




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> ?                                | \$3,000/ Individual   \$6,000/family  | Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .   |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. <a href="#">Preventive Services</a> , Primary Care, <a href="#">Urgent Care</a> and Generic drugs.   | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. 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 charge</a> 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<br>(You will pay the least)   | Non-Participating Provider<br>(You will pay the most) |   |
| <b>If you visit a health care <a href="#">provider's office</a> or <a href="#">clinic</a></b>  | Primary care visit to treat an injury or illness       | \$30 <a href="#">copay</a> /visit<br><a href="#">Deductible</a> does not apply.  | Not Covered   | None  |
|  | <a href="#">Specialist</a> visit                       | \$60 <a href="#">copay</a> /visit after <a href="#">deductible</a>   | Not Covered   | None  |
|  | <a href="#">Preventive care/screening/immunization</a> | No Charge<br><a href="#">Deductible</a> does not apply   | 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 after <a href="#">deductible</a>   | Not Covered   | None  |
|  | Imaging (CT/PET scans, MRIs)                           | 50% <a href="#">coinsurance</a> after <a href="#">deductible/test</a>  | 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><br>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  | \$10 <a href="#">copay</a> /prescription (retail)<br>\$25 <a href="#">copay</a> /prescription (mail order) <a href="#">Deductible</a> does not apply                           | 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                                  | \$80 <a href="#">copay</a> /prescription after <a href="#">deductible</a> /prescription (retail)<br>\$200 <a href="#">copay</a> after <a href="#">deductible</a> /prescription | 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> .     |

\* 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<br>(You will pay the least)  | Non-Participating Provider<br>(You will pay the most)     |  |
|   |  | (mail order).   |   | Failure to obtain <u>preauthorization</u> 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. Tier 2 includes high cost generics and preferred brand. |
|   | Non-preferred brand drugs                      | \$120 <u>copay</u> /prescription after <u>deductible</u> /prescription (retail)<br>\$300 <u>copay</u> after <u>deductible</u> /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 <u>formulary</u> products (can include non-preferred generic products).  |
|   | <u>Specialty drugs</u>                         | 50% <u>coinsurance</u> after <u>deductible</u> /prescription (retail)   | 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) | 50% <u>coinsurance</u> after <u>deductible</u>  | Not Covered   | Requires <u>preauthorization</u> for certain services, failure to obtain <u>preauthorization</u> may result in denial of benefits.   |
|   | Physician/surgeon fees                         | 50% <u>coinsurance</u> after <u>deductible</u> /  | Not Covered   | None   |
| If you need immediate medical attention | <u>Emergency room care</u>                     | 50% <u>coinsurance</u> after <u>deductible</u>  | 50% <u>coinsurance</u> after <u>deductible</u>            | None   |
|   | <u>Emergency medical transportation</u>        | \$60 <u>copay</u> after <u>deductible</u> /transportation   | \$60 <u>copay</u> after <u>deductible</u> /transportation | 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.  |
|   | <u>Urgent care</u>                             | \$60 <u>copay</u> /visit.   | Not Covered   | None   |

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| Common Medical Event   | Services You May Need                     | What You Will Pay  |   | Limitations, Exceptions, & Other Important Information  |
|--|---|--|---|---|
|  |   | Participating Provider<br>(You will pay the least)   | Non-Participating Provider<br>(You will pay the most) |   |
|  |   | <u>Deductible</u> does not apply   |   |   |
| <b>If you have a hospital stay</b>   | Facility fee (e.g., hospital room)        | 50% <u>coinsurance</u> after <u>deductible</u>   | Not Covered   | Requires <u>preauthorization</u> for certain services, failure to obtain <u>preauthorization</u> may result in denial of benefits.  |
|  | Physician/surgeon fees                    | \$0 <u>copay</u> after <u>deductible</u> /visit  | Not Covered   | None  |
| <b>If you need mental health, behavioral health, or substance abuse services</b> | Outpatient services                       | \$30 <u>copay</u> /office visit<br><u>Deductible</u> does not apply and 50% <u>coinsurance</u> after <u>deductible</u> for other outpatient services | Not Covered   | Requires <u>preauthorization</u> for certain services, failure to obtain <u>preauthorization</u> may result in denial of benefits. Depending on type of service, a <u>copayment</u> or <u>coinsurance</u> may apply.      |
|  | Inpatient services                        | 50% <u>coinsurance</u> after <u>deductible</u>   | Not Covered   | Requires <u>preauthorization</u> for certain services, failure to obtain <u>preauthorization</u> may result in denial of benefits.  |
| <b>If you are pregnant</b>   | Office visits                             | \$60 <u>copay</u> after <u>deductible</u> /occurrence  | Not Covered   | <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. *See section 3(l)                        |
|  | Childbirth/delivery professional services | \$0 <u>copay</u> after <u>deductible</u>   | Not Covered   | Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).   |
|  | Childbirth/delivery facility services     | 50% <u>coinsurance</u> after <u>deductible</u>   | Not Covered   | Requires <u>preauthorization</u> for certain services, failure to obtain <u>preauthorization</u> may result in denial of benefits. Depending on the type of services, a <u>copayment</u> or <u>coinsurance</u> may apply. |
| <b>If you need help recovering or have other special health</b>                  | <a href="#">Home health care</a>          | \$60 <u>copay</u> after <u>deductible</u> /visit   | Not Covered   | Requires <u>preauthorization</u> for certain services, failure to obtain <u>preauthorization</u> may result in denial of benefits. Limited to   |

\* 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<br>(You will pay the least)  | Non-Participating Provider<br>(You will pay the most) |  |
| <b>needs</b>                                  |   |   |   | 60 visits per year.  |
|   | <a href="#">Rehabilitation services</a>   | \$60 <u>copay</u> after <u>deductible</u> /visit  | Not Covered   | Requires <u>preauthorization</u> for certain services, failure to obtain <u>preauthorization</u> may result in denial of benefits.   |
|   | <a href="#">Habilitation services</a>     | \$60 <u>copay</u> after <u>deductible</u> /visit  | Not Covered   | Requires <u>preauthorization</u> for certain services, failure to obtain <u>preauthorization</u> may result in denial of benefits.   |
|   | <a href="#">Skilled nursing care</a>      | 50% <u>coinsurance</u> after <u>deductible</u>  | 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.                            |
|   | <a href="#">Durable medical equipment</a> | 30% <u>coinsurance</u> after <u>deductible</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>          | \$60 <u>copay</u> after <u>deductible</u> /day<br>50% <u>coinsurance</u> after <u>deductible</u> in an inpatient setting. | Not Covered   | Depending on the type of services, a <u>copayment</u> or <u>coinsurance</u> may apply. Limited to <u>plan</u> requirements. *See section 3(j)  |
| <b>If your child needs dental or eye care</b> | Children's eye exam                       | \$60 <u>copay</u> after <u>deductible</u> /visit  | Not Covered   | One routine eye exam annually. *See section 3(w)   |
|   | Children's glasses                        | \$60 <u>copay</u> after <u>deductible</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/2022/04/eoc-deductible-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 [plan's](#) overall [deductible](#) \$3,000
- [Specialist](#) [copayment](#) \$60
- Hospital (facility) [coinsurance](#) 50%
- Other [cost sharing](#) 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$3,000        |
| <a href="#">Copayments</a>        | \$300          |
| <a href="#">Coinsurance</a>       | \$3,500        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Peg would pay is</b> | <b>\$6,800</b> |

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$3,000
- [Specialist](#) [copayment](#) \$60
- Hospital (facility) [coinsurance](#) 50%
- Other [cost sharing](#) 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$3,000        |
| <a href="#">Copayments</a>        | \$500          |
| <a href="#">Coinsurance</a>       | \$70           |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Joe would pay is</b> | <b>\$3,570</b> |

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$3,000
- [Specialist](#) [copayment](#) \$60
- Hospital (facility) [coinsurance](#) 50%
- Other [cost sharing](#) 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$2,800        |
| <a href="#">Copayments</a>        | \$10           |
| <a href="#">Coinsurance</a>       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,810</b> |

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