



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 ? | \$3,000/ Individual \$6,000/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 Services , Primary Care, Urgent Care 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 https://www.healthcare.gov/coverage/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 ? | \$9,100/ individual \$18,200/ 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 healthcare this plan does not cover. | Even though you pay these expenses, they don't count towards the out-of-pocket limit . |
| 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 . |

 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 | \$30 copay /visit Deductible does not apply. | Not Covered | None |
| | Specialist visit | \$60 copay /visit after deductible | 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) | \$30 copay /visit after deductible | Not Covered | None |
| | Imaging (CT/PET scans, MRIs) | 50% coinsurance after deductible/test | 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 | \$10 copay /prescription (retail) \$25 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 1 includes preferred generics and some lower cost brand products. *See Section 3(n). |
| | Preferred brand drugs | \$80 copay /prescription after deductible /prescription (retail) \$200 copay after deductible /prescription | 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 . |

* 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) | |
| | | (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) \$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 |

* 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) | |
| | | <u>Deductible</u> does not apply | | |
| If you have a hospital stay | 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 |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$30 <u>copay</u> /office visit <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. |
| If you are pregnant | 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. |
| If you need help recovering or have other special health | Home health care | \$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 (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| needs | | | | 60 visits per year. |
| | Rehabilitation services | \$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. |
| | Habilitation services | \$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. |
| | Skilled nursing care | 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. |
| | Durable medical equipment | 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). |
| | Hospice services | \$60 <u>copay</u> after <u>deductible</u> /day 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) |
| If your child needs dental or eye care | 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 | • Cosmetic Surgery | • Non-emergency care when traveling outside the U.S. |
| • Acupuncture | • Dental care (Adult) | • Routine eye care (Adult) |
| • Bariatric surgery | • Infertility treatment | • Weight loss programs |
| • Children's dental check-up | • Long-term care | |

| 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) | • Private-duty nursing (Inpatient private duty nursing) | • Routine foot care (diabetes related services) |
| • 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.

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*)

| | |
|---------------------------|-----------------|
| Total Example Cost | \$12,700 |
|---------------------------|-----------------|

In this example, Peg would pay:

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

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*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$5,600 |
|---------------------------|----------------|

In this example, Joe would pay:

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

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*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$2,800 |
|---------------------------|----------------|

In this example, Mia would pay:

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

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