</a>

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
				may result in denial of benefits. Limited to 25 days per year.
	<a href="#">Durable medical equipment</a>	30% <u>coinsurance</u>	Not Covered	Requires <u>preauthorization</u> for certain services, failure to obtain <u>preauthorization</u> may result in denial of benefits. Limited to <u>plan</u> requirements. *See Section 3(e).
	<a href="#">Hospice services</a>	\$65 <u>copay</u> /day \$800 <u>copay</u> /day in an inpatient setting.	Not Covered	Inpatient copay applies per day up to 5 days. Limited to <u>plan</u> requirements. *See section 3(j)
<b>If your child needs dental or eye care</b>	Children's eye exam	\$65 <u>copay</u> /visit	Not Covered	One routine eye exam annually. *See section 3(w)
	Children's glasses	\$65 <u>copay</u> /pair	Not Covered	For select frames, standard lenses, and contact lenses only, for children 18 years old and younger. Limited to <u>plan</u> requirements. *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 <https://www.communityhealthchoice.org/wp-content/uploads/2022/05/eoc-gold-copay-2023.pdf>

## 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  
\*See Section 4(16) of your [plan](#) document
- 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.
- Routine eye care (Adult)
- Weight loss programs

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

- Chiropractor care (35 visits per year)
- Hearing aids (each ear, every three years)
- Private-duty nursing (Inpatient private duty nursing)
- Routine foot care (diabetes related services)

**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](http://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.

### 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 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): Dinekehgo shika at'ohwol ninisingo, kwijigo 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist</a> <a href="#">copayment</a>	\$65
■ Hospital (facility) <a href="#">copayment</a>	\$800
■ Other <a href="#">cost sharing</a>	30%

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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1,400
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Peg would pay is</b>	<b>\$1,400</b>

### Managing Joe's Type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist</a> <a href="#">copayment</a>	\$65
■ Hospital (facility) <a href="#">copayment</a>	\$800
■ Other <a href="#">cost sharing</a>	30%

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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1,000
<a href="#">Coinsurance</a>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$1,200</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist</a> <a href="#">copayment</a>	\$65
■ Hospital (facility) <a href="#">copayment</a>	\$800
■ Other <a href="#">cost sharing</a>	30%

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1,200
<a href="#">Coinsurance</a>	\$70
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,270</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.