COMMUNITY HEALTH CHOICE

Consumer Choice Plan Disclosure Statement

COMMUNITY HEALTH CHOICE, INC.

This health plan does not include the same level of benefits required in other plans.
This HMO plan is a consumer choice plan. This plan doesn't include the same level of benefits that are in Texas health plans known as state-mandated plans. This plan does include all health benefits required by the Affordable Care Act.

To see all benefits offered by this plan, go to the plan's "Summary of Benefits and Coverage."

Benefit/coverage:	This plan:	A health plan with required benefits (state-mandated plan):
Deductible The amount you pay for care before the plan begins to share the cost.	Has a deductible.	Has no deductibles for in-network care.
Out-of-pocket costs The amount you pay when you receive care, up to an annual limit.	Includes out-of-pocket costs that meet federal requirements but may sometimes be more than in a state-mandated plan.	A copay must be less than 50% of the total cost of the service. Annual out-of-pocket costs must be capped at 200% of your annual premium cost if you alert the plan.
Habilitative and Rehabilitative care Care that helps you improve skills for daily living.	Includes a limit of combined 35 visits per year for chiropractic care.	Has no limit on the amount of care if it is needed for medical reasons.
Home Health Services	Includes a limit of 60 visits per year.	Has no limit on the amount of care that is ordered by your doctor.
Skilled Nursing Facility	Includes a limit of 25 visits per year.	Has no limit on the amount of care that is ordered by your doctor.

If you want a plan with all required benefits:
We also offer a state-mandated plan that includes all required benefits. This plan is not on **Healthcare.gov** and does not allow you to get help with premiums and out-of-pocket costs.

To learn more about this plan, call **1-855-315-5386** or visit **https://www.communityhealthchoice.org**.

By signing your application to enroll in this plan, you acknowledge the following:

- I understand the consumer choice plan I am applying for does not provide the same level of coverage required in other Texas health plans (state-mandated plans).
- I understand if my health changes and this plan does not meet my needs, in most cases I won't be able to get a new plan until the next open enrollment period.
- I understand I can get more information about consumer choice plans from the Texas Department of Insurance's website, www.tdi.texas.gov/consumer/consumerchoice.html, or by calling the Consumer Help Line at 1-800-252-3439.

Don't sign this document if you don't understand it.
No firme este documento si no lo comprende.

Print the name of the person applying: _____

Signature of the person applying: _____

Date of signature: _____

Name of business, if applicable: _____

Community Health Choice must give you a copy of this statement upon request.

COMMUNITY CARES

2024
PLAN BROCHURE

COMMUNITY HEALTH CHOICE

COMMUNITY CARES

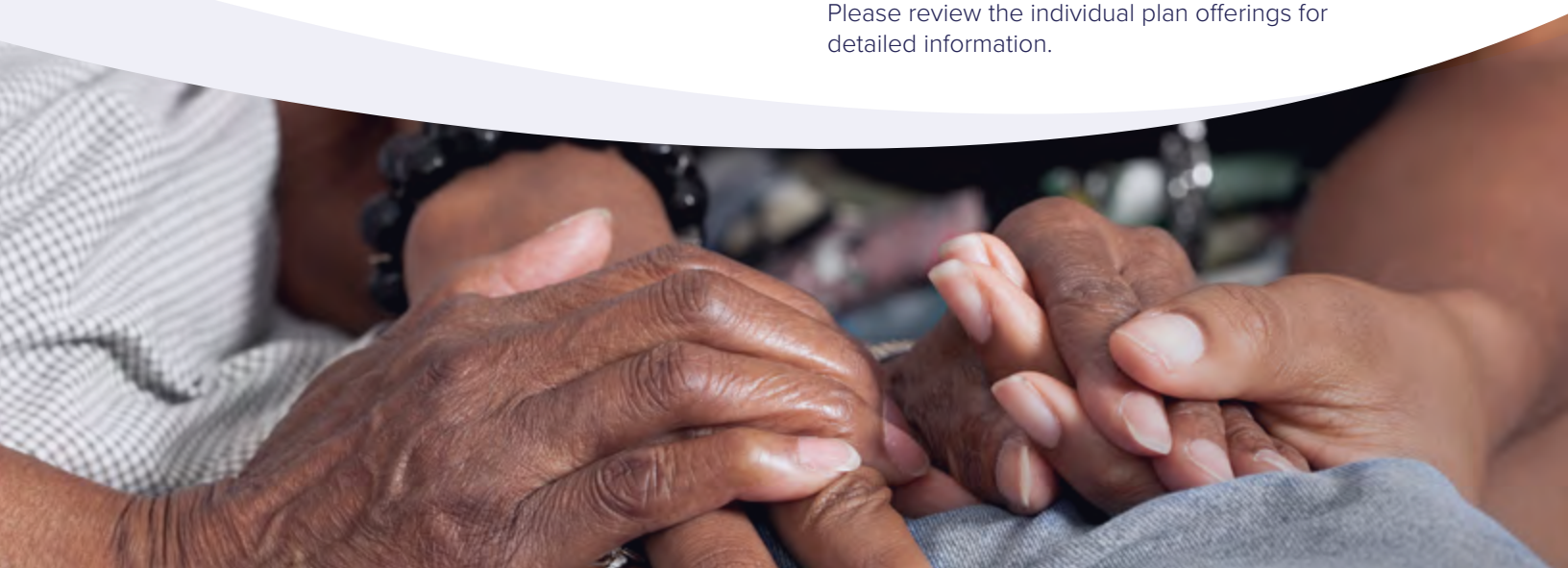
CONNECTING YOU TO THE BEST AFFORDABLE HEALTH INSURANCE FOR EVERY STAGE OF YOUR LIFE.

Community Health Choice is committed to opening doors to better health for our Members. We exist to make sure you have health insurance coverage so you can get the care you need.

We live this commitment all year long because you shouldn't have to pay more to get the health care you deserve. That's why we make it easy to get quality health coverage that combines affordability with an unmatched level of personal service.

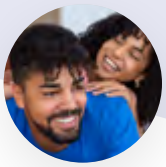
- **$0** **Preventive Services**
- **Low copay on many generic drugs**
- **Free 24/7 telehealth**
- **One of the largest Provider and facilities network in Southeast Texas**
- **Most primary care visits, specialist visits, urgent care, and generic drugs are not subject to deductible**
- **No referrals needed for specialists**

*Benefits listed above are not included on all plans. Please review the individual plan offerings for detailed information.







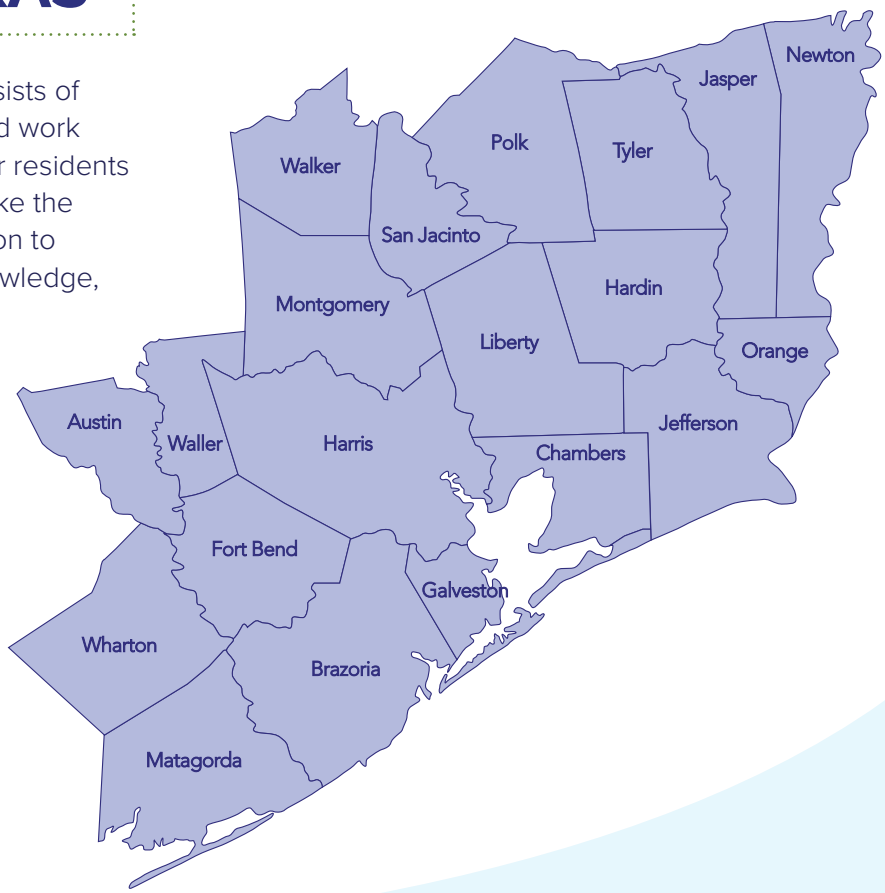



COVERING

SOUTHEAST TEXAS

Community's Member service area consists of 20 counties in Texas. Our teams live and work here. We understand the challenges our residents and Members face. And because we take the health and well-being of our entire region to heart, we proudly share a wealth of knowledge, special programs, care management, and valuable community resources like no one else can.

- Austin
- Brazoria
- Chambers
- Fort Bend
- Galveston
- Hardin
- Harris
- Jasper
- Jefferson
- Liberty
- Matagorda
- Montgomery
- Newton
- Orange
- Polk
- San Jacinto
- Tyler
- Walker
- Waller
- Wharton



CHOOSING THE PLAN

THAT'S RIGHT FOR YOU

Once you understand the differences, it's easier to find the best plan that fits you and your family. We want you to get all the coverage you need without paying for benefits you don't.

SELECT PLANS – LIMITED NETWORK

Community offers Select Plans that have a smaller network of high-quality providers that allows us to pass the cost savings to the consumer in the form of lower premiums and out-of-pocket costs. These Select Plans provide a way to contain costs without sacrificing the quality of care our participating providers give. The Select Plans are only available to Harris County residents.

Our Select Plans Include:
SELECT BRONZE 16
SELECT SILVER 19
SELECT GOLD 22

BRONZE, SILVER OR GOLD?

No matter which metal category you choose, you can save a lot of money on your monthly premium based on your income. When you fill out a Marketplace insurance application, you'll find out if you qualify for these savings.

Visit **HealthCare.gov** for more information.

Bronze Plans

Lowest premium costs
Higher out-of-pocket costs when you receive care

60%	40%
PLAN PAYS	YOU PAY

Silver Plans

Higher premium costs than Bronze plans
Lower out-of-pocket costs than Bronze plans

70%	30%
PLAN PAYS	YOU PAY

Gold Plans

Higher premium costs than Silver plans
Lower out-of-pocket costs than Silver plans

80%	20%
PLAN PAYS	YOU PAY

COMMUNITY 2024 PLAN DESIGNS

COMMUNITY HEALTH CHOICE

Bronze

PLANS/VISITS	PREMIER BRONZE 003 PLAN ID 27248TX0010003	PREMIER VIRTUAL BRONZE 11 PLAN ID 27248TX0010011	SELECT BRONZE 016 PLAN ID 27248TX0010016	PREMIER BRONZE 18 PLAN ID 27248TX0010018
Medical Deductible (individual/family)	$7,700 / $15,400	$9,450 / $18,900	$8,100 / $16,200	$7,500 / $15,000
Out-of-Pocket Max (individual/family)	$9,450 / $18,900	$9,450 / $18,900	$9,450 / $18,900	$9,400 / $18,800
MEDICAL BENEFITS	MEMBER COPAYS/COINSURANCE			
PCP Office Visit	*$40	*Tier 1 (Doctors on Demand): $0 Tier 2: No charge after deductible	*$35	*$50
Specialist Office Visit	$70	No charge after deductible	$90	*$100
Outpatient Facility	40%		50%	50%
Outpatient Surgery	40%		50%	50%
Urgent Care Services	*$70		*$90	*$75
Ambulance Services	$70		$90	$100
Emergency Room Services	40%		50%	50%
Inpatient Hospital Care	40%		50%	50%
Inpatient Skilled Nursing Facility	40%		50%	50%
Outpatient Mental/Behavioral Substance Abuse	*$40	*Tier 1 (Doctors on Demand): $0 Tier 2: No charge after deductible	*$35	*$50
Inpatient Mental/Behavioral Substance Abuse	40%	No charge after deductible	50%	50%
Outpatient Rehabilitation	$70		$90	$100
Medical Imaging (CT/PET Scans, MRIs)	40%		50%	50%
Routine Lab/X-Ray/Diagnostic Imaging	$40		$35	50%
PRESCRIPTION DRUGS	MEMBER COPAYS/COINSURANCE			
Prescription Drug Deductible (individual/Family) (90-day mail order supply available at 2.5 times copay)	Combined with Medical Deductible	Combined with Medical Deductible	Combined with Medical Deductible	Combined with Medical Deductible
Generic	*$16	No charge after deductible	*$30	*$25
Preferred Brand	$70		$60	$50
Non-Preferred Brand	$120		$130	$100
Specialty High-Cost Drugs	45%		50%	$500

* Services are exempt from deductible where indicated (PCP/Specialist/Urgent Care/Generic RX).
For deductible plans: All coinsurance/copays apply after annual deductible has been met unless otherwise indicated.

COMMUNITY 2024 PLAN DESIGNS

COMMUNITY HEALTH CHOICE

Silver

PLANS/VISITS	**COMMUNITY PREMIER SILVER 004** PLAN ID 27248TX0010004			
	SILVER 004 251% FPL AND ABOVE	**SILVER 004 (73)** 201%-250% FPL	**SILVER 004 (87)** 151%-200% FPL	**SILVER 004 (94)** 100%-150% FPL
Medical Deductible (individual/Family)	$3,300 / $6,600	$3,200 / $6,400	N/A	N/A
Out-of-Pocket Max (individual/Family)	$9,450 / $18,900	$7,500 / $15,000	$3,000 / $6,000	$2,000 / $4,000
MEDICAL BENEFITS	MEMBER COPAYS/COINSURANCE			
PCP Office Visit	*$30	*$30	$25	$10
Specialist Office Visit	*$60	*$60	$50	$20
Outpatient Facility	40%	40%	40%	10%
Outpatient Surgery	40%	40%	40%	10%
Urgent Care Services	*$60	*$60	$50	$20
Ambulance Services	$60	$60	$50	$20
Emergency Room Services	40%	40%	40%	10%
Inpatient Hospital Care	40%	40%	40%	10%
Inpatient Skilled Nursing Facility	40%	40%	40%	10%
Outpatient Mental/Behavioral Substance Abuse	*$30	*$30	$25	$10
Inpatient Mental/Behavioral Substance Abuse	40%	40%	40%	10%
Outpatient Rehabilitation	$60	$60	$50	$10
Medical Imaging (CT/PET Scans, MRIs)	40%	40%	40%	10%
Routine Lab/X-Ray/Diagnostic Imaging	$30	$30	$25	$10
PRESCRIPTION DRUGS	MEMBER COPAYS/COINSURANCE			
Prescription Drug Deductible (individual/Family) (90-day mail order supply available at 2.5 times copay)	Combined with Medical Deductible	Combined with Medical Deductible	N/A	N/A
Generic	*$10	*$10	$10	$5
Preferred Brand	$70	$60	$50	$20
Non-Preferred Brand	$110	$100	$85	$40
Specialty High-Cost Drugs	50%	40%	30%	20%

* Services are exempt from deductible where indicated (PCP/Specialist/Urgent Care/Generic RX).
For deductible plans: All coinsurance/copays apply after annual deductible has been met unless otherwise indicated.

COMMUNITY 2024 PLAN DESIGNS

COMMUNITY HEALTH CHOICE

Silver

PLANS/VISITS	COMMUNITY PREMIER SILVER 12 PLAN ID 27248TX0010012				COMMUNITY PREMIER SILVER 13 PLAN ID 27248TX0010013			
	SILVER 12 251% FPL AND ABOVE	**SILVER 12 (73)** 201%-250% FPL	**SILVER 12 (87)** 151%-200% FPL	**SILVER 12 (94)** 100%-150% FPL	**SILVER 13** 251% FPL AND ABOVE	**SILVER 13 (73)** 201%-250% FPL	**SILVER 13 (87)** 151%-200% FPL	**SILVER 13 (94)** 100%-150% FPL
Medical Deductible (individual/Family)	$3,000 / $6,000	$2,500 / $5,000	$500 / $1,000	N/A	$9,100 / $18,200	$7,500 / $15,000	$2,200 / $4,400	$700 / $1,400
Out-of-Pocket Max (individual/Family)	$9,450 / $18,900	$7,100 / $14,200	$2,500 / $5,000	$1,800 / $3,600	$9,100 / $18,200	$7,500 / $15,000	$2,200 / $4,400	$700 / $1,400
MEDICAL BENEFITS	MEMBER COPAYS/COINSURANCE							
PCP Office Visit	*$30	*$30	*$25	$10	*$10	*$10	*$10	*$5
Specialist Office Visit	$60	$60	$50	$20	*$20	*$15	*$15	*$10
Outpatient Facility	50%	50%	30%	10%	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Outpatient Surgery	50%	50%	30%	10%				
Urgent Care Services	*$60	*$60	*$50	$20	*$20	*$15	*$15	*$10
Ambulance Services	$60	$60	$50	$20	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Emergency Room Services	50%	50%	40%	10%				
Inpatient Hospital Care	50%	50%	40%	10%				
Inpatient Skilled Nursing Facility	50%	50%	40%	10%				
Outpatient Mental/Behavioral Substance Abuse	*$30	*$30	*$25	$10	*$10	*$10	*$10	*$5
Inpatient Mental/Behavioral Substance Abuse	50%	50%	40%	10%	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Outpatient Rehabilitation	$60	$60	$50	$20				
Medical Imaging (CT/PET Scans, MRIs)	50%	50%	40%	10%				
Routine Lab/X-Ray/Diagnostic Imaging	$30	$30	$25	$10				
PRESCRIPTION DRUGS	MEMBER COPAYS/COINSURANCE							
Prescription Drug Deductible (individual/Family) (90-day mail order supply available at 2.5 times copay)	Combined with Medical Deductible	Combined with Medical Deductible	Combined with Medical Deductible	N/A	Combined with Medical Deductible	Combined with Medical Deductible	Combined with Medical Deductible	Combined with Medical Deductible
Generic	*$10	*$10	*$5	$5	*$10	*$5	*$5	*$5
Preferred Brand	$80	$80	$70	$20	No charge after deductible	No charge after deductible	No charge after deductible	No charge after deductible
Non-Preferred Brand	$120	$120	$100	$40				
Specialty High-Cost Drugs	50%	50%	40%	20%				

* Services are exempt from deductible where indicated (PCP/Specialist/Urgent Care/Generic RX).
For deductible plans: All coinsurance/copays apply after annual deductible has been met unless otherwise indicated.

COMMUNITY 2024 PLAN DESIGNS

COMMUNITY HEALTH CHOICE

Silver

PLANS/VISITS	COMMUNITY SELECT SILVER 19 PLAN ID 27248TX0010019				COMMUNITY PREMIER SILVER 20 PLAN ID 27248TX0010020			
	SILVER 19 251% FPL AND ABOVE	**SILVER 19 (73)** 201%-250% FPL	**SILVER 19 (87)** 151%-200% FPL	**SILVER 19 (94)** 100%-150% FPL	**SILVER 20** 251% FPL AND ABOVE	**SILVER 20 (73)** 201%-250% FPL	**SILVER 20 (87)** 151%-200% FPL	**SILVER 20 (94)** 100%-150% FPL
Medical Deductible (individual/Family)	$4,500 / $9,000	$3,500 / $7,000	$500 / $1,000	N/A	$5,900 / $11,800	$5,700 / $11,400	$700 / $1,400	N/A
Out-of-Pocket Max (individual/Family)	$9,100 / $18,200	$7,250 / $14,500	$3,000 / $6,000	$1,600 / $3,200	$9,100 / $18,200	$7,200 / $14,400	$3,000 / $6,000	$1,800 / $3,600
MEDICAL BENEFITS	MEMBER COPAYS/COINSURANCE							
PCP Office Visit	*$30	*$30	*$20	$5	*$40	*$30	*$20	$0
Specialist Office Visit	*$80	*$80	*$40	$25	*$80	*$60	*$40	$10
Outpatient Facility	40%	30%	30%	10%	40%	40%	30%	25%
Outpatient Surgery	40%	30%	30%	10%	40%	40%	30%	25%
Urgent Care Services	*$80	*$80	*$40	$25	*$60	*$45	*$30	$5
Ambulance Services	$80	$80	$40	$25	$80	$60	$40	$10
Emergency Room Services	40%	30%	30%	10%	40%	40%	30%	25%
Inpatient Hospital Care	40%	30%	30%	10%	40%	40%	30%	25%
Inpatient Skilled Nursing Facility	40%	30%	30%	10%	40%	40%	30%	25%
Outpatient Mental/Behavioral Substance Abuse	*$30	*$30	*$20	$5	*$40	*$30	*$20	$0
Inpatient Mental/Behavioral Substance Abuse	40%	30%	30%	10%	40%	40%	30%	25%
Outpatient Rehabilitation	$80	$80	$40	$25	*$40	*$30	*$20	$10
Medical Imaging (CT/PET Scans, MRIs)	40%	30%	30%	10%	40%	40%	30%	25%
Routine Lab/X-Ray/Diagnostic Imaging	$30	$30	$20	$5	40%	40%	30%	25%
PRESCRIPTION DRUGS	MEMBER COPAYS/COINSURANCE							
Prescription Drug Deductible (individual/Family) (90-day mail order supply available at 2.5 times copay)	Combined with Medical Deductible	Combined with Medical Deductible	Combined with Medical Deductible	N/A	Combined with Medical Deductible	Combined with Medical Deductible	Combined with Medical Deductible	N/A
Generic	*$10	*$10	*$10	$5	*$20	*$20	*$10	$0
Preferred Brand	$40	$40	$25	$15	*$40	*$40	*$20	$15
Non-Preferred Brand	$100	$80	$60	$40	$80	$80	$60	$50
Specialty High-Cost Drugs	50%	50%	50%	30%	$350	$350	$250	$150

* Services are exempt from deductible where indicated (PCP/Specialist/Urgent Care/Generic RX).
For deductible plans: All coinsurance/copays apply after annual deductible has been met unless otherwise indicated.

COMMUNITY 2024 PLAN DESIGNS

COMMUNITY HEALTH CHOICE

Gold

PLANS/VISITS	PREMIER GOLD 001 OFF-EXCHANGE PLAN ID 27248TX0010001	PREMIER GOLD 005 PLAN ID 27248TX0010005	PREMIER GOLD 021 PLAN ID 27248TX0010021	SELECT GOLD 022 PLAN ID 27248TX0010022
Medical Deductible (individual/Family)	N/A	$1,600/ $3,200	$1,500/ $3,000	$1,800/ $3,600
Out-of-Pocket Max (individual/Family)	$9,450 / $18,900	$9,450 / $18,900	$8,700 / $17,400	$9,450 / $18,900
MEDICAL BENEFITS	MEMBER COPAYS/COINSURANCE			
PCP Office Visit	$30	*$20	*$30	*$15
Specialist Office Visit	$65	*$40	*$60	*$30
Outpatient Facility	$300	25%	25%	30%
Outpatient Surgery	$300	25%	25%	30%
Urgent Care Services	$65	*$40	*$45	*$30
Ambulance Services	$65	$40	$60	$30
Emergency Room Services	$800	25%	25%	30%
Inpatient Hospital Care	**$800	25%	25%	30%
Inpatient Skilled Nursing Facility	**$800	25%	25%	30%
Outpatient Mental/Behavioral Substance Abuse	$30	*$20	*$30	*$15
Inpatient Mental/Behavioral Substance Abuse	**$800	25%	25%	30%
Outpatient Rehabilitation	$65	$40	*$30	$30
Medical Imaging (CT/PET Scans, MRIs)	$500	25%	25%	30%
Routine Lab/X-Ray/Diagnostic Imaging	$30	$20	25%	$15
PRESCRIPTION DRUGS	MEMBER COPAYS/COINSURANCE			
Prescription Drug Deductible (individual/Family) (90-day mail order supply available at 2.5 times copay)	N/A	Combined with Medical Deductible	Combined with Medical Deductible	Combined with Medical Deductible
Generic	$25	*$10	*$15	*$10
Preferred Brand	$40	$50	*$30	*$50
Non-Preferred Brand	$80	$75	*$60	$100
Specialty High-Cost Drugs	30%	35%	*$250	40%

* Services are exempt from deductible where indicated (PCP/Specialist/Urgent Care/Generic RX).
** Copay applies for first 5 days of admission for all inpatient services.
For deductible plans: All coinsurance/copays apply after annual deductible has been met unless otherwise indicated.

FIND OUT

HOW YOU CAN GET COVERED IN 2024!

Visit
CommunityHealthChoice.org

Call us at **713.295.6704**
or toll-free at **1.855.315.5386**

Email **Marketplace@**
CommunityHealthChoice.org

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COMMUNITY
HEALTH CHOICE