




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 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. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. |
| 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 ? | Not Applicable. | This plan does not have an out-of-pocket limit on your expenses. |
| What is not included in the out-of-pocket limit ? | Not Applicable. | This plan does not have an out-of-pocket limit on your expenses. |
| 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 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 our network provider might use an out-of-network provider for some services (such as lab works). 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 . |

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 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) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | No Charge | Not Covered | None |
| | Specialist visit | No Charge | 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 needed are preventive. Then check what your plan will pay for. |
| If you have a test | Diagnostic test (x-ray, blood work) | No Charge | Not Covered | None |
| | Imaging (CT/PET scans, MRIs) | No Charge | Not Covered | Requires preauthorization for certain services. Failure to obtain an authorization may result in denial of benefits. *See Section 3(g) |
| 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/2022/04/formulary-2023.pdf | Generic drugs | No Charge | 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 1 includes preferred generics and some lower cost brand products. *See Section 3(n). |
| | Preferred brand drugs | No Charge | 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 |

* For more information about limitations and exceptions, see the [plan](#) or policy document <https://www.communityhealthchoice.org/wp-content/uploads/2022/04/eoc-deductible-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) | |
| | | | | difference between the preferred and generic. Tier 2 includes high cost generics and preferred brand. |
| | Non-preferred brand drugs | No Charge | Not Covered | Covers up to 30 day supply (retail). Covers up to 90 day supply (mail order). Tier 3 includes non-preferred <u>formulary</u> products (can include non-preferred generic products). |
| | Specialty drugs | No Charge | Not Covered | Covers up to 30 day supply (retail) Tier 4 includes <u>specialty drugs</u> . |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No Charge | Not Covered | Requires <u>preauthorization</u> for certain services, failure to obtain <u>preauthorization</u> may result in denial of benefits. |
| | Physician/surgeon fees | No Charge | Not Covered | None |
| If you need immediate medical attention | Emergency room care | No Charge | No Charge | None |
| | Emergency medical transportation | No Charge | No Charge | Requires <u>preauthorization</u> for certain services such as air transportation, non-emergency ground transportation, facility-to-facility transfers, <u>out-of-network</u> and out of area transfers. |
| | Urgent care | No Charge | Not Covered | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No Charge | Not Covered | Requires <u>preauthorization</u> for certain services, failure to obtain <u>preauthorization</u> may result in denial of benefits. |
| | Physician/surgeon fees | No Charge | Not Covered | None |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | No Charge | Not Covered | Requires <u>preauthorization</u> for certain services, failure to obtain <u>preauthorization</u> may result in denial of benefits. |
| | Inpatient services | No Charge | Not Covered | Requires <u>preauthorization</u> for certain services, failure to obtain <u>preauthorization</u> |

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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. |
| If you are pregnant | Office visits | No Charge | Not Covered | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Requires <u>preauthorization</u> for certain services, failure to obtain <u>preauthorization</u> may result in denial of benefits. *See section 3(l) |
| | Childbirth/delivery professional services | No Charge | Not Covered | |
| | Childbirth/delivery facility services | No Charge | Not Covered | |
| If you need help recovering or have other special health needs | Home health care | No Charge | Not Covered | Requires <u>preauthorization</u> for certain services, failure to obtain <u>preauthorization</u> may result in denial of benefits. Limited to 60 visits per year. |
| | Rehabilitation services | No Charge | Not Covered | Requires <u>preauthorization</u> for certain services, failure to obtain <u>preauthorization</u> may result in denial of benefits. |
| | Habilitation services | No Charge | Not Covered | Requires <u>preauthorization</u> for certain services, failure to obtain <u>preauthorization</u> may result in denial of benefits. |
| | Skilled nursing care | No Charge | Not Covered | Requires <u>preauthorization</u> for certain services, failure to obtain <u>preauthorization</u> may result in denial of benefits. Limited to 25 days per year. |
| | Durable medical equipment | No Charge | 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). |
| | Hospice services | No Charge | Not Covered | Limited to <u>plan</u> requirements. *See section 3(j) |
| If your child needs dental or eye care | Children's eye exam | No Charge | Not Covered | One routine eye exam annually. *See section 3(w) |

* For more information about limitations and exceptions, see the [plan](https://www.communityhealthchoice.org/wp-content/uploads/2022/04/eoc-deductible-2023.pdf) or policy document <https://www.communityhealthchoice.org/wp-content/uploads/2022/04/eoc-deductible-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) | |
| | Children's glasses | No Charge | 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 |

Excluded Services & Other Covered Services:

| Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .) | | |
|---|--|--|
| <ul style="list-style-type: none"> • Abortion with exception of limited services *See Section 4(16) of your <u>plan</u> document • Acupuncture • Bariatric surgery • Children's dental check-up | <ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Adult) • Infertility treatment • Long-term care | <ul style="list-style-type: none"> • 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 <u>plan</u> document.) | | |
|--|---|---|
| <ul style="list-style-type: none"> • Chiropractor care (35 visits per year) • Hearing aids (each ear, every three years) | <ul style="list-style-type: none"> • Private-duty nursing (Inpatient private duty nursing) | <ul style="list-style-type: none"> • 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 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](#).

* For more information about limitations and exceptions, see the plan or policy document <https://www.communityhealthchoice.org/wp-content/uploads/2022/04/eoc-deductible-2023.pdf>

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, 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 [plan's](#) overall [deductible](#) \$0
- [Specialist](#) [copayment](#) \$0
- Hospital (facility) [coinsurance](#) 0%
- Other [cost sharing](#) 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 | \$12,700 |
|---------------------------|-----------------|

In this example, Peg would pay:

| | |
|---------------------|--|
| <i>Cost Sharing</i> | |
|---------------------|--|

| | |
|-----------------------------|-----|
| Deductibles | \$0 |
| Copayments | \$0 |
| Coinsurance | \$0 |

| | |
|---------------------------|--|
| <i>What isn't covered</i> | |
|---------------------------|--|

| | |
|----------------------|-----|
| Limits or exclusions | \$0 |
|----------------------|-----|

| | |
|-----------------------------------|------------|
| The total Peg would pay is | \$0 |
|-----------------------------------|------------|

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](#) [copayment](#) \$0
- Hospital (facility) [coinsurance](#) 0%
- Other [cost sharing](#) 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 | \$5,600 |
|---------------------------|----------------|

In this example, Joe would pay:

| | |
|---------------------|--|
| <i>Cost Sharing</i> | |
|---------------------|--|

| | |
|-----------------------------|-----|
| Deductibles | \$0 |
| Copayments | \$0 |
| Coinsurance | \$0 |

| | |
|---------------------------|--|
| <i>What isn't covered</i> | |
|---------------------------|--|

| | |
|----------------------|-----|
| Limits or exclusions | \$0 |
|----------------------|-----|

| | |
|-----------------------------------|------------|
| The total Joe would pay is | \$0 |
|-----------------------------------|------------|

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist](#) [copayment](#) \$0
- Hospital (facility) [coinsurance](#) 0%
- Other [cost sharing](#) 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 | \$2,800 |
|---------------------------|----------------|

In this example, Mia would pay:

| | |
|---------------------|--|
| <i>Cost Sharing</i> | |
|---------------------|--|

| | |
|-----------------------------|-----|
| Deductibles | \$0 |
| Copayments | \$0 |
| Coinsurance | \$0 |

| | |
|---------------------------|--|
| <i>What isn't covered</i> | |
|---------------------------|--|

| | |
|----------------------|-----|
| Limits or exclusions | \$0 |
|----------------------|-----|

| | |
|-----------------------------------|------------|
| The total Mia would pay is | \$0 |
|-----------------------------------|------------|

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