




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-2024/>. 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 at Indian Health Care Provider (IHCP) or with IHCP referral at non-IHCP; or \$5,900 / individual or \$11,800 / 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 care, Urgent care, Mental/Behavioral Health and Substance Use Disorder services and generic drugs are covered.	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 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 ?	\$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 health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward 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, 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 ?	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	Indian Health Care Provider (IHCP) (You will pay the least)	What You Will Pay Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	\$40 copay ; deductible does not apply	Not covered	None
	Specialist visit	No charge	\$80 copay ; deductible does not apply	Not covered	None
	Preventive care/ screening/ immunization	No charge	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)	No charge	40% coinsurance	Not covered	None
	Imaging (CT/PET scans, MRIs)	No charge	40% coinsurance	Not covered	Requires preauthorization for certain services. Failure to obtain an authorization may result in denial of benefits.

* For more information about limitations and exceptions, see the plan or policy document at <https://www.communityhealthchoice.org/wp-content/uploads/2023/04/eoc-deductible-2024.pdf>

Common Medical Event	Services You May Need	Indian Health Care Provider (IHCP) (You will pay the least)	What You Will Pay Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
<p>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/2023/04/formulary-premier-2024.pdf</p>	Generic drugs	No charge	\$20 copay /prescription (retail); \$50 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.
	Preferred brand drugs	No charge	\$40 copay /prescription (retail); \$100 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). 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. Tier 2 includes high cost generics and preferred brand.
	Non-preferred brand drugs	No charge	\$80 copay /prescription (retail); \$200 copay /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 formulary products (can include non-preferred generic products).
	Specialty drugs	No charge	\$350 copay /prescription (retail)	Not covered	Covers up to 30-day supply (retail) Tier 4 includes specialty drugs.

* For more information about limitations and exceptions, see the plan or policy document at <https://www.communityhealthchoice.org/wp-content/uploads/2023/04/eoc-deductible-2024.pdf>

If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	40% coinsurance	Not covered	Requires preauthorization for certain services, failure to obtain preauthorization may result in denial of benefits.
	Physician/surgeon fees	No charge	40% coinsurance	Not covered	None
If you need immediate medical attention	Emergency room care	No charge	40% coinsurance	40% coinsurance	None
	Emergency medical transportation	No charge	\$80 copay /transportation	\$80 copay /transportation	Requires preauthorization for certain services such as air transportation, non-emergency ground transportation, facility-to-facility transfers, out-of-network and out of area transfers.
	Urgent care	No charge	\$60 copay /visit; deductible does not apply	Not covered	None

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Common Medical Event	Services You May Need	Indian Health Care Provider (IHCP) (You will pay the least)	What You Will Pay Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	40% coinsurance	Not covered	Requires preauthorization for certain services, failure to obtain preauthorization may result in denial of benefits.
	Physician/surgeon fees	No charge	No charge	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	\$40 copay /office visit; deductible does not apply. 40% coinsurance after deductible for other outpatient services	Not covered	Requires preauthorization for certain services, failure to obtain preauthorization may result in denial of benefits. Depending on type of service, a copayment or coinsurance may apply.
	Inpatient services	No charge	40% coinsurance	Not covered	None
If you are pregnant	Office visits	No charge	\$80 copay /occurrence	Not covered	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply.
	Childbirth/delivery professional services	No charge	40% coinsurance	Not covered	Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Requires preauthorization for certain services, failure to obtain preauthorization may result in denial of benefits. Depending on the type of services, a copayment or coinsurance may apply.
	Childbirth/delivery facility services	No charge	40% coinsurance	Not covered	

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Common Medical Event	Services You May Need	Indian Health Care Provider (IHCP) (You will pay the least)	What You Will Pay Non-IHCP In-Network Provider	Non-IHCP Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care	No charge	\$80 copay /visit	Not covered	Requires preauthorization for certain services, failure to obtain preauthorization may result in denial of benefits. Limited to 60 visits per year.
	Rehabilitation services	No charge	\$40 copay /visit; deductible does not apply	Not covered	Requires preauthorization for certain services, failure to obtain preauthorization may result in denial of benefits.
	Habilitation services	No charge	\$40 copay /visit; deductible does not apply	Not covered	Requires preauthorization for certain services, failure to obtain preauthorization may result in denial of benefits.
	Skilled nursing care	No charge	40% coinsurance	Not covered	Requires preauthorization for certain services, failure to obtain preauthorization may result in denial of benefits. Limited to 25 days per year.
	Durable medical equipment	No charge	30% coinsurance	Not covered	Requires preauthorization for certain services, failure to obtain preauthorization may result in denial of benefits. Limited to plan requirements.

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Common Medical Event	Services You May Need	Indian Health Care Provider (IHCP) (You will pay the least)	What You Will Pay Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Hospice services	No charge	\$80 copay /day 40% coinsurance in an inpatient setting	Not covered	Depending on the type of services, a copayment or coinsurance may apply. Limited to plan requirements.
If your child needs dental or eye care	Children's eye exam	No charge	\$80 copay	Not covered	One routine eye exam annually.
	Children's glasses	No charge	\$80 copay	Not covered	For select frames, standard lenses, and contact lenses only, for children 18 years old and younger. Limited to plan requirements.
	Children's dental check-up	Not Covered	Not Covered	Not Covered	None

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
- 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)
- 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](#).

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	\$5,900
■ Specialist copayment	\$80
■ Hospital (facility) coinsurance	40%
■ Other coinsurance	40%

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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$4,140
Copayments	\$0
Coinsurance	\$4,960
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$9,160

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$5,900
■ Specialist copayment	\$80
■ Hospital (facility) coinsurance	40%
■ Other coinsurance	40%

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1,290
Copayments	\$1,620
Coinsurance	\$572
What isn't covered	
Limits or exclusions	\$55
The total Joe would pay is	\$3,537

Mia's Simple Fracture

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

■ The plan's overall deductible	\$5,900
■ Specialist copayment	\$80
■ Hospital (facility) coinsurance	40%
■ Other coinsurance	40%

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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$853
Copayments	\$400
Coinsurance	\$563
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,816

Note: These numbers assume the patient received care from an IHCP [provider](#) or with IHCP [referral](#) at a non-IHCP. If you receive care from a non-IHCP [provider](#) without a [referral](#) from an IHCP your costs may be higher.