HEALTH BENEFIT PLAN

EVIDENCE OF COVERAGE

HEALTH INSURANCE MARKETPLACE-DEDUCTIBLE 2027

COMMUNITY HEALTH CHOICE



CommunityHealthChoice.org

713.295.6704 | 1.855.315.5386

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524-DR026

FEDERALLY FACILITATED HEALTH INSURANCE MARKETPLACE
CONSUMER CHOICE HEALTH BENEFIT PLAN

EVIDENCE OF COVERAGE

Community Health Choice, Inc.
4888 Loop Central Dr., Suite 600
Houston, Texas 77081
713.295.6704 and 1.855.315.5386
TDD: 7-1-1
www.communityhealthchoice.org

PLEASE READ THIS CONTRACT CAREFULLY

This Evidence of Coverage (Contract) is a Contract issued to You as our member (You / Your) and states the coverage to which You are entitled and describes the healthcare plan terms including restrictions and limitations.

We agree to pay benefits for Services rendered to You, subject to all the terms of this Contract.

This Contract is issued in consideration of the Contract Holder's application, incorporated herein, and in consideration of the Contract Holder's payment of premium as provided under this Contract.

Omissions or misstatements of material facts in the application may cause Your Contract to be voided and claims to be denied. Please check Your application for errors and write to Us if any information is not correct or is incomplete.

This Contract and the coverage it provides becomes effective 12:00 a.m. (Your time) of the Effective Date stated on Your Member Identification Card. This Contract and the coverage it provides terminates at 12:00 midnight (Your time) on the date of termination. The provisions stated above, and on the following pages, are part of this Contract.

This Consumer Choice Health Benefit Plan, either in whole or in part, does not provide state-mandated health benefits normally required in evidences of coverage in Texas. This standard health-benefit plan may provide a more affordable health plan for You. Although, at the same time, it may provide You with fewer health plan benefits than those normally included as state-mandated health benefits in Texas. Please consult with Your insurance agent to discover which state-mandated health benefits are excluded in this Evidence of Coverage.

Eligibility

A Contract Holder who resides, lives, or works in the Service Area and their Dependents. A Dependent may reside anywhere in the United States. If Coverage was purchased through the Marketplace, a person must have been determined eligible through the Marketplace.

Renewability

This Contract remains in effect at the option of the Contract Holder except as provided in the "Renewability and Termination" section of this Contract.

Right to Return Contract

You have the right to return this Contract within 10 calendar days of receiving it and to have the portion of premium You paid refunded if, after examination of the Contract, You are not satisfied with it for any reason. If You choose to return this Contract within the 10-day period, it is considered void from the beginning and the parties will be in the same position as if no Contract had been issued. If Services are rendered or we pay claims during the 10 days, You are responsible for such Services or claims.

_____
[Signature of Officer]

Lisa Wright
President and Chief Executive Officer

Have a Complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a Complaint with the Texas Department of Insurance, you should also file a Complaint or Appeal through your insurance company or HMO. If you don't, you may lose your right to Appeal.

Community Health Choice

To get information or file a complaint with your insurance company or HMO:

Call: 713.295.6704
Toll-free: 1.855.315.5386
Email: ServiceImprovement@CommunityHealthChoice.org
Mail: Community Health Choice
Service Improvement
4888 Loop Central Drive, Suite 600
Houston, Texas 77081

The Texas Department of Insurance

To obtain help with an insurance question or file a Complaint with the state:

Call: 1.800.252.3439
Online: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: MC 111-1A, P.O. Box 12030, Austin, TX 78711

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Community Health Choice

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Llame a: 713.295.6704
Teléfono gratuito: 1.855.315.5386
Correo electrónico: Service Improvement@CommunityHealthChoice.org
Dirección postal: Community Health Choice
Service Improvement
4888 Loop Central Drive, Suite 600
Houston, Texas 77081

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame: 1.800.252.3439
En línea: www.tdi.texas.gov
Correo electrónico: ConsumerProtection@tdi.texas.gov
Dirección postal: MC 111-1A, P.O. Box 12030, Austin, TX 78711

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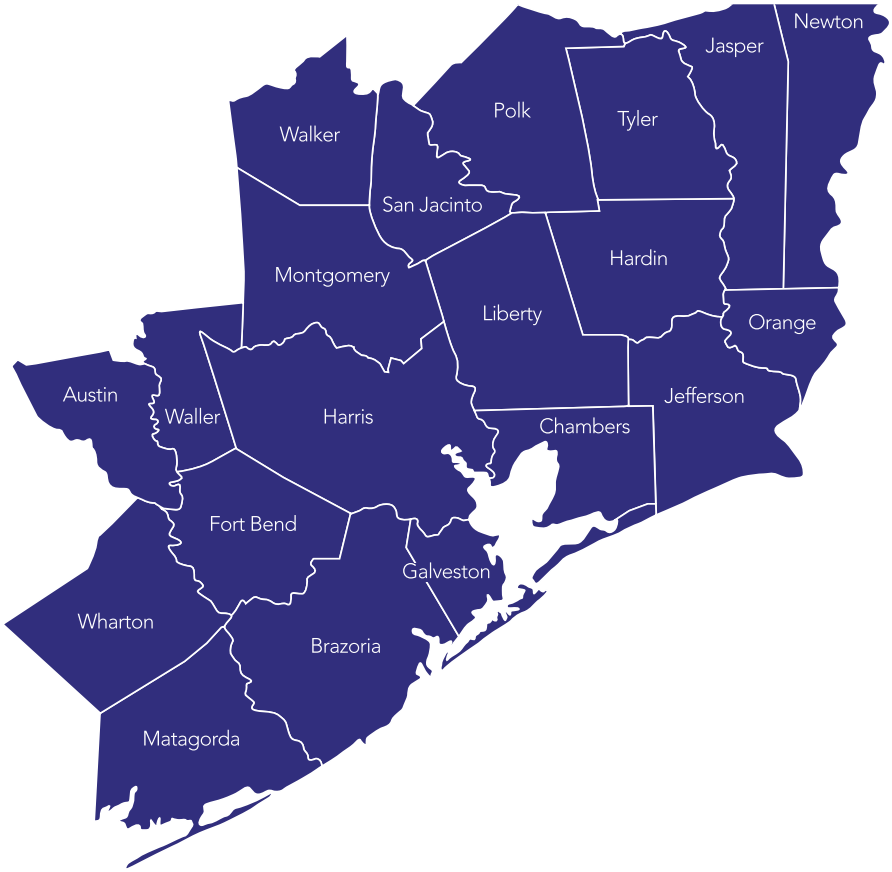
Schedule of Benefits. 66

Welcome to Community Health Choice, Inc.

Thank you for choosing Community Health Choice, Inc. (Community) as Your health benefits plan. Community is committed to arranging access for You to excellent care when You are sick or injured, and benefits to keep You healthy. We encourage You to read this Evidence of Coverage and learn about the ways this plan can help You.

This Evidence of Coverage provides benefits established by the Federal Government in the Affordable Care Act. In Texas, a Federally Facilitated Health Insurance Marketplace was created through which Qualified Health Plans are offered to eligible persons. The Federal Government and the State of Texas have established rules for the general operation of this plan. To make this coverage more affordable, You may be eligible for Federal advance payment tax credits to help pay for Your cost
of coverage. Please refer to the "Premium Payment" section of this Contract.

Service Area



The Service Area is also listed at www.communityhealthchoice.org. You may also call Member Services at the telephone number on Your Member Identification Card.

1. Definitions

Acquired Brain Injury means a neurological insult to the brain, which is not hereditary, congenital or degenerative. The injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment
of physical functioning, sensory processing, cognition, or psychosocial behavior.

Advanced Imaging for the purpose of this definition, includes Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Positron Emission Tomography (PET), Single Photon Emission Computed Tomography (SPECT), Computed Tomography (CT) imaging, and Nuclear Medicine.

Adverse Determination a determination by Us or Our designee that health care Services or Prescription Drugs furnished
or proposed to be furnished to a Covered Person are not Medically Necessary or are Experimental or Investigational. An Adverse Determination does not include a denial based solely on failure to obtain required Prior Authorization or other administrative noncompliance with Our processes and procedures, unless applicable law requires otherwise.

Affordable Care Act means the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152).

Appeal means Our formal process by which a Covered Person, an individual acting on behalf of a Covered Person, or a Covered Person's Provider of record may request reconsideration of an Adverse Determination or Denial of Benefits.

Autism Spectrum Disorder means a neurobiological disorder that includes autism, Asperger's syndrome, or pervasive developmental disorder—not otherwise specified. A neurobiological disorder means an Illness of the nervous system caused by genetic, metabolic, or other biological factors.

Bodily Injury means bodily damage other than Illness, including all related conditions and recurrent symptoms, resulting from sudden physical trauma which could not be avoided or predicted in advance. The Bodily Injury must be the direct cause of the loss, independent of disease, bodily infirmity, or any other cause. Bodily damage resulting from infection or muscle strain due to athletic or physical activity is considered an Illness and not a Bodily Injury.

Bone Marrow Transplant means the transplant of human blood precursor cells that are administered to a patient following high-dose, ablative or myelosuppresive chemotherapy. Such cells may be derived from bone marrow, circulating blood, or a combination of bone marrow and circulating blood obtained from the patient in an autologous transplant from a matched related or unrelated donor or cord blood. If chemotherapy is an integral part of the treatment involving a Covered Organ Transplant of bone marrow, the term bone marrow includes the harvesting, the transplantation, and the chemotherapy components.

Brand-Name Drug means a drug, medicine or medication that is manufactured and distributed by only one pharmaceutical manufacturer, or any drug product that has been designed as brand name by an industry- recognized source used by Us.

Calendar Year means the period of time beginning on any January 1st and ending on the following December 31st. The first Calendar Year begins for a Covered Person on the date benefits under this Contract first become effective for that Covered Person and ends on the following December 31st.

Cognitive Communication Therapy means Services designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information.

Cognitive Rehabilitative Therapy means Services designed to address therapeutic cognitive activities, based on an assessment and understanding of the individual's brain-behavioral deficit.

Community means Community Health Choice, Inc., a licensed health maintenance organization.

Community Reintegration Therapy (CTR) is a specialized, multidisciplinary form of rehabilitation designed to help individuals transition from a clinical or residential setting back into daily life.

Chemical Dependency means the abuse of, or psychological or physical dependence on, or addiction to alcohol or a controlled substance.

Clinical Trial means a clinical research study or clinical investigation that is conducted in relation to the prevention, detection, or treatment of cancer or other Life-Threatening Disease and is approved by:

1. The Centers for Disease Control (CDC) and Prevention of the U.S. Department of Health and Human Services;
2. The National Institutes of Health (NIH);
3. The U.S. Food and Drug Administration (FDA);
4. The U.S. Department of Defense (DOD);
5. The U.S. Department of Veterans Affairs (VA); or
6. An Institutional review board of an institution in the state that has an agreement with the Office for Human Research Protection (OHRP) of the U.S. Department of Health and Human Services (HHS);
7. The Agency for Health Care Research and Quality;
8. The Centers for Medicare and Medicaid Services; or
9. The Department of Energy.

Comparable Emergency Facility a location at which Emergency Services are rendered, including a stationary or mobile facility, a freestanding emergency medical care facility, a Rural Health Clinic, a Level V Trauma Facility, or another properly licensed or certified facility with the personnel and equipment necessary to provide Emergency Services consistent with applicable law and generally accepted standards of care.

For purposes of Emergency Care related to Mental Illness or Mental Health conditions, Comparable Emergency Facility also includes a facility capable of providing 24-hour residential and psychiatric Services, including a facility operated or designated by the Texas Department of State Health Services, a licensed private mental hospital, a community center or facility operated by a community center, an identifiable psychiatric unit of a general hospital, or a hospital operated by a federal agency, each to the extent authorized under applicable law.

Complaint means an expression of dissatisfaction, orally or in writing, by a Complainant regarding any aspect of Our operations, including plan administration, access to care, the quality of care, the manner in which Services are provided, or a disenrollment decision. A Complaint does not include a misunderstanding or misinformation that is promptly resolved to the Covered Person's satisfaction, and does not include a request to review an Adverse Determination or other Denial of Benefits that is subject to Appeal.

Complainant means a Covered Person, or a Physician, Provider, or other person designated to act on behalf of a Covered Person, who files a Complaint.

Complications of Pregnancy means conditions, requiring Hospital Confinement (when a pregnancy is not terminated), whose diagnoses are distinct from pregnancy, but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity. Complications of Pregnancy do not include false labor, occasional spotting, Physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a clinically distinct complication of pregnancy.

Confined/Confinement means the status of being a resident patient in a Hospital or Healthcare Treatment Facility receiving Inpatient Services. Confinement does not mean detainment in Observation Status. Successive Confinements are considered to be one Confinement if they are:

1. Due to the same Bodily Injury or Illness; and
2. Separated by fewer than 30 consecutive days when the Covered Person is not Confined.

Consumer Choice Health Benefit Plan means group or individual accident or sickness insurance policy, or evidence of coverage that, in whole or in part, does not offer or provide state-mandated health benefits, but provides creditable coverage as defined by the Texas Insurance Code § 1205.004(a) or 1501.102(a).

Contract means this document, together with any amendments, riders, and endorsements that describe the agreement between You and Us.

Contract Holder means a person who meets all eligibility requirements and enrollment requirements of this Contract and whose application as the Primary Applicant has been accepted and for whom premium payment has been received by Us.

Contractual Denial means a denial, reduction, termination, or failure to provide or make payment for a benefit based on eligibility, enrollment, rescission, and exclusion or limitation of this Contract, or another term of this Contract that does not involve a determination of Medical Necessity or whether a Service is Experimental or Investigational.

Coinsurance means the percentage of covered expenses that a Covered Person must pay for certain Covered Services,
as shown on the Schedule of Benefits.

Copayment/Copay means a specified dollar amount or amount expressed as a percentage shown on the Schedule of Benefits You are obligated to pay to a Physician or Provider toward covered expenses of certain benefits specified in this Contract each time a Covered Service is received, regardless of any amounts that may be paid by Us. Any Copayments do not apply toward the Deductible.

Cosmetic Surgery means Surgery, procedure, injection, medication, or treatment primarily designed to improve appearance, self-esteem or body image and/or to relieve or prevent social, emotional or psychological distress.

Cost Share means the Deductible and/or Copayment that must be paid by the Covered Person for Prescription Drugs.

Covered Service means a service or supply that is covered under this Contract, is Medically Necessary, and is otherwise eligible for payment under this Contract. A Covered Service is not Experimental or Investigational and is not otherwise excluded or limited by this Contract or any amendment, rider, or endorsement. Except for Emergency Care and other Services required to be covered under applicable law, Covered Services are generally available only within the Service Area and in accordance with this Contract's Participating Provider and authorization requirements.

Covered Organ Transplant means only the Services, care and treatment received for or in connection with the pre-approved transplant of the organs identified in the "Your Contract Benefits" section, which are Medically Necessary Services, and which are not Experimental or Investigational. Transplantation of multiple organs, when performed simultaneously, is considered one organ transplant.

Covered Person means the Contract Holder eligible to receive Contract benefits.

Custodial Care means Services given to a Covered Person if:

1. The Covered Person needs Services that include, but are not limited to, assistance with dressing, bathing, preparation and feeding of special diets, walking, supervision of medication that is ordinarily self- administered, getting in and out of bed, and maintaining continence;
2. The Services are required to primarily maintain and not likely to improve the Covered Person's condition; or
3. Long-Term Care Services whether provided at home, in the community, in assisted living, or in-nursing homes.

Services may still be considered Custodial Care by Us even if:

1. The Covered Person is under the care of a Healthcare Practitioner,

2. The Services are prescribed by a Healthcare Practitioner to support or maintain the Covered Person's condition;

3. Services are being provided by a Nurse; or

4. The Services involve the use of skills which can be taught to a layperson and do not require the technical skills of a Nurse.

Deductible means the amount of covered expense that an individual and/or family must incur in a Plan Year and is responsible to pay before any Copayment is applied. This amount will be applied on a Plan-Year basis and does not apply to certain Services. The Deductible is shown on the Schedule of Benefits.

One or more of the following Deductibles may apply to Covered Services:

1. Deductible. The amount of Covered Expense an individual and/or a family must incur in the Plan Year before benefits become payable and before any Copayment is applied. Deductible does not apply to Preventive Services.

2. Family Deductible. Each Plan Year, once the number of individual Deductibles, as shown on the Schedule of Benefits, are fulfilled, no further individual Deductibles will have to be paid for the rest of that same Plan Year.

Denial of Benefits means any denial, reduction, termination, or failure to provide or make payment for a benefit under this Contract, including an Adverse Determination and a Contractual Denial.

Dental Injury means an injury to a Sound Natural Tooth caused by a sudden and external force that could not be predicted in advance and could not be avoided. It does not include biting or chewing injuries.

Dependent means Contract Holder's legally recognized spouse, natural born child, step-child, legally adopted child, a child placed for adoption, or a child for whom the Contract Holder is a party in a suit in which adoption of the child is sought by the Contract Holder, whose age is less than the Limiting Age, a child whose age is less than the Limiting Age and for whom You have received a court or administrative order to provide coverage until such court or administrative order is no longer in effect, the child is enrolled for comparable health insurance or will be enrolled in comparable coverage that will take effect no later than the Effective Date of the cancellation or non-renewal, an unmarried grandchild, if the grandchild is a Dependent for Federal Income Tax purposes at the time of application, whose age is less than the Limiting Age or the Contract Holder's adult child who meets the following conditions:

1. Is beyond the Limiting Age of a child;

2. Is unmarried;

3. Has a physical or mental disability; and

4. Incapable of self-sustaining employment.

In order for the covered adult Dependent child to remain eligible as specified above, We must receive notification within 31 days of the covered Dependent child's attainment of the Limiting Age of these conditions.

Each child, other than the child who qualifies because of a court or administrative order, must meet all of the qualifications of a Dependent as determined by Us.

You must furnish satisfactory proof to Us upon Our request that the condition as defined in the items above continuously exists on and after the date the Limiting Age is reached. After two years from the date the first proof was furnished, We may not request such proof more often than annually. If satisfactory proof is not submitted to Us, the child's coverage will not continue beyond the last date of eligibility.

The Limiting Age for each child to be considered a Dependent under this Contract is the child's 26th birthday.

Diabetes Equipment means:

1. Blood glucose monitors, including noninvasive glucose monitors and glucose monitors designed to be used by blind individuals;

2. Insulin pumps and associated appurtenances;

3. Insulin infusion devices;

4. Podiatric appliances for the prevention of complications associated with diabetes; and

5. New or improved Diabetes Equipment approved by the United States Food and Drug Administration.

Diabetic Supplies means:

1. Test strips for blood glucose monitors;
2. Visual reading and urine test strips;
3. Lancets and lancet devices;
4. Insulin and insulin analogs;
5. Injection aids;
6. Syringes;
7. Prescriptive and non-Prescription oral agents for controlling blood sugar levels;
8. Glucagon emergency kits;
9. Alcohol swabs; and
10. New or improved Diabetic Supplies, including improved insulin or another Prescription drug, approved by the United States Food and Drug Administration.

Diagnostic Imaging means an imaging examination using mammography, ultrasound imaging, or magnetic resonance imaging designed to evaluate:

1. a subjective or objective abnormality detected by a Physician or patient in a breast;
2. an abnormality seen by a Physician on a screening mammogram;
3. an abnormality previously identified by a Physician as probably benign in a breast for which follow-up imaging is recommended by a Physician; or
4. an individual with a personal history of breast cancer or dense breast tissue.

Dispensing Limit means the monthly drug dosage limit and/or the number of months the drug usage is usually needed to treat a particular condition.

Drug Formulary means a list of Prescription Drugs, medications, and supplies designated by Us, including any applicable Dispensing Limits, Prior Authorization requirements, and Step Therapy requirements. The current Drug Formulary is available on Community's website or by contacting Member Services at the telephone number on Your Member Identification Card.

Durable Medical Equipment means equipment, defined by Medicare Part B, which meets the following criteria:

1. It can withstand repeated use;
2. It is primarily and customarily used to serve a medical purpose rather than being primarily for comfort or convenience;
3. It is usually not useful to a person except to treat a Bodily Injury or Illness;
4. It is Medically Necessary and necessitated by the Covered Person's Bodily Injury or Illness;
5. It is not typically furnished by a Hospital or Skilled-Nursing Facility; and
6. It is prescribed by a Healthcare Practitioner as appropriate for use in the home.

Effective Date means the first date all the terms and provisions of this Contract apply. It is the date that appears on Your Member Identification Card.

Electronic/Electronically means relating to technology having electrical, digital, magnetic, wireless, optical, electromagnetic or similar capabilities.

Emergency Care means covered services provided to evaluate and treat an Emergency Medical Condition, including the medical screening examination and the Services required to evaluate and stabilize the Covered Person, in accordance with applicable law. An Emergency Medical Condition is a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson with an average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention could result in serious jeopardy to the person's health, serious impairment of bodily functions, serious dysfunction of any bodily organ or part, serious disfigurement, or, for a pregnant person, serious jeopardy to the health of the pregnant person or fetus. Emergency Care is not subject to Prior Authorization to the extent prohibited by applicable law and, when required by applicable law, will be covered without regard to whether the Provider or facility is Participating or Non-Participating. Coverage is based on the Covered Person's presenting symptoms and circumstances, not solely on the final diagnosis. Services furnished after the Covered Person is stabilized are not Emergency Care, except to the extent required by applicable law, and may be subject to the terms of this Contract applicable to Post-Stabilization Services and other Covered Services.

Emergency Medical Services Provider means a person who uses or maintains emergency medical services vehicles, medical equipment, and emergency medical services personnel to provide emergency medical services.

Experimental or **Investigational** means any procedure, treatment, supply, device, equipment, facility or drug (all Services) determined by Our Medical Director or his/her designee to:

1. Not be a benefit for diagnosis or treatment of an Illness or a Bodily Injury;
2. Not be as beneficial as any established alternative; or
3. Not show improvement outside the Investigational setting.

A drug, biological product, device, treatment or procedure that meets any one of the following criteria will be considered Experimental or Investigational:

1. Cannot be lawfully marketed without the final approval of the United States Food and Drug Administration (FDA) for the particular Illness or Bodily Injury and which lacks such final FDA approval for the use or proposed use, unless:
    a. Found to be accepted for that use in the most recently published edition of the United States Pharmacopoedia-Drug Information for Healthcare Professional (USP-DI) or in the most recently published edition of the American Hospital Formulary Service (AHFS) Drug Information;
    b. Identified as safe, widely used and generally accepted as effective for that use as reported in nationally recognized peer reviewed medical literature published in the English language as of the date of service; or
    c. Is mandated by state law.
2. Is a device required to receive Premarket Approval (PMA) or 510K approval by the FDA, but has not received a PMA or 510K approval;
3. Is not identified as safe, widely used, and generally accepted as effective for the proposed use as reported in nationally recognized peer reviewed medical literature published in the English language as of the date of service;
4. Is the subject of a National Cancer Institute (NCI) Phase I, II or III trial, or any trial not recognized by NCI regardless of the Phase except as expressly provided in this Contract;
5. Is identified as not covered by the Centers for Medicare and Medicaid Services (CMS) Medicare Coverage Issues Manual, a CMS Operational Policy Letter or a CMS National Coverage Decision except as required by state or federal law;

6. The FDA has not determined the device to be contraindicated for the particular Illness or Bodily Injury for which the device has been prescribed; or

7. The treatment, Services or supplies are:
   a. Not as effective in improving health outcomes and not as cost effective as established technology; or b. Not usable in appropriate clinical contexts in which established technology is not employable

Any service which is not covered due to being Experimental or Investigational is eligible for review of that determination by an Independent Review Organization (IRO). See the Appeals Process to Independent Review Organization provision in the "General Provisions" section of this Contract.

Family Member means You or Your spouse, or You or Your spouse's child, brother, sister or parent.

Family Out-of-Pocket Maximum means each Plan Year once a family has fulfilled the Family Out-of-Pocket Maximum amount, as shown on the Schedule of Benefits, no Covered Person in that family will have any additional out-of-pocket responsibility for Covered Services for the rest of that same Plan Year. The maximum amount any one Covered Person in a family can contribute toward the Family Out-of-Pocket Maximum in a Calendar Year is the amount applied toward the individual Out-of-Pocket Maximum.

Federally Facilitated Health Insurance Marketplace means a structured Marketplace created by the Affordable Care Act where qualified individuals and small business can shop for private health insurance coverage.

Fertility Preservation Services means the collection and preservation of sperm, unfertilized oocytes, and ovarian tissues but does not include the storage of such unfertilized genetic material.

Free-Standing Surgical Facility means any licensed public or private establishment that has permanent facilities that are equipped and operated primarily for the purpose of performing outpatient Surgery. It does not provide Services or accommodations for patients to stay overnight.

Generic Drug means a drug, medicine or medication that is manufactured, distributed, and available from a pharmaceutical manufacturer and identified by a chemical name, or any drug product that has been designated as generic by an industry-recognized source used by Us.

Healthcare Practitioner means an individual practitioner, professionally licensed by the appropriate state agency, to diagnose or treat a Bodily Injury or Illness, and who provides Services within the scope of that license. A Healthcare Practitioner's Services are not covered if the practitioner resides in the Covered Person's home or is a Family Member.

Healthcare Treatment Facility means only a facility, institution or clinic duly licensed by the appropriate state agency and is primarily established and operating within the scope of its license. Healthcare Treatment Facility does not include a Residential Treatment Center or halfway house.

Home Healthcare Agency means a Home Healthcare Agency or Hospital which meets all of the following requirements:

1. It must primarily provide skilled nursing Services and other therapeutic Services under the supervision of Healthcare Practitioners or Nurses;
2. It must be operated according to established processes and procedures by a group of professional medical people, including Healthcare Practitioners and Nurses;
3. It must maintain clinical records on all patients; and
4. It must be licensed by the jurisdiction where it is located, if licensure is required. It must be operated according to the laws of that jurisdiction which pertains to agencies providing home healthcare.

Home Healthcare Plan means a plan of healthcare established with a home healthcare Provider. The Home Healthcare Plan must consist of:

1. Physician certification;
2. Services provided by a licensed Home Health Agency;

3. Care by or under the supervision of a Nurse or another Healthcare Practitioner and not for Custodial Care;
4. Physical, speech, occupational and respiratory therapy;
5. Medical social work and nutrition Services; or
6. Medical appliances, equipment and laboratory Services, if expenses incurred for such supplies would have been Covered Services during a Confinement.

A Healthcare Practitioner must:

1. Review and approve the Home Healthcare Plan;
2. Certify and verify that the Home Healthcare Plan is required in lieu of Confinement or a continued Confinement; and
3. Not be related to the Home Healthcare Agency by ownership or Contract.

Home Healthcare Visit means home healthcare Services provided by any one Healthcare Practitioner for four consecutive hours or any portion thereof.

Hospice Care Agency means an agency that:

1. Has the primary purpose of providing hospice Services to Hospice Patients;
2. Is licensed and operated according to the laws of the state in which it is located;
3. Meets the following requirements:
   a. Has obtained any required certificate of need;
   b. Provides 24-hour-a-day, seven-day-a-week service, supervised by a Healthcare Practitioner,
   c. Has a full-time administrator;
   d. Keeps written records of Services provided to each patient;
   e. Has a coordinator who:
      i. Is a Nurse; and
      ii. Has four years of full-time clinical experience, of which at least two were involved in caring for terminally ill patients; and
4. Has a licensed social service coordinator.

Hospice Care Program means a coordinated, interdisciplinary program provided by a hospice designed to meet the special physical, psychological, spiritual, and social needs of a terminally ill Covered Person and his/her immediate Family Members, by providing Palliative Care and supportive medical, nursing, and other Services through at-home or inpatient care. A hospice must:

1. Be licensed by the laws of the jurisdiction where it is located and run as a hospice as defined by those laws; and
2. Provide a program of treatment for a least two unrelated individuals who have been medically diagnosed as having no reasonable prospect for cure for their Illness; and as estimated by their Healthcare Practitioners, are expected to live less than six months as a result of that Illness.

For purposes of the Hospice Care benefit only, immediate Family Member is considered to be the Covered Person's parent, spouse, and children or stepchildren.

Hospice Facility means a licensed facility or part of a facility that:

1. Principally provides hospice care;
2. Keeps medical records of each patient;
3. Has an ongoing quality assurance program;

4. Has a Healthcare Practitioner on call at all times;
5. Provides 24-hour-a-day skilled nursing Services under the direction of a Nurse; and
6. Has a full-time administrator.

Hospice Patient means a terminally ill person who has six months or less to live, as certified by a Healthcare Practitioner.

Hospital means an institution that meets all of the following requirements:

1. It must provide, for a fee, medical care and treatment of sick or injured patients on an inpatient basis;
2. It must provide or operate, either on its premises or in facilities available to the Hospital on a pre- arranged basis, medical, diagnostic, and surgical facilities;
3. Care and treatment must be given by and supervised by Healthcare Practitioners. Nursing Services must be provided on a 24-hour basis and must be given by or supervised by Nurses;
4. It must be licensed by the laws of the jurisdiction where it is located;
5. It must be operated as a Hospital as defined by those laws; and
   a. It must not be primarily a convalescent, rest or nursing home; or
   b. Facility providing custodial, educational or rehabilitative care. The Hospital must be accredited by one of the following:
      1. The Joint Commission on the Accreditation of Hospitals;
      2. The American Osteopathic Hospital Association;
      3. The Commission on the Accreditation of Rehabilitative Facilities; or
      4. DNV (Det Norske Veritas).

Identification or **ID Cards** means cards each Covered Person receives that contain Our address and telephone number.

Illness means disturbance in function or structure of the Covered Person's body that causes physical signs or symptoms that if left untreated, will result in a deterioration of the health state of the structure or system(s) of the Covered Person's body. Congenital defects will be treated the same as any other Illness. Complications of Pregnancy will be treated the same as any other Illness.

Infertility Treatment means any treatment, supply, medication or service given to achieve pregnancy or to achieve or maintain ovulation. This includes, but is not limited to:

1. Artificial insemination;
2. In vitro fertilization;
3. GIFT;
4. ZIFT;
5. Tubal ovum transfer;
6. Embryo freezing or transfer;
7. Sperm storage or banking;
8. Ovum storage or banking;
9. Embryo or zygote banking;
10. Diagnostic and/or therapeutic laparoscopy;
11. Hysterosalpingography;
12. Ultrasonography;
13. Endometrial biopsy; and
14. Any other assisted reproductive techniques or cloning methods.

Inpatient Services are Services rendered to a Covered Person during their Confinement.

Intensive Outpatient Program means a freestanding or Hospital-based program that provides services for at least 3 hours per day, two or more days per week, to treat Mental Illness, Chemical Dependency, or specializes in the treatment of co-occurring Mental Illness with Chemical Dependency.

Legend Drug means any medicinal substance the label of which, under the Federal Food, Drug and Cosmetic Act, is required to bear the legend: Caution: Federal Law prohibits dispensing without Prescription.

Life-Threatening Disease means a disease or condition from which the likelihood of death is probable unless the course of the disease is interrupted.

Limiting Age means the Dependent's 26th birthday.

Low-Dose Mammography means:

1. The x-ray examination of the breast using equipment dedicated specifically for mammography including an x-ray tube, filter, compression device, and screens with an average radiation exposure delivery of less than one rad mid-breast and with two views for each breast;

2. Digital mammography; or

3. Breast tomosynthesis.

Low Vision Aids means optical, electronic, or adaptive tools designated to improve visual function and daily life for individuals with vision loss that cannot be corrected by standard glasses or surgery.

Mail-Order Pharmacy means a Pharmacy that provides covered mail-order Pharmacy Services, as defined by Us and delivers covered Prescriptions or refills through the mail to Covered Persons.

Maintenance Care means Services furnished mainly to:

1. Maintain, rather than improve, a level of physical or mental function; or

2. Provide a protected environment free from exposure that can worsen the Covered Person's physical or mental condition.

Marketplace means the Federally Facilitated Health Insurance Marketplace through which Qualified Health Plans are offered to eligible persons in Texas.

Medical Home is a team health care delivery model led by a Physician, P.A., or N.P. that provides comprehensive and continuous medical care to patients with the goal of obtaining maximized health outcomes.

Medically Necessary means health care Services, treatment, or procedures provided to diagnose, evaluate, prevent, palliate, or treat an Illness, Bodily Injury, condition, disease, or its symptoms, and that are clinically appropriate in type, frequency, extent, site, and duration; consistent with generally accepted standards of medical practice; supported by the Covered Person's medical records and condition; not primarily for the convenience of the Covered Person or Provider; furnished in the most appropriate and cost-effective setting required by the Covered Person's condition; and not Experimental or Investigational.

The fact that a Healthcare Practitioner prescribes, recommends, authorizes, or directs a Service does not, by itself, make the Service Medically Necessary or covered under this Contract.

Mental Health means mental, emotional, or substance use conditions and disorders, and the Services and treatments provided for those conditions and disorders, to the extent covered under this Contract and applicable law.

Mental Illness means a mental, emotional, or behavioral disorder, including a substance use disorder, as recognized under generally accepted diagnostic standards and to the extent covered under this Contract and applicable law.

Neurobehavioral Testing means an evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and premorbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the individual, family, or others.

Neurobehavioral Treatment means interventions that focus on behavior and the variables that control behavior.

Neurocognitive Rehabilitation means Services designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.

Neurocognitive Therapy means Services designed to address neurological deficits in informational processing and to facilitate the development of higher-level cognitive abilities.

Neurofeedback Therapy means Services that utilize operant conditioning learning procedures based on electroencephalography (EEG) parameters and are designed to result in improved mental performance and behavior, and stabilized mood.

Neurophysiological Testing means the administering of a comprehensive battery of tests that evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning.

Neuropsychological Treatment means interventions designed to improve or minimize deficits in behavioral and cognitive processes.

Non-Participating Pharmacy means a Pharmacy that does not participate in Our network as a Participating Pharmacy.

Non-Participating Physician means a Physician who does not participate in Our network as a Participating Physician.

Non-Participating Provider means a Provider that does not participate in Our network as a Participating Provider.

Nuclear Medicine means radiology in which radioisotopes (compounds containing radioactive forms of atoms) are introduced into the body for the purpose of imaging, evaluating organ function or localizing disease or tumors.

Nurse means a registered Nurse (R.N.), a licensed practical Nurse (L.P.N.), or a licensed vocational Nurse (L.V.N.).

Observation Status means outpatient hospital or facility-based services provided while a Covered Person has not been admitted as an Inpatient and is being evaluated, monitored, or treated to determine whether inpatient admission, discharge, or other care is appropriate. Observation Status does not mean that the Covered Person is Confined as an Inpatient.

Off-Label Drug means an approved drug legally prescribed for a purpose for which it has not been specifically approved by the United States Food and Drug Administration.

Organ Transplant Treatment Period means 365 days from the date of discharge from the Hospital following a Covered Organ Transplant received while covered by Us.

Out-of-Pocket Maximum means the most a Covered Person or family must pay during a Plan Year for Covered Services that are subject to the annual limitation on cost-sharing under applicable law and this Contract. Amounts that count toward the Out-of-Pocket Maximum include applicable Deductibles, Copayments, and Coinsurance for Covered Services. Amounts do not count toward the Out-of-Pocket Maximum if they are not required to count under applicable law, including amounts for non-covered Services, charges above the amount protected by law, and penalties or charges that are not recognized as cost-sharing under applicable law. See the Schedule of Benefits for the specific individual and family amounts that apply under this Contract.

1. Utilization management or Prescription Drug penalties;
2. Non-covered Services; or
3. Other Contract limits.

There are separate individual and family Participating Provider Out-of-Pocket Maximums. See the Schedule of Benefits for the specific amounts.

Outpatient Day-Treatment Services means structured Services provided to address deficits in physiological, behavioral, and/or cognitive functions. Such Services may be delivered in settings that include transitional residential, community integration, or nonresidential treatment settings.

Outpatient Services means Services that are rendered to a Covered Person while they are not Confined as a registered inpatient. Outpatient Services include, but are not limited to, Services provided in:

1. A Healthcare Practitioner's office;
2. A Hospital outpatient setting;
3. A free-standing surgical facility;
4. A licensed birthing center; or
5. An independent laboratory or clinic.

Palliative Care means care given to a Covered Person focusing on relieving symptoms like pain and stress to improve daily life, rather than treating the cause of the illness itself.

Partial Hospitalization means Services provided in an outpatient program by a Hospital or Healthcare Treatment Facility in which patients do not reside for a full 24-hour period.

1. For a comprehensive and intensive multidisciplinary interdisciplinary Mental Health or Substance Abuse Disorder treatment for a minimum of five hours a day, five days per week;

2. That provides for social, psychological, and rehabilitative training programs with a focus on reintegration back into the community and admits children and adolescents or adults who must have a treatment program designed to meet the special needs of that age range; and

3. That has Healthcare Practitioners readily available for the emergent and urgent needs of the patients. The partial Hospitalization program must be accredited by the Joint Commission of the Accreditation of Hospitals or in compliance with an equivalent standard.

Licensed drug abuse rehabilitation programs and alcohol rehabilitation programs accredited by the Joint Commission on the Accreditation of Health Care Organizations or approved by the appropriate state agency are also considered partial Hospitalization Services.

Partial Hospitalization does not include Services that are for:

1. Custodial Care; or
2. Day care.

Participating Pharmacy means a Pharmacy that has signed a direct agreement with Us or has been Contracted by Us to provide covered Pharmacy Services, covered Specialty Pharmacy Services or covered Mail-Order Pharmacy Services as defined by Us, to Covered Persons including covered Prescription or refills delivered through the mail.

Participating Physician means a Physician that is designated as such and has signed a direct agreement with Us as an independent contractor, or who has been contracted by Us to provide Services to Covered Persons.

Participating Provider means a Hospital, Healthcare Treatment Facility, Healthcare Practitioner or other Provider who is designated as such and has signed a direct agreement with Us as an independent contractor, or who has been contracted by Us to provide Services to Covered Persons.

Pharmacist means a person who is licensed to prepare, compound, and dispense medication and who is practicing within the scope of his/her license.

Pharmacy means a licensed establishment where Prescription medications are dispensed by a Pharmacist.

Physician means: 1) an individual licensed to practice medicine in this state; 2) a professional association organized under the Texas Professional Association Act (Article 1528f, Vernon's Texas Civil Statutes); 3) an approved nonprofit health corporation certified under Chapter 162, Occupations Code; 4) a medical school or medical and dental unit, as defined or described by Section 61.003, 61.501, or 74.601, Education Code, that employs or contracts with Physicians to teach or provide medical Services or employs Physicians and contracts with Physicians in a practice plan; or 5) another person wholly owned by Physicians.

Plan Year means the period of time beginning on the date benefits under this Contract become effective for that Covered Person and end December 31 of that year.

Post-Acute Care Treatment Services means Services provided after acute-care Confinement and/or treatment that is based on an assessment of the individual's physical, behavioral, or cognitive functional deficits, which include a treatment goal of achieving functional changes by reinforcing, strengthening, or reestablishing previously learned patterns of behavior and/or establishing new patterns of cognitive activity or compensatory mechanisms.

Post-Acute Transition Services means short-term medical and support services designed to bridge the gap between a hospital stay and a patient's return to their home or a long-term care setting.

Post-Stabilization Services means covered services related to an Emergency Medical Condition that are provided after the Covered Person is stabilized and that are Medically Necessary to maintain the stabilized condition or, when clinically appropriate, to improve or resolve the condition. After the Covered Person is stabilized, additional services may require timely notice to Us, review by Us, or Prior Authorization, to the extent permitted by applicable law. We may arrange for the transfer of the Covered Person to a Participating Provider or facility when the Covered Person is stable for transfer, the transfer is clinically appropriate, and the transfer complies with applicable law. If the treating Provider requests authorization and We do not respond within the time required by applicable law, cannot be reached, or if the Covered Person cannot be safely transferred, Post-Stabilization Services will be covered until the Covered Person can be safely transferred or discharged, or as otherwise required by applicable law. All Post-Stabilization Services remain subject to Medical Necessity review and all other applicable terms, conditions, exclusions, and limitations of this Contract to the extent permitted by law.

Prescription means a direct order for the preparation and use of a drug, medicine, or medication, or biological. The drug, medicine, or medication, or biological must be obtainable only by Prescription.

The Prescription must be given by a Healthcare Practitioner to a Pharmacist for the benefit of and use by a Covered Person for the treatment of a Bodily Injury or Illness which is covered under this Contract. The Prescription may be given to the Pharmacist verbally, Electronically, or in writing by the Healthcare Practitioner.

The Prescription must include at least:

1. The name of the Covered Person;
2. The type and quantity of the drug, medicine, medication, or biological prescribed and the directions for its use;
3. The date the Prescription was prescribed; and
4. The name and address of the prescribing Healthcare Practitioner.

Pre-Surgical/Procedural Testing means:

1. Laboratory tests or radiological examinations done on an outpatient basis in a Hospital or other facility accepted by the Hospital before Hospital Confinement or outpatient Surgery or procedures; and
2. The tests must be for the same Bodily Injury or Illness causing the Covered Person to be Hospital Confined or to have the outpatient Surgery or procedure.

Preventive Services means the evidence-based items, services, counseling, screenings, immunizations, preventive medications, and preventive care that must be covered under applicable federal and Texas law, as appropriate for a Covered Person, including:

1. evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF);
2. immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for

Disease Control and Prevention and adopted by the CDC Director for routine use;

3. evidence-informed preventive care and screenings for infants, children, and adolescents provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
4. additional preventive care and screenings for women provided for in the comprehensive guidelines supported by HRSA.

Preventive Services also include other preventive services required to be covered under applicable Texas law. Preventive Services will be covered and administered in accordance with applicable law, including any requirements relating to frequency, method, treatment, setting, medical management, and items and services integral to the furnishing of a recommended preventive service.

For information about the Preventive Services that apply under this Contract, contact Member Services at the telephone number on Your Member Identification Card. The current recommendations and guidelines described in this definition are incorporated as they may be amended from time to time and will apply in accordance with the effective dates required by applicable law.

Primary Care Physician or **Primary Care Provider (PCP)** means a Physician or Provider who has agreed with Community to provide a Medical Home to You and who is responsible for providing initial and primary care to patients, maintaining the continuity of patient care, and initiating referral for care. Provider types that can be PCPs are from any of the following

practice areas: General Practice, Family Practice, Internal Medicine, Pediatrics, Obstetrics/Gynecology (OB/GYN), Advanced Practice Nurses (APNs) and Physician Assistants (when APNs and PAs are practicing under the supervision of a Physician specializing in Family Practice, Internal Medicine, Pediatrics or Obstetrics/Gynecology who also qualifies as a PCP under this Contract), Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) and similar community clinics; and Specialty Care Physicians who are willing to provide a Medical Home to selected Covered Persons with special needs and conditions.

Prior Authorization means a determination by Us, or Our designee, made before a Service or Prescription Drug is provided, that the Service or Prescription Drug is Medically Necessary. Prior Authorization is not a guarantee that the Service or Prescription Drug is covered under this Contract and is not a guarantee of payment. Payment remains subject to all applicable terms of this Contract, including benefit limitations, exclusions, Covered Person eligibility at the time Services are provided, and other applicable claim review standards.

If Prior Authorization is required and is not obtained, the Service or Prescription Drug may be denied and You may be responsible for the cost, subject to the terms of this Contract and applicable law. A denial based solely on failure to obtain required Prior Authorization is a Contractual Denial unless applicable law requires it to be treated differently.

Provider of Record means the Physician or Provider who is primarily responsible for the Covered Person's care for the condition, Service, or Prescription Drug at issue and who is identified as such in the applicable medical record, request, or claim.

Provider means:

1. A person, other than a Physician, who is licensed or otherwise authorized to provide a health care service in this state, including:
   a. Chiropractor, registered Nurse, Pharmacist, Optometrist, registered Optician, or Acupuncturist; or
   b. a Pharmacy, Hospital, or other institution or organization;
2. A person who is wholly owned or controlled by a Provider or by a group of Providers who are licensed or otherwise authorized to provide the same health care service; or
3. A person who is wholly owned or controlled by one or more Hospitals and Physicians, including a Physician-Hospital organization.

Psychophysiological Testing means an evaluation of the interrelationships between the nervous system and other bodily organs and behavior.

Psychophysiological Treatment means interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.

Qualified Health Plan means a health plan that is certified as a qualified health plan under applicable federal law and Marketplace requirements.

Reconstructive Surgery means Surgery to improve the function of, or attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.

Reconstructive Surgery for Craniofacial Abnormalities means Surgery on the face or head to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.

Rehabilitation Services means specialized treatment for Illness or a Bodily Injury which meets all of the following requirements:

1. Is a program of Services provided by one or more members of a multi-disciplinary team;
2. Is designed to improve the patient's function and independence;
3. Is under the direction of a qualified Healthcare Practitioner,
4. Includes a formal written treatment plan with specific attainable and measurable goals and objections; and
5. May be provided in either an inpatient or outpatient setting.

Remediation means the process or processes of restoring or improving a specific function.

Research Institution means the institution or other person or entity conducting a phase I, phase II, phase III or phase IV Clinical Trial.

Residential Treatment Center means an institution that:

1. Is licensed as a 24-hour residential, intensive facility where individuals live at the facility while in treatment and are monitored by trained staff.
2. The facility is NOT licensed as a Hospital;
3. Provides a multidisciplinary or interdisciplinary treatment plan in a controlled environment, with periodic supervision of a licensed Healthcare Practitioner, such as a Physician with a specialty in psychiatry, other psychiatric prescriber and/or or Ph.D or PsyD. psychologist; and
4. Provides programs such as social, psychological, and rehabilitative training, age appropriate for the special needs of the age group of individuals, with a focus on reintegration back into the community.

Residential treatment is utilized to provide structure, support, and reinforcement of the treatment required to reverse the course of behavioral and emotional deterioration and/or provide treatment to support relapse prevention in the case of a substance abuse.

Routine Nursery Care means the charges made by a Hospital or licensed birthing center for the use of the Nursery. It includes normal Services and supplies given to well newborn children following birth. Healthcare practitioner visits are not considered Routine Nursery Care. Treatment of Bodily Injury, Illness, birth abnormality or congenital defect following birth and care resulting from prematurity are not considered Routine Nursery Care.

Routine Patient Care Costs mean the costs of any Medically Necessary healthcare service for which coverage is provided under this Contract, without regard to whether the Covered Person is participating in a Clinical Trial.

Routine Patient Care Costs do not include:

1. The cost of an Investigational new drug or device that is not approved for any indication by the U.S. Food and Drug Administration (FDA), including a drug or device that is the subject of the Clinical Trial;

2. The cost of a service that is not a healthcare service, regardless of whether the service is required in connection with participation in a Clinical Trial;
3. The cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
4. The cost associated with managing a Clinical Trial; or
5. The cost of a healthcare service that is specifically excluded from coverage under this Contract.

Self-Administered Injectable Drug means an FDA-approved medication that a person may administer to himself/herself by means of intramuscular, intravenous or subcutaneous injection excluding insulin, and prescribed for use by the
Covered Person.

Service Area means the geographic area designated by Community and approved when required by applicable law, within which Covered Services are generally available and accessible to Covered Persons. Current Service Area information is available on Community's website or by contacting Member Services at the telephone number on Your Member Identification Card.

Services means procedures, surgeries, consultations, advice, diagnosis, referrals, treatment, supplies, drugs, devices or technologies.

Skilled-Nursing Facility means a facility that provides continuous Skilled-Nursing Services on an inpatient basis for persons recovering from an Illness or a Bodily Injury. The facility must meet all of the following requirements:

1. Be licensed by the state to provide Skilled-Nursing Services;
2. Be staffed by an on-call Healthcare Practitioner 24-hours-per-day;
3. Provide Skilled-Nursing Services supervised by an on-duty Nurse 24-hours-per-day;
4. Maintain full and complete daily medical records for each patient; and
5. Not primarily be a place for rest, for the aged or for Custodial Care or provide care for Mental Health although these Services may be provided in a distinct section of the same physical facility. The facility may also provide extended care or Custodial Care which would not be covered under this Contract.

Sound Natural Tooth means a tooth that:

1. Is organic and formed by the natural development of the body (not manufactured, capped, crowned or bonded);
2. Has not been extensively restored;
3. Has not become extensively decayed or involved in periodontal disease; and
4. Is not more susceptible to injury than a whole natural tooth (for example a tooth that has been previously broken, chipped, filled, cracked or fractured).

Special Circumstances means a condition for which the treating Healthcare Practitioner or Healthcare Provider reasonably believes that discontinuing care by the treating Healthcare Practitioner or Provider could cause harm to the Covered Person. Examples of Special Circumstances include:

1. A Covered Person with a disability;
2. A Covered Person with an acute condition;
3. A Covered Person with a Life-Threatening Disease; or
4. A Covered Person who is past the 24th week of pregnancy.

Specialty Care Physician means a network Healthcare Practitioner who has received training in a specific medical field other than the specialties listed for a PCP.

Specialty Drug means a drug, medicine, or medication, or biological used as a specialized therapy developed for chronic, complex Illnesses or Bodily Injuries. Specialty drugs may:

1. Require Nursing Services or special programs to support patient compliance;
2. Require disease-specific treatment programs;
3. Have limited distribution requirements; or
4. Have special handling, storage or shipping requirements.

Specialty Pharmacy means a Pharmacy that provides covered specialty Pharmacy Services, as defined by Us, to Covered Persons.

Step Therapy means a form of utilization management for certain Prescription Drugs. When permitted by applicable law, Community may require use of one or more alternative drugs before covering another prescribed drug. Step Therapy will be administered in accordance with this Contract and applicable law, including any exception process, continuity-of-benefits protection, or limitation on the use of Step Therapy required by federal or Texas law.

Sub-Acute Medical Care means a level of specialized treatment for a Covered Person who has an Illness or a Bodily Injury that:

1. Does not require the Covered Person to have a prior admission as an inpatient in a Healthcare Treatment Facility;
2. Does not require intensive diagnostic and/or invasive procedures; and
3. Requires Healthcare Practitioner direction, intensive nursing care, significant use of ancillaries services, and an outcome-focused, interdisciplinary approach using a professional medical team to deliver complex clinical interventions.

Sub-Acute Rehabilitation Facility means a facility that provides Sub-Acute Medical Care for Rehabilitation Services for Illness or a Bodily Injury on an inpatient basis. This type of facility must meet all of the following requirements:

1. Be licensed by the state in which the Services are rendered to provide Sub-Acute Medical Care for Rehabilitation Services;
2. Be staffed by an on-call Healthcare Practitioner 24-hours-per-day;
3. Provide Nursing Services supervised by an on-duty Nurse 24-hours-per-day;
4. Maintain full and complete daily medical records for each patient; and
5. Not primarily provide care for Mental Health although these Services may be provided in a distinct section of the same physical facility. The facility may also provide extended care or Custodial Care, which would not be covered under this Contract.

Surgery means categorized as Surgery in the Current Procedural Terminology (CPT) Manuals published by the American Medical Association. The term Surgery includes, but is not limited to:

1. Excision or incision of the skin or mucosal tissues or insertion for exploratory purposes into a natural body opening;
2. Insertion of instruments into any body opening, natural or otherwise, done for diagnostic or other therapeutic purposes; and
3. Treatment of fractures.

Teledentistry Dental Service means a Health Care Service delivered by a dentist, or a health professional acting under the delegation and supervision of a dentist, acting within the scope of the dentist's or health professional's license or certification to a patient at a different physical location than the dentist or health professional using telecommunications or information technology.

Telehealth Services means a Health Care Service, other than Telemedicine Medical Service, delivered by a health professional licensed, certified, or otherwise entitled to practice in this state and acting within the scope of the health professional's license, certification, or entitlement to a Covered Person at a different location than the health professional using telecommunications or information technology. Covered Services delivered to a Covered Person as a Telehealth Service are covered on the same basis and to the same extent they would be if delivered in an in-person setting.

Telemedicine Medical Services means a Health Care Service delivered by a Physician licensed in this state, or a health professional acting under the delegation and supervision of a Physician licensed in this state, and acting within the scope of the Physician or healthcare professional's license to a patient at a different physical location than the Physician or health professional using telecommunications or information technology. Covered Services delivered to a Covered Person as a Telemedicine Medical Service are covered on the same basis and to the same extent they would be if delivered in an in-person setting.

Urgent Care means Health Services or Mental Health Services provided in a setting other than an emergency, which are typically provided in a setting such as a Physician or Provider's office or Urgent Care Center, as a result of acute injury or Illness that is severe or painful enough to lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, Illness or Injury is of such nature that failure to obtain treatment within a reasonable period of time would result in serious deterioration of the condition of his or her health.

Urgent Care Center means any licensed public or private Non-Hospital free standing facility that has permanent facilities equipped to provide Urgent Care Services on an outpatient basis.

Usual and Customary means the customary fee in the geographic area in which Services are provided, which is reasonably based on the circumstances.

We, Us or **Our** means or otherwise refers to the insurer as shown on the cover page of this Contract.

Workers' Compensation means coverage provided under an insurance policy pursuant to the Texas Workers Compensation Act, Texas Labor Code Title 5, Subtitle A, as compensation for a compensable injury during the course and scope of employment.

You/Your means the Covered Person.

2. Access to Care

a. How to Find a Participating Provider

An up-to-date directory of Participating Providers is available on Community's website. Before receiving Services, You should confirm that the Provider participates in Your specific plan, as participation may vary by product. If You need help locating a Participating Provider or would like to request a paper copy of the directory, contact Member Services at the telephone number on Your Member Identification Card.

b. Use of Participating Providers

To receive the highest level of benefits under this Contract, You must obtain Covered Services from Participating Providers, except as otherwise stated in this Contract or required by applicable law. Participating Providers have agreed to accept discounted or negotiated fees, and You remain responsible for any applicable Deductible, Copayment, or other cost-sharing required under this Contract. We offer different managed care plans, and a Provider who participates in one Community plan may not necessarily be a Participating Provider under another Community plan.

Before receiving non-emergency Services, You should confirm that the Provider is a Participating Provider under Your specific plan to avoid additional out-of-pocket expense or a reduction in benefits.

Except for Emergency Care, Post-Stabilization Services to the extent required by applicable law, authorized referrals to Non-Participating Providers, reliance on materially inaccurate provider directory information, continuity of care rights, or as otherwise required by applicable law, Services received from Non-Participating Providers are not covered under this Contract.

If Community authorizes Covered Services from a Non-Participating Provider because a Participating Provider is not reasonably available, or if You receive Emergency Care from a Non-Participating Provider, Your cost-sharing responsibility will be determined in accordance with this Contract and applicable law. In circumstances where applicable law requires You to be protected from additional charges, You will not be responsible for more than the Participating Provider cost-sharing amount.

c. Selecting a Primary Care Physician or Provider (PCP)

In addition to selecting a PCP, You may choose a Participating OB/GYN Physician to provide Medically Necessary Services within the scope of that Physician's practice without first obtaining a referral from Your PCP.

You must select a Primary Care Physician or Provider (PCP) for Yourself and each Covered Dependent. Your PCP serves as Your Medical Home and helps coordinate Your overall care. We offer a number of Participating Providers from which You may choose a PCP.

You may choose any PCP who is a Participating Provider in Your plan's network and is accepting new patients. You may choose a pediatrician as the PCP for Your child.

d. Seeking Emergency Care Services

If You need Emergency Care, go to the nearest appropriate emergency room or other facility able to provide Emergency Care. If Your condition permits, You may choose a Participating Hospital emergency room, but You do not need Prior Authorization for Emergency Care, and Emergency Care will be covered in accordance with applicable law whether the Provider or facility is Participating or Non-Participating. Coverage for Emergency Care is based on Your presenting symptoms and circumstances, not solely on the final diagnosis.

After You are stabilized, additional Services may require timely notice to Us, review by Us, or Prior Authorization, to the extent permitted by applicable law. We may arrange for transfer to a Participating Hospital or other Participating Provider or facility when You are stable for transfer, the transfer is clinically appropriate, and the

transfer complies with applicable law. Follow-up care after Emergency Care should be received from Participating Providers, unless otherwise authorized by Us or required by applicable law. If Emergency Care or Post-Stabilization Services are provided by a Non-Participating Provider or facility in a circumstance protected by applicable law, Your cost-sharing and any protections against additional billing will be determined in accordance with applicable law.

e. Direct Access to OB/GYN

You may access a Participating OB/GYN Physician directly, without Prior Authorization from Community or a referral from Your PCP, for routine obstetrical and gynecological care within the scope of the Physician's practice.

Certain Services recommended or provided by an OB/GYN Physician may still require Prior Authorization or may be subject to other terms of this Contract, including use of Participating Providers for referred Services unless otherwise authorized by Us or required by applicable law.

f. Role of the PCP

Your PCP is responsible for providing primary medical care and helping to guide and initiate referrals for any care You receive from other medical care Providers, including Specialty Care Physicians.

g. When a PCP is Not Available

When Your PCP is unavailable, You may need to obtain Services from the back-up Participating Provider designated
by Your PCP. You must make sure the Provider is a Participating Physician or Participating Provider in your specific plan's network to avoid additional out-of-pocket expenses. Please be sure to discuss these back-up arrangements with Your PCP.

h. Seeing a Specialist

You may access Participating Specialty Care Physicians directly without a referral from Your PCP, unless otherwise stated in this Contract. When Specialty Care is needed, You and Your PCP should coordinate Your care with Participating Providers.

Certain Services provided by a Specialist may still require Prior Authorization. Prior Authorization is not a guarantee of coverage or payment, and failure to obtain required Prior Authorization may result in denial of benefits or Covered Person financial responsibility, subject to the terms of this Contract and applicable law.

A list of Services requiring Prior Authorization is available on Community's website or by contacting Member Services at the telephone number on Your Member Identification Card.

i. Seeking Urgent Care Services

Urgent Care Services are for non-emergency conditions that require prompt medical attention. If You need Urgent Care, You should contact Your PCP or the PCP's designated back-up Provider when appropriate.

If Your PCP is unavailable, You may obtain Urgent Care Services from a Participating Urgent Care Center or another Participating Provider. Follow-up care after an Urgent Care visit should be received from Your PCP or another Participating Provider, unless otherwise authorized by Us or required by applicable law.

You remain responsible for any applicable Deductible, Copayment, or other cost-sharing for Urgent Care Services under this Contract. Before receiving non-emergency Services, You should confirm that the Urgent Care Center or other Provider participates in Your specific plan.

j. Telehealth Services

Telehealth Services are available as Covered Services under this Contract when provided in accordance with the terms of this Contract and applicable law. Telehealth Services may be appropriate for certain non-emergency conditions and may allow you to receive care from a Participating Provider without an in-person visit when clinically appropriate.

Telehealth Services are not a substitute for Emergency Care. If You believe You are experiencing an Emergency Medical Condition, You should seek Emergency Care immediately. For urgent but non-emergency conditions, You may use Telehealth Services when appropriate or seek Urgent Care Services from a Participating Provider or Participating Urgent Care Center.

Coverage for Telehealth Services remains subject to all applicable terms of this Contract, including Medical Necessity, Prior Authorization when required, Provider participation requirements, Service Area rules to the extent applicable,
and any Deductible, Copayment, or other Cost-Sharing shown on the Schedule of Benefits.

k. Durable Medical Equipment

Durable Medical Equipment will be supplied by Participating Providers who are contracted and credentialed as DME providers with Community.

l. Use of Non-Participating Providers

Except for Emergency Care, Post-Stabilization Services to the extent required by applicable law, authorized referrals to Non-Participating Providers, reliance on materially inaccurate provider directory information, or as otherwise required by applicable law, Covered Services from Non-Participating Providers are not covered under this Contract. If You choose to receive non-emergency Covered Services from a Non-Participating Provider when those Services are available from Participating Providers, You will be responsible for the cost of care. If Community determines that a Participating Provider is not reasonably available and authorizes care by a Non-Participating Provider, Your cost-sharing will be no greater than it would have been for care rendered by a Participating Provider. If You receive Covered Services from a Non-Participating Provider in a circumstance protected by applicable law, including Emergency Care and certain services furnished at a Participating Provider or facility by a Non-Participating Provider, You will not be responsible for more than the Participating Provider cost-sharing amount to the extent required by applicable law, and Non-Participating Providers may not bill You for amounts beyond the cost-sharing permitted by applicable law. Community will reimburse Non-Participating Providers in accordance with applicable law.

m. Notice of Rights

Your Rights with a Health Maintenance Organization (HMO) Plan
Notice from the Texas Department of Insurance

Your plan
Your HMO plan contracts with doctors, facilities, and other health care providers to treat its members. Providers that contract with your health plan are called "contracted providers" (also known as "in-network providers"). Contracted providers make up a plan's network. Your plan will only pay for health care you get from doctors and facilities in its network. However, there are some exceptions, including for emergencies, when you didn't pick the doctor, and for ambulance services.

Your plan's network
Your health plan must have enough doctors and facilities within its network to provide every service the plan covers. You shouldn't have to travel too far or wait too long to get care. This is called "network adequacy." If you can't find the care you need, ask your health plan for help. You have the right to receive the care you need under your in-network benefit. If you don't think the network is adequate, you can file a complaint with the Texas Department of Insurance at www.tdi.texas.gov or by calling 800.252.3439.

List of doctors
You can get a directory of health care providers that are in your plan's network. You can get the directory online at www.CommunityHealthChoice.org or by calling 713.295.6704 or toll-free at 1.855.315.5386. If you used your health plan's directory to pick an in-network health care provider and they turn out to be out-of-network, you might not have to pay the extra cost that out-of-network providers charge.

Bills for health care
If you got health care from a doctor that was out-of-network when you were at an in-network facility, and you didn’t pick the doctor, you won’t have to pay more than your regular copay, coinsurance, and deductible. Protections also apply if you got emergency care at an out-of-network facility or lab work or imaging in connection with in-network care.

As of January 1, 2022, the No Surprises Act prohibits surprise billing for Consumers with:

1. Out-of-network emergency services, including air ambulance (but not ground ambulance) services; and
2. In-network non-emergency services provided under certain circumstances.

If you get a bill for more than you're expecting, contact your health plan. Learn more about how you're protected from surprise medical bills at tdi.texas.gov.

3. Utilization Management

a. Prior Authorization

Prior Authorization is required for certain Services and Prescription Drugs under this Contract unless Prior Authorization is not required by applicable law or an applicable exemption applies. Prior Authorization requirements apply only to the extent permitted by applicable law.

Prior Authorization addresses Medical Necessity and appropriateness as applicable, but it is not a guarantee that a Service or Prescription Drug is covered or that payment will be made. Payment remains subject to all applicable terms of this Contract, including Covered Person eligibility, benefit limitations, exclusions, claim submission requirements, and other applicable review standards.

Current Prior Authorization requirements and Prescription Drug Formulary information are available on Community's website or by contacting Member Services at the telephone number on Your Member Identification Card. Prior Authorization requirements may change in accordance with applicable law and plan administration.

Your Physician or Provider must contact Us by telephone, Electronically or in writing to request the appropriate authorization. The telephone number to call to request authorization is on Your Member Identification Card. No benefits are payable for Services or Prescription Drugs that are not Covered Services.

We will issue Prior Authorization determinations within the timeframes required by applicable federal and Texas law, including any shorter timeframes that apply to urgent requests, concurrent review, post-stabilization treatment, or
life-threatening conditions. Renewal requests will be reviewed and decided in accordance with applicable law.

b. Reduction of Payment

If Prior Authorization is required and is not obtained, coverage may be denied, reduced, or otherwise administered in accordance with this Contract and applicable law. A failure to obtain Prior Authorization will be treated in the manner required by applicable law, including any law that limits when a Covered Person may be held financially responsible.

We will pay benefits for Covered Services as stated in the "Schedule of Benefits" and this Contract section, and according to the "General Exclusions" and "Prescription Drug Exclusions" sections and any amendments or riders which are a part of Your Contract that may modify Your benefits.

If You obtain non-Covered Services, You are responsible for making the full payment to the Physician or Provider. The fact that a Physician or Provider has performed or prescribed a medically appropriate service, or the fact that it may be the only available treatment for a Bodily Injury or Illness, does not mean that the service is covered under this Contract.

If You have a Deductible under this Contract, You must pay Your Deductible in full before We make any payments. You are required to pay any Copayments directly to the Physician or Provider. Once You have met Your Out-of-Pocket Maximum, You will no longer be responsible for Copayments for Participating Providers for the remainder of the plan year. You are responsible for demonstrating that You have paid these Copayments. There are no Deductibles or Copayments for Preventive Services.

A Covered Person who has Special Circumstances may be eligible for continuation of Services from a terminated Provider through continuity of care. A terminated Provider is a Participating Provider whose Contract is terminated or not renewed.

A Covered Person who is currently receiving treatment from a Participating Provider and who may be affected by the provider's termination from the network will receive reasonable advance notice of the impending termination, to the extent required by applicable law. The notice will describe any rights the Covered Person may have to request continuity of care or continuation of Services and how to contact Member Services for assistance.

All terms and provisions of this Contract are applicable to Covered Services provided during the period of continued care by the terminated Provider. The terminated Provider must identify the Special Circumstances, request approval for continued treatment when required by Community's procedures, and agree not to seek payment from the Covered Person of any amount for which the Covered Person would not have been responsible if the Provider had remained a Participating Provider. Any dispute regarding the medical necessity or appropriateness of continued treatment by the terminated Provider will be resolved in accordance with the Provider contract, this Contract, and applicable law.

Continuity of care is not available:

a. If the Provider was terminated due to medical competence or professional behavior;

b. After the 90th day after the Effective Date of the Provider's termination; or

c. After the expiration of the nine-month period after the Effective Date of the Provider's termination if the Covered Person was diagnosed as having a terminal lllness at the time of the termination.

If a Covered Person has Special Circumstances or is past the 24th week of pregnancy at the time of the Provider's termination, continuity of care extends through delivery of the child and applies to the immediate postpartum care and follow-up checkup within the six- week period after delivery.

If a claim is denied as being Experimental or Investigational, You have the right to seek review of the denial by an Independent Review Organization. Refer to the Appeals, Complaints and External Review Rights provision in the "General Provisions" section in this Contract for more information.

4. Your Contract Benefits Management

Refer to the "General Exclusions" and "Prescription Drug Exclusions" sections in this Contract. All terms and provisions of this Contract, including the Prior Authorization requirement specified in this Contract are applicable to Covered Services. Cost sharing and limitations depend on the type and site of service.

a. Acquired Brain Injury

Rehabilitative and habilitative therapy and Services that are Medically Necessary for the treatment of an Acquired Brain Injury, including Cognitive Rehabilitation Therapy, Cognitive Communication Therapy, Neurocognitive Therapy, Neurocognitive Rehabilitation, Neurobehavioral Testing, Neurobehavioral Treatment, Neurophysiological Testing, Neurophysiological Treatment, Neuropsychological Testing, Neuropsychological Treatment, Psychophysiological Testing, Psychophysiological Treatment, Neurofeedback Therapy, Remediation, Community Reintegration Therapy, including outpatient day treatment Services, and Post-Acute Care Treatment Services, if such Services are necessary as a result of and related to an Acquired Brain Injury.

Reasonable expenses related to periodic reevaluation of the care of an individual who:

1. has incurred an Acquired Brain Injury;
2. has been unresponsive to treatment; and
3. becomes responsive to treatment at a later date.

Rehabilitative and habilitative therapy and Services for an Acquired Brain Injury may be provided at a Hospital, an acute or post-acute rehabilitation Hospital, an assisted living facility or any other facility at which appropriate Services or therapies may be provided.

Treatment goals for therapy or Services related to the treatment of an Acquired Brain Injury may include maintenance of functioning or the prevention of or slowing of further deterioration.

In this section, therapy means the scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an Acquired Brain Injury. Service means the work of testing, treatment, and providing therapies to an individual with an Acquired Brain Injury.

b. Autism Spectrum Disorder

Generally recognized Services prescribed in relation to Autism Spectrum Disorder by a Covered Person's PCP or

Specialty Care Physicians in a treatment plan recommended by a Physician. Individuals providing treatment prescribed under the treatment plan must be a Healthcare Practitioner:

- who is licensed, certified, or registered by an appropriate agency of the state of Texas;
- whose professional credential is recognized and accepted by an appropriate agency of the United States
  - who is certified as a Provider under the TRICARE military health system; or
  - an individual acting under the supervision of a health practitioner

For purposes of this section, generally recognized Services may include Services such as:

- Evaluation and Assessment Services;
- Applied behavior analysis;
- Behavior training and behavior management;

- Speech therapy;
- Occupational therapy;
- Physical therapy; or
- Medications or nutritional supplements used to address symptoms of Autism Spectrum Disorder.

c. Biomarker Testing

Biomarker testing for the purpose of diagnosis, treatment, appropriate management, or ongoing monitoring of a Covered Person's disease or condition to guide treatment when the test is supported by the following kinds of medical and scientific evidence:

1. a labeled indication for a test approved or cleared by the US Food and Drug Administra-tion;
2. an indicated test for a drug approved by the US food and Drug Administration;
3. a national coverage determination made by the Centers for Medicare and Medicaid Services or a local coverage determination made by a Medicare administrative contrac-tor;
4. nationally recognized clinical practice guidelines; or
5. consensus statements.

Biomarker testing is only available as described above and when use of biomarker testing provides clinical utility because use of the test for the condition:

1. is evidence based;
2. is scientifically valid based on the medical and scientific evidence as described above;
3. informs the Covered Person's outcome and a Provider's clinical decision; and
4. predominately addresses the acute or chronic issue for which the test is being ordered, except that a test may include some information that cannot be immediately used in the formulation of a clinical decision.

Coverage for biomarker testing will be provided in a manner that limits disruptions in care, including limiting the number of biopsies and biospecimen samples.

d. Dental Services

Limited treatment for a Dental Injury to a Sound Natural Tooth. The Covered Person must seek treatment within 48 hours of the time of the accident or upon the Effective Date of coverage, whichever comes later. We will limit Covered Services to the least expensive service that We determine will produce professionally adequate results. Cost sharing and limitations depend on the type and site of service.

The plan would also cover dental services necessary for the treatment or correction of a congenital defect and oral Surgery defined as maxillofacial surgical procedure limited to:

1. Excision of non-dental related neoplasms, including benign tumors and cysts and all malignant and premalignant lesions and growths;
2. Incision and drainage of facial abscess;
3. Surgical procedures involving salivary glands and ducts and non-dental related procedures of the accessory sinuses; and
4. Reduction of a dislocation of, excision of, and injection of the temporomandibular joint, except as excluded under the Plan; and
5. Removal of complete bony impacted teeth.

e. Diabetes Services

The following Services are for a Covered Person with diabetes:

1. Outpatient self-management training and education, including medical nutritional therapy prescribed by a Healthcare Practitioner for the treatment of:

   a. Diabetes mellitus;

   b. Gestational diabetes;

   c. Insulin dependent or non-insulin dependent diabetes; and

   d. Medical conditions associated with elevated blood glucose levels.

Equipment and supplies for diabetes are covered under Durable Medical Equipment and Medical Supplies. Prescription Drugs for the treatment of diabetes are covered under the Prescription Drug provision.

Emergency refills are also covered of the following equipment or supplies dispensed to the Covered Person by a pharmacist, pursuant to the exercise of the pharmacist's professional judgment and without the authorization of the prescribing Physician, in the same manner as for a nonemergency refill of such diabetes equipment or diabetes supplies, if the pharmacist:

(a) is unable to contact the prescribing Physician after reasonable effort;

(b) is provided with documentation showing that the Covered Person was previously prescribed insulin or insulin-related equipment or supplies by a Physician;

(c) assesses the Covered Person to determine whether the emergency refill is appropriate;

(d) creates a record that documents the Covered Person's visit that includes notation describing the documentation provided showing that the Covered Person was previously prescribed insulin or insulin-related equipment or supplies by a Physician; and

(e) makes a reasonable attempt to inform the prescribing Physician of the emergency refill at the earliest reasonable time.

The quantity of an emergency refill of insulin may not exceed a 30-day supply. The quantity of an emergency refill of insulin-related equipment or supplies may not exceed the lesser of a 30-day supply or the smallest available package.

f. Durable Medical Equipment and Medical Supplies

Equipment or devices specifically designed and intended for the care and treatment of a Bodily Injury or Illness for the following:

1. Non-motorized wheelchair;
2. Hospital bed;
3. Ventilator
4. Oxygen and rental of equipment for its administration;
5. Initial prosthetic and orthotic devices or supplies, including, but not limited to, limbs and eyes. The benefit is limited to the most appropriate model of prosthetic or orthotic device that adequately meets the medical needs of the Covered Person as determined by the Covered Person's treating Physician, podiatrist and prosthetist or orthotist. Replacement or repair of prosthetic and orthotic devices is a Covered Expense unless the repair or replacement is necessitated by misuse or loss;

6. Services related to the fitting and use of prosthetic devices and orthotic devices.
7. Casts, splints (other than dental), trusses, braces (other than orthodontic), and crutches;
8. Standard wigs following cancer treatment (not to exceed one per lifetime). The Covered Person is responsible for any applicable Deductible and/or Durable Medical Equipment Coinsurance. Community will cover up to maximum of $250;
9. The following special supplies, when prescribed by the Healthcare Practitioner:
   a. Surgical dressings;
   b. Catheters;
   c. Colostomy bags, rings, and belts;
   d. Flotation pads;
   e. Enteral formula supplies/kits
10. Diabetic equipment and supplies;
11. Dietary formulas regardless of formula delivery method necessary for the treatment of phenylketonuria (PKU) or other heritable diseases;
12. Amino-acid based elemental formulas, regardless of the formula delivery method, used for the diagnosis and treatment of:
    a. Immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins;
    b. Severe food protein-induced enterocolitis syndromes;
    c. Eosinophilic disorders, as evidenced by the results of biopsy; and
    d. Disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.
13. Hearing aids for each ear, every three years, and supplies for a Covered Person, including fitting and dispensing Services and the provision of ear molds as necessary to maintain optimal fit of hearing aids,
14. One cochlear implant in each ear for a Covered Person and an external speech processor and controller with necessary component replacement parts as medically and audiologically necessary every three years; and
15. Other Durable Medical Equipment. Additional information is available from Member Services at the telephone number on Your Member Identification Card.

Costs for these items will be limited to the lesser of the rental cost or the purchase price. If We determine the lesser cost is the purchase option, any amount paid as rent for such Durable Medical Equipment shall be credited toward the purchase price. If the Covered Person chooses to upgrade the equipment or device, they will be responsible for the price difference between the cost of the standard item and the cost of the upgraded item.

If the equipment and device include comfort or convenience items or features that exceed what is Medically Necessary, We will not pay more than what is Medically Necessary. For example, the reimbursement for a motorized wheelchair will be limited to the reimbursement for a standard wheelchair, when a standard wheelchair is all that is Medically Necessary.

No benefits will be provided for, or on account of duplicate or similar rentals of Durable Medical Equipment.

Durable Medical Equipment will be supplied by Participating Providers that are contracted and credentialed as DME providers with Community.

g. Emergency Services

Covered Services for Emergency Care in a Hospital emergency facility, a freestanding emergency medical care facility, or Comparable Emergency Facility are covered in accordance with this Contract and applicable law. If Emergency Care is furnished by a Non-Participating Physician, Provider, or facility, You will not be responsible for more than the applicable Participating Provider cost-sharing amount to the extent required by applicable law. Non-Participating Physicians, Providers, and facilities may not bill You for amounts beyond the cost-sharing permitted by applicable law in circumstances protected by applicable law. Community will reimburse Non-Participating Physicians, Providers, and facilities for Emergency Care in accordance with applicable law.

h. Healthcare Treatment Facility Services

1. Daily room and board and general nursing care up to the semi-private room rate for each day of Confinement, including, but not limited to:

   a. not less than 48 hours following a mastectomy and 24 hours following a lymph node dissection for the treatment of breast cancer unless You and Your attending Physician determines a shorter period is appropriate; and

   b. not less than 48 hours after an uncomplicated vaginal delivery and 96 hours after an uncomplicated delivery by cesarean section;

2. Confinement in a critical care unit or intensive care unit and related Services;
3. Operating room and related facilities;
4. Ancillary Services;
5. Whole blood, including the cost of blood, blood plasma, and blood plasma expanders that are not donated by
   or for the Covered Person, and the administration of whole blood and blood plasma;
6. Other Healthcare Treatment Facility charges;
7. Drugs, medicines and biologics that are provided or administered to the Covered Person while Confined in a Hospital or Skilled-Nursing Facility;
8. Regularly-scheduled treatment such as dialysis, chemotherapy, inhalation therapy or radiation therapy in a Healthcare Treatment Facility as ordered by the Covered Person's Healthcare Practitioner;
9. Outpatient Services in a Hospital or Free-Standing Surgical Facility;
10. Short-term rehabilitation therapy Services in an acute care Hospital setting;
11. Laboratory, pathology Services and other diagnostic tests;
12. Meals and special diets when Medically Necessary;
13. Inpatient private duty nursing when Medically Necessary;
14. Special duty nursing when Medically Necessary
15. Anesthesia and Oxygen services; and
16. X-ray Services.

i. Healthcare Practitioner Services

1. Healthcare Practitioner visits;
2. Diagnostic laboratory and radiology tests;

3. Diagnostic follow-up care related to the hearing impairment for a Dependent child from birth through 24 months of age;
4. Second surgical opinions;
5. Surgery;
6. Services of a surgical assistant and/or assistant;
7. Services of a Physician assistant (P.A.), registered Nurse (R.N.), or a certified operating room technician when Medically Necessary;
8. Anesthesia administered by a Healthcare Practitioner or certified registered anesthetist attendant to a Surgery;
9. Services of a pathologist;
10. Services of a radiologist;
11. Services related to the administration of amino acid-based elemental formulas as provided under the Prescription Drugs provision;
12. Injections and allergy injections, therapy, testing, and serum;
13. Nutritional counseling for nutrition-sensitive conditions by a nutritionist or dietician; and
14. Telemedicine Medical Services, Teledentistry Dental Services or Telehealth Medical Services

A Healthcare Practitioner's office visit includes only the following Services:

1. Taking a history;
2. Performing an examination;
3. Making a diagnosis or medical decision and associated treatment;
4. Administering allergy injections or other injections;
5. Diagnostic laboratory and radiology tests; and
6. Electrocardiogram (EKG).

j. Home Healthcare

Services provided by a Home Healthcare Agency at the Covered Person's home. Home Healthcare Services are subject to authorization guidelines. All Home Healthcare Services must be provided on a part-time or intermittent basis in conjunction with a home healthcare plan. See Schedule of Benefits for Limitations.

No benefits will be provided for, or on account of:

1. Charges for mileage or travel time to and from the Covered Person's home;
2. Wage or shift differentials for any representative of a Home Healthcare Agency;
3. Charges for supervision of home healthcare agencies;
4. Custodial Care; or
5. Provision or administration of Self-Administered Injectable Drugs that the Covered Person is capable of administering.

k. Hospice Care

Covered Services provided under a Hospice Care Program furnished in a Facility or in the Covered Person's home by a Hospice Care Agency. A Healthcare Practitioner must certify that the Covered Person is terminally ill.

1. Room and board in a Hospice Facility;
2. Part-time nursing care provided by or supervised by a Nurse for up to eight hours per day;
3. Hospice consultation for the Hospice Patient by a licensed clinical social worker or pastoral counselor;
4. Medical Social Services for the terminally ill Covered Person including:
   a. Assessment of social, emotional, and medical needs as well as the home and family situation; and
   b. Identification of the community resources available;
5. Psychological and dietary counseling;
6. Part-time Home Health Aide Services for up to eight hours in any one day; and
7. Medical supplies, drugs and medicines prescribed by a Healthcare Practitioner for Palliative Care.

No benefits will be provided for, or on account of:

1. Funeral arrangements;
2. Financial or legal counseling, including estate planning or drafting of a will;
3. Homemaker or Caretaker Services, including:
   a. Sitter or Companion Services;
   b. Housecleaning; or
   c. Household maintenance;
4. Services of a social worker other than a licensed clinical social worker;
5. Services by a licensed pastoral counselor to a member of his or her congregation. These are Services in the course of the duties to which the counselor is called as a pastor or minister; and
6. Respite care.

l. Mental Health Services

Covered Services for Mental Health are provided under the same terms and conditions applicable to medical and surgical benefits, including the prohibition on financial requirements and the imposition of any quantitative or non-quantitative treatment limits that are more restrictive than those applicable to medical and surgical benefits.

Covered Services provided by a:

1. Healthcare Practitioner;
2. Hospital; or
3. Healthcare Treatment Facility.

Covered Inpatient Mental Health Care Services for:

1. Inpatient Services including room and board; and
2. Healthcare practitioner visits.

Covered Outpatient Mental Health Care and Office Services for Mental Health incurred for:

1. Office exams or consultations including laboratory tests and X-rays; and
2. Psychotherapy.

Additional covered Services for Mental Health:

1. Intensive Outpatient Program;
2. A partial Hospitalization program; and
3. A Residential Treatment Center.

No benefits will be provided for, or on account of:

1. A halfway house.

m. Maternity Care and Newborn Services

Prenatal, delivery and Inpatient Services for Maternity Care and Postnatal Care.

Covered Services for a covered Dependent newborn child include but are not limited to the following:

1. Bodily injury or Illness;
2. Care and treatment for premature birth; and
3. Medically diagnosed birth defects and abnormalities.

Congenital defects will be treated the same as any other Bodily Injury or Illness for which Covered Services are provided.

When You or Your newborn is discharged from inpatient care before a minimum of 48 hours following an uncomplicated vaginal delivery, and 96 hours following an uncomplicated delivery by cesarean section, Covered Services include post-delivery Outpatient Services.

Post-delivery care includes maternal and neonatal physical assessments (physical evaluations for both You and Your newborn) as well as administration of the newborn screening test, newborn screening test kit, parent education, assistance and training in breast-feeding and bottle-feeding. The post-delivery outpatient visit may be provided at the mother's home, healthcare Provider's office or a health care facility. A Physician, registered Nurse, or other licensed health care professional may provide the Services. This visit is in addition to Your coverage for outpatient post-natal obstetrical care.

n. Outpatient Therapies

Rehabilitative and habilitative Outpatient Services ordered and performed by a Healthcare Practitioner for the following:

1. Services for:
   a. Documented loss of physical function;
   b. Pain;

c. Developmental defect; or

d. Developmental delay.

2. Physical Therapy Services;
3. Occupational Therapy Services;
4. Chiropractic Services such as spinal manipulations, adjustments and modalities;
5. Speech Therapy or Speech Pathology Services;
6. Cognitive Rehabilitation Services;
7. Audiology Therapy Services;
8. Treatment related to hearing aids and cochlear implants, including habilitation and rehabilitation as Medically Necessary for educational gain;
9. Radiation Therapy Services;
10. Chemotherapy;
11. Respiratory or Pulmonary Therapy Services;
12. Cardiac Rehabilitation Services; and
13. Nutritional counseling for a child with developmental delays.

Covered Services include therapies that result in a practical improvement in the level of functioning within a reasonable period of time and the therapy is not considered Maintenance Care. When determined to be Medically Necessary by the Healthcare Practitioner, Therapy Services for a Covered Person who has a physical disability will not be considered Maintenance Care. These Therapy Services are provided without regard as to whether the purpose of the therapy is to maintain or improve functional capacity.

Therapy Services for a Dependent child with a developmental delay must be provided in accordance with an individual family service plan issued by the Interagency Council on Early Childhood Intervention under Chapter 73 of the Texas Human Resources Code.

Therapy Services rendered during a Home Healthcare Visit are covered under the Home Healthcare provision.

See Schedule of Benefits for limitations.

o. Prescription Drugs

Any payments under this provision apply toward the Covered Person's Out-of-Pocket Maximum. Benefits may be subject to Dispensing Limits, Prior Authorization or Step Therapy requirements, if any.

If the dispensing Pharmacy's charge is less than the Prescription Drug Copayment, the Covered Person will be responsible for the lesser amount.

The amount paid by Us to the dispensing Pharmacy may not reflect the ultimate cost to Us for the drug.

Prescription Drug Copayments are made on a per Prescription or refill basis and will not be adjusted if We receive any retrospective volume discounts or Prescription Drug rebates.

Some retail pharmacies participate in Our 90-day refill program, which allows a Covered Person to receive a 90-day supply of a Prescription or refill for eligible maintenance drugs. The cost is 2.5 times the applicable Copayment as shown on the Schedule of Benefits. Specialty Drugs or Self-Administered Injectable Drugs are limited to a maximum of a 30-day supply.

Tablet splitting is a voluntary program in which the PBM may designate certain Formulary Drugs that the Covered Person can split the tablet of a higher strength dosage at home. Under this program, the Covered Person gets half the usual quantity for a 30-day supply, for example 15 tablets for a 30-day supply. Participants who use tablet splitting will pay half the normal Copayment amount.

We must be notified of any Cost Share that is applicable to a Covered Person's claim that is waived by the Pharmacy. Any amount thus waived and not paid by the Covered Person would not apply to any Prescription Drug Out-of-Pocket Maximum.

We may allow for the synchronization of refills for maintenance Prescription Drugs and the proration of the Cost Share for a partial supply of certain Prescription Drugs.

For Prescription eye drops, a refill will be allowed if the Covered Person pays timely at the point of sale and the original Prescription states that additional quantities of eye drops are needed, the refill does not exceed the total quantity of dosage units authorized by the prescribing Physician or Provider on the original Prescription, including refills, and the refill is dispensed on or before the last day of the prescribed dosage period and not earlier than the 21st day after the date a Prescription for a 30- day supply of eye drops is dispensed, not earlier than the 42nd day after the date a Prescription for a 60-day supply of eye drops is dispensed, or not earlier than the 63rd day after the date a Prescription for a 90-day supply of eye drops is dispensed.

When a contraceptive drug, device, product, or supply is covered under this Contract or is otherwise required to be covered under applicable federal or Texas law, a Covered Person may obtain the quantity required by applicable law. Coverage, cost-sharing, and any applicable medical management will be administered in accordance with applicable law, including any requirement to cover an extended supply of contraceptives, any exception process required for medically appropriate contraceptive care, and any prohibition on cost-sharing for preventive contraceptive care.

Community Health Choice may encourage use of generic medications when a therapeutically appropriate generic equivalent is available. However, this paragraph does not apply in a manner that limits or delays access to contraceptive drugs, devices, products, or other preventive medications, products, or services that are required to be covered under applicable federal or Texas law. When coverage without cost-sharing is required by law for a particular product because no medically appropriate equivalent is available, because the attending provider determines another product is medically appropriate, or because an exception, accommodation, or other process required by law applies, coverage will be administered in accordance with applicable law. If a brand drug is covered under the terms of this Contract and applicable law, the Covered Person will pay the applicable Cost Share only to the extent permitted by law.

The Specialty Pharmacy program is part of Your Pharmacy benefit and may apply to specialty Prescriptions that meet criteria permitted by applicable law. Nothing in this program will be applied in a manner that limits access to contraceptive drugs, devices, products, supplies, counseling, or other preventive medications or products required to be covered under applicable federal or Texas law, that impairs a Covered Person's right to request a formulary, utilization-management, or step-therapy exception required by applicable law, or that restricts access to clinically administered drugs in a manner prohibited by applicable law. Enrollees may access covered Prescription drug benefits at Participating Pharmacies in accordance with this Contract and applicable law, subject only to restrictions permitted by applicable law.

1. The drug is subject to restricted distribution by the U.S. Food and Drug Administration; or
2. The drug requires special handling, Provider coordination, or patient education that cannot be provided by a retail Pharmacy.

We may charge enrollees a different cost-sharing amount for obtaining a covered drug at a retail Pharmacy, but all cost sharing will count towards the plan's annual limitation on cost sharing.

If the following conditions are met, We will apply any reported third-party payments, financial assistance, discounts, product vouchers or other reductions in Cost Share made by or on Your behalf for a Covered Prescription Drug:

1. A generic equivalent does not exist;

2. A generic equivalent does exist but the Covered Person has obtained access to the Covered Prescription Drug through Prior Authorization, Step Therapy, or through exception or appeal;

3. An interchangeable biological product does not exist; or

4. An interchangeable biological product does exist but the Covered Person has obtained access to the Covered Prescription Drug through Prior Authorization, Step Therapy, or through exception or appeal.

Covered Prescription Drugs under this Contract are:

1. Drugs, medicines or medications, and the necessary Services associated with the administration of those drugs, medicines or medications, prescribed to treat a chronic, disabling, or life-threatening Illness that:

   a. have been approved by the United States Food and Drug Administration for at least one indication;

      and

   b. are recognized by the following for the treatment of the indication for which the drug is prescribed (1) a Prescription drug reference compendium approved by the Department of Insurance, or (2) substantially accepted peer reviewed medical literature.

2. Drugs, medicines or medications that under Federal or state law may be dispensed only by Prescription from a Healthcare Practitioner;

3. Drugs, medicines or medications that are included on the Drug Formulary;

4. Insulin and Diabetic Supplies that are included on the Drug Formulary. Cost-sharing for insulin included on the Drug Formulary shall not exceed $25.00 per prescription for a 30-day supply, regardless of the amount or type of insulin needed to fill the prescription;

5. Hypodermic needles or syringes when prescribed by a Healthcare Practitioner for use with insulin or Self-Administered Injectable Drugs that are included on the Drug Formulary. Hypodermic needles and syringes used in conjunction with covered drugs may be available at no cost to the Covered Person;

6. Hypodermic needles, syringes or other method of delivery necessary for administration of a Specialty Drug, if included with the charge for the Specialty Drug. These may be available at no cost to the Covered Person;

7. Specialty drugs and Self-Administered Injectable Drugs that are included on the Drug Formulary approved by Us limited to a 30-day supply, unless otherwise determined by Us;

8. Drugs, medicines, medications, devices, products, supplies, and related pharmacy items or Services required to be covered under the Affordable Care Act or other applicable federal or Texas law, including contraceptive dugs, devices, and products and other preventative items when required by applicable law and administered in accordance with such law;

9. Prescribed, orally administered anticancer medication that is used to kill or slow the growth of cancerous cells;

10. Spacers and/or peak flow meters for the treatment of asthma; and

11. Enteral formulas and nutritional supplements necessary for the treatment of phenylketonuria (PKU) or other inherited diseases.

If a Covered Person has a chronic, complex, rare, or life-threatening condition and the Covered Person's treating Physician or Provider determines that:

1. a delay would make disease progression probably; or

2. the use of a Participating Pharmacy would

   a. make death or patient harm probable;

   b. potentially cause a barrier to the Covered Person's adherence to the plan of care;

   c. or because of the timelines of the delivery or dosage requirements, necessitate de-livery by a non-Participating Pharmacy,

We will not:

3. Require clinically-administered Covered Prescription Drugs to be dispensed only by certain Participating Pharmacies;

4. Limit or exclude clinically-administered Covered Prescription Drugs based on the Covered Person's choice of Pharmacy or because the Covered Prescription Drug was not dispensed by a Participating Pharmacy;

5. Require a Participating Physician or Provider to bill for or be reimbursed for the delivery and administration of clinically-administered Covered Prescription Drugs under a pharmacy bene-fit instead of a medical benefit without:

   a. informed written consent of the Covered Person; and

   b. a written attestation from the Participating Physician or Provider that a delay in the Prescription Drug's administration will not place the patient at an increased risk; or

6. Require that a Covered Person pay an additional fee or higher Cost Share based on the Covered Person's choice of Pharmacy or because the Covered Prescription Drug was not dispensed by a Participating Pharmacy.

The Drug Formulary identifies covered drugs, applicable tiers, dispensing limits, and any Prior Authorization or Step Therapy requirements. Formulary and utilization management information is available through Member Services and Community's current member materials. If a specific drug is not listed on the Drug Formulary or is otherwise subject to restriction, a Covered Person, the Covered Person's designee, or the prescribing Physician or Provider may request a formulary exception, step-therapy exception, or other review in accordance with applicable law and the Appeal provisions of this Contract. A denial of a formulary exception request or a step-therapy exception request will be treated as an Adverse Determination to the extent required by applicable law.

Step Therapy does not require a failure to respond to more than one different drug or proof of a history of failure of more than one different drug (excluding generic or pharmaceutical equivalent) for the treatment of serious mental illness in Covered Persons over the age of 18.

Community maintains a readily accessible process for prescribing providers to request step-therapy exceptions and other pharmacy benefit exceptions in the manner required by applicable Texas and federal law. Requests will be reviewed in accordance with the timelines, standards, and notice requirements required by applicable law.

If a specific drug, medicine or medication is not listed on the Drug Formulary (or otherwise covered by Us), a Covered Person or a Covered Person's designee or a prescribing Physician may request an exception orally or in writing.

We will respond to Your request no later than 72 hours after the receipt date of the request. An expedited review is available for exigent circumstances such as when a Covered Person is suffering from a health condition that may seriously jeopardize the Covered Person's life, health or ability to regain maximum function or when a Covered Person is undergoing a current course of treatment using a non-Drug Formulary Drug. We will respond to an expedited request based on exigent circumstances and notify the Covered Person or the Covered Person's designee and the prescribing Physician no later than 24 hours following receipt date of the request.

If We do not approve an exception request for a Prescription, You have the right to Appeal that decision. Please refer to the Appeals, Complaints and External Review Rights provision in the "General Provisions" section. In addition, We will provide coverage of the non-formulary drug for the duration of the exigency, to the extent required by applicable law.

Step Therapy is not required for Prescription drugs associated with the treatment of stage-four advanced, metastatic cancer or associated conditions. This exception applies only to a Prescription drug, the use of which is: (1) consistent with best practices for the treatment of stage-four advanced, metastatic cancer or an associated condition; (2) supported by peer-reviewed, evidence-based literature; and (3) approved by the United States Food and Drug Administration.

For Covered Prescription Drugs prescribed to treat an autoimmune disease, hemophilia or Von Willebrand disease, We do not require Covered Persons to receive more than one Prior Authorization annually. This exception to Prior Authorization does not apply to: (1) opioids, benzodiazepines, barbiturates, or carisoprodol; (2) Prescription drugs that have a typical treatment period of less than 12 months; (3) drugs that: (A) have a boxed warning assigned by the United States Food and Drug Administration for use; and (B) must have specific provider assessment; or (4) the use of a drug approved for use by the United States Food and Drug Administration in a manner other than the approved use.

Prescription Drug coverage is subject to change. Based on state law, advanced written notice must be sent to You for the following modifications that affect Prescription Drug coverage:

1. Removal of a drug from the Drug Formulary;
2. Requirement that You receive Prior Authorization for a drug;
3. An imposed or altered quantity limit;
4. An imposed step-therapy restriction;
5. Moving a drug to a higher cost-sharing level unless a generic alternative to the drug is available

We will make these types of changes to Prescription Drug coverage only at renewal of the Contract, unless an earlier change is permitted by applicable law. We will provide written notice no later than 60 days before the Effective Date of the change, to the extent required by applicable law. If applicable Texas law requires continuation of benefits or delayed application of the change for a Covered Person already using the affected drug, Community will administer the change in accordance with applicable law.

p. Preventive Care Services

Covered Preventive Care Services include Preventive Services as defined in this Contract and as otherwise required by applicable federal and Texas law.

Covered Preventive Care Services are provided for the purpose of screening for, evaluating risk of, preventing, or detecting disease or other health conditions in accordance with current applicable recommendations and guidelines and any applicable Texas mandates. Routine Nursery Care is not included in this Preventive Care Services provision unless expressly stated elsewhere in this Contract.

For information about the Preventive Care Services that apply under this Contract, contact Member Services at the telephone number on Your Member Identification Card. The applicable preventive recommendations and guidelines are incorporated as they may be amended from time to time and will apply in accordance with the effective dates required by applicable law.

Deductible, Copayment, and Coinsurance requirements do not apply to Covered Preventive Care Services to the extent prohibited by applicable law when such Services are rendered by a Participating Provider or otherwise as required by applicable law. If a visit, item, or service also includes evaluation, diagnosis, monitoring, treatment, or other non-preventive Services, cost-sharing may apply to the non-preventive portion in accordance with this Contract and applicable law. Preventive Care Services may be subject to reasonable medical management only to

the extent permitted by applicable law. If Community applies medical management to a recommended preventive service, Community will provide any exceptions process required by applicable law so that a Covered Person may obtain coverage without cost-sharing for a medically appropriate frequency, method, treatment, setting, item, product, drug, device, or service when required by law.

Covered Preventive Care Services include, but are not limited to, the following categories and Services when required by applicable federal or Texas law and when appropriate for the Covered Person: routine adult physical examinations and well-woman visits; well-child visits and developmental surveillance and screening; immunizations; preventive screenings, counseling, and preventive medications recommended by USPSTF; women's preventive Services supported by HRSA, including contraceptive care, breastfeeding support, and prenatal preventive Services; preventive Services for infants, children, and adolescents supported by HRSA; preventive cancer screenings, including breast, cervical, colorectal, and prostate screenings to the extent required by applicable law; preventive screenings and counseling for behavioral health and substance use conditions; and other preventive screenings, laboratory Services, imaging, tests, supplies, and related items or Services required to complete a covered preventive service under applicable law. Texas-specific preventive mandates, including those relating to certain cancer screenings, diagnostic breast imaging required to complete the screening process when mandated, and other state-required preventive Services, are covered in accordance with applicable law

q. Reconstructive Surgery

We will provide benefits for Covered Services for Reconstructive Surgery incurred for the following:

1. To restore function for conditions resulting from a Bodily Injury;
2. That is incidental to or follows a covered Surgery resulting from Illness or a Bodily Injury of the involved part if trauma, infection or other disease occurred;
3. Following a Medically Necessary mastectomy. Reconstructive Surgery includes all stages and revisions of reconstruction of the breast on which the mastectomy has been performed, reconstruction of the other breast to establish symmetry, prostheses and physical complications in all stages of mastectomy, including lymphedemas;
4. Reconstructive Surgery for Craniofacial Abnormalities; and
5. Because of a congenital Illness or anomaly of a member to improve the function of or attempt to create a normal appearance of the abnormal body structure.

No benefits are available for Surgery or treatment to change the texture or appearance of the skin or to change the size, shape, or appearance of facial or body features (including but not limited to a Covered Person's nose, eyes, ears, cheeks, chin, chest or breasts).

Except as otherwise provided in this Contract, Cosmetic Services and Services for complications from Cosmetic Services are not covered regardless of whether the initial Surgery occurred while the Covered Person was covered under this Contract or under any prior coverage.

r. Routine Care During Clinical Trials

We will pay for Covered Services that are Routine Patient Care Costs furnished to a Covered Person participating in a Phase I, Phase II, Phase III, or Phase IV Clinical Trial if the Service, item or drug is otherwise covered under this Contract.

No benefits will be provided for Services that are a part of the subject matter of the Clinical Trial and that are customarily paid for by the Research Institution conducting the Clinical Trial.

For Covered Persons receiving Medically Necessary treatment for cancer, including surgery, chemotherapy, or radiation, that the American Society of Clinical Oncology or the American Society for Reproductive Medicine

has established may directly or indirectly cause impaired fertility, Fertility Preservation Services are covered in accordance with applicable law.

s. Skilled-Nursing Facility and Rehabilitation Services

Covered Services include:

1. Daily room and board;
2. General nursing Services for each day of Confinement; and
3. Rehabilitation Services,

Rendered while Confined in a Sub-Acute Rehabilitation Facility or Skilled-Nursing Facility, provided the Covered Person is under the regular care of a Healthcare Practitioner who has reviewed and approved the Confinement. Services in a Sub-Acute Rehabilitation Facility or Skilled-Nursing Facility must be:

1. Provided in lieu of care in a Hospital; or
2. For the same condition that required Confinement in a Hospital. The Covered Person must enter the Sub-Acute Rehabilitation Facility or Skilled-Nursing Facility within 14 days after discharge from the Hospital.

Coverage for Sub-Acute Rehabilitation Facility or Skilled-Nursing Facility will cease when measurable and significant progress toward expected and reasonable outcomes has been achieved or has plateaued.

Rehabilitation Services provided in a skilled nursing facility include but are not limited to:

1. Treatment of complications of the condition that required an inpatient Hospital stay;
2. Physical therapy, occupational therapy and speech therapy;
3. Pulmonary rehabilitation programs; and
4. The evaluation of the need for the Services listed above.

The timeline and place-of-service requirements described above do not apply to Covered Persons receiving therapy services for an Acquired Brain Injury. For more information about benefits related to Acquired Brain Injury, see Section 4.a. Benefits (a).

See Schedule of Benefits for limitations.

t. Transplant Services

If a Covered Person requires an organ transplant or is a donor to a Covered Person, all related Services including, but not limited to the following, must be preauthorized in advance by Us;

1. Hospital and Healthcare Practitioner Services; and
2. Organ acquisition and donor costs, including Pre-Transplant Services, the acquisition procedure, and any complications resulting from the acquisition.

Donor costs will not exceed the Organ Transplant Treatment Period. After the benefits of a Covered Person who is a recipient are paid, We will provide reimbursement of Covered Services of a live donor to the extent that the benefits remain and are available under this Contract. Any existing benefits available through the health coverage of the donor will be secondary to the benefits available under this Contract.

Prior Authorization from Us is required in advance of the organ transplant. The Covered Person's Healthcare Practitioner must notify Us in advance of the need for an initial evaluation for the organ transplant in order for Us to determine if the organ transplant will be covered. For approval of the organ transplant itself, We must be given a reasonable opportunity to review the clinical results of the evaluation before rendering a determination.

Prior authorization requests should be submitted using Community's current submission methods and within the timeframes required by this Contract and applicable law.

1. At least 5 days prior to an elective admission as an inpatient in a hospital, extended care or rehabilitation facility, or hospice facility.
2. At least 30 days prior to the initial evaluation for organ transplant services
3. Within 24 hours of any inpatient admission, including emergent inpatient admissions.
4. At least 5 days prior to the scheduled start of home health services, except those enrollees needing home health services after hospital discharge.

Once coverage for the organ transplant is approved, We will advise the Healthcare Practitioner. Benefits are payable only if the Pre-Transplant Services, the organ transplant and post-discharge Services are approved by Us. Coverage for Post-discharge Services and treatment of complications after transplantation are limited to the Organ Transplant Treatment Period.

Covered Services for a Covered Organ Transplant includes Pre-Transplant Services, transplant inclusive of any chemotherapy and associated Services, Post-Discharge Services and treatment of complications after transplantation of the following organs or procedures only:

1. Heart;
2. Lung(s);
3. Liver;
4. Kidney;
5. Bone marrow;
6. Pancreas;
7. Auto-islet cell;
8. Intestine;
9. Multivisceral;
10. Any combination of the above listed organs; and
11. Any organ not listed above, if required by state or federal law.

Corneal transplants and porcine heart valve implants, which are tissues rather than organs, are considered part of regular Contract benefits and are subject to other applicable provisions of this Contract.

No benefits will be provided for, or on account of:

1. Transplants which are Experimental or Investigational;
2. A transplant that does not meet Our pre-transplant criteria;
3. Expenses that are eligible to be paid under any private or public research fund, government program except Medicaid, or another funding program, whether or not such funding was applied for or received;
4. Expenses related to a transplant for which We do not approve coverage based on Our established criteria;
5. A denied transplant. This includes the pre-transplant evaluation, Pre-Transplant Services, the transplant procedure, Post-Discharge Services, immunosuppressive drugs and expenses related to complications of such transplant;
6. Expenses related to the storage of cord blood and stem cells unless it is an integral part of an organ transplant approved by Us; or
7. Expenses related to an organ transplant performed outside of the United States and any care resulting from that organ transplant, except to the extent otherwise required by applicable law or expressly authorized by Community under this Contract.

u. Transplant Transportation and Lodging

Direct non-medical costs for:

1. The Covered Person receiving the organ transplant when the Hospital performing the Covered Organ Transplant is more than 100 miles away from the Covered Person's residence; and

2. One designated caregiver or support person (two, if the Covered Person receiving the Covered Organ Transplant is under 18 years of age), if they live more than 100 miles from the Hospital performing the Covered Organ Transplant.

Direct non-medical costs include:

1. Transportation Covered Services to and from the Hospital where the Covered Organ Transplant is performed limited to two round trips per Covered Organ Transplant; and

2. Temporary lodging at a prearranged location when requested by the Hospital performing the Covered Organ Transplant and approved by Us.

All direct, non-medical costs for the Covered Person receiving the Covered Organ Transplant and the designated caregiver(s) or support person(s) are limited to a combined maximum per Covered Organ Transplant as shown on the Schedule of Benefits.

v. Transportation

Professional air and ground ambulance services from the scene of a medical emergency to the nearest appropriate medical facility equipped to provide Emergency Care are covered in accordance with this Contract and applicable law. If emergency ambulance services are provided by a Non-Participating Provider in a circumstance protected by applicable law, You will not be responsible for more than the applicable Participating Provider cost-sharing amount to the extent required by applicable law, and Community will reimburse the Non-Participating Provider in accordance with applicable law. All non-emergency transportation services, including ground or air ambulance, require Prior Authorization unless otherwise required by applicable law. Non-emergency air ambulance services are covered only when ambulance transportation is Medically Necessary and terrain, distance, the Covered Person's physical condition, or other circumstances require air ambulance rather than ground ambulance services.

w. Urgent-Care Services

Covered Services include Urgent-Care Services in an Urgent-Care Center participating in the Provider Network.

x. Pediatric Vision Services

Covered Services include

1. One (1) routine eye exam visit annually for children 18 (up to the end of the month in which the enrollee turns 19) and under;
2. Low Vision Aids and services may be covered subject to Medical Necessity review and other allowable limitations;
3. Vision correction aids once per Plan Year ear for children 18 (up to the end of the month in which the enrollee turns 19) and under:
   a. One (1) pair of ophthalmic lenses, one eyeglass frame with a retail value up to one hundred and thirty dollars ($130). This includes Single, Bifocal, Trifocal and Lenticular scratch resistant lenses, in CR-39, glass or polycarbonate materials, with standard anti-reflective coating (e.g. Sharpview). The following lenses and lens options are also covered for eligible Covered Persons: fashion and gradient tinting, ultraviolet protective coating, and oversized and glass-grey #3 Prescription sunglass lenses; or

   b. Prescription contact lenses (in lieu of eyeglasses) with a retail value up to one hundred dollars ($100) including Medically Necessary contact lenses for the following conditions keratoconus; pathological myopia; aphakia; anisometropia; aniseikonia; aniridia; corneal disorders; post-traumatic disorders; and, irregular astigmatism require Prior Authorization.

Vision screening is a brief evaluation (like an eye chart) and can be performed by a Primary Care Doctor as part of a routine or annual physical exam. A vision screening does not diagnose or correct vision or eye health issues. This is not the same as a routine eye exam. A routine eye exam (with or without dilation) is used to determine the health of the eyes and related structures, visual acuity, and determination of the patient's refractive state, prescribing corrective lenses if necessary. This can be done by Optometrists or Ophthalmologists with specialized diagnostic equipment to check vision, screen for diseases, and update the Prescription for eyewear.

5. General Exclusions and Limitations

Below is a list of limitations and exclusions on Covered Services. Please review the entire document, as there may be multiple limitations applicable to a particular service. These limitations and exclusions apply even if a Physician or Provider has performed or prescribed a medically appropriate service. This does not prevent Your Healthcare Practitioner from providing or performing the service. However, the service will not be a Covered Service paid for sby Us.

If a claim is denied as being Experimental or Investigational, You have the right to seek review of the denial by an Independent Review Organization. Refer to the Appeals, Complaints and External Review Rights provision in the "General Provisions" section in this Contract for more information.

Unless specifically stated otherwise, no benefits will be provided for, or on account of, the following items:

1. Services provided by a non-Participating Provider, except when:

   a. Authorized by Us; or

   b. The Services are Emergency Care, Post-Stabilization Services to the extent required by applicable law, continuity-of-care Services, Services furnished in reliance on materially inaccurate provider directory information, services furnished by a Non-Participating Provider in connection with a Participating facility, laboratory, imaging, ambulance, or other protected circumstance under applicable law, or other Services that must be covered under applicable law;

      i. Professional ambulance service; or

      ii. Services in a Hospital emergency room, freestanding emergency medical care facility or Comparable Emergency Facility;

2. Services incurred before the Effective Date or after the termination date of this Contract;

3. Services not Medically Necessary to prevent, alleviate, cure or heal Bodily Injury or Illness, except for the specified routine Preventive Services;

4. Charges for prophylactic services, including, but not limited to, prophylactic mastectomy or any other Services performed to prevent a disease process from becoming evident in the organ tissue at a later date unless Medically Necessary; provided, however, that this exclusion does not apply to Covered Preventive Care Services, Preventive Services, risk-reducing items or Services, or other preventive screenings, counseling, medications, procedures, imaging, laboratory Services, supplies, or related items or Services when coverage is required by applicable federal or Texas law.

5. Services that are Experimental or Investigational, or related to such, whether incurred prior to, in connection with, or subsequent to the service that is Experimental or Investigational except as expressly provided in this Contract. The fact that a service is the only available treatment for a condition may not make it eligible for coverage if We deem it to be Experimental or Investigational;

6. Complications directly related to a service that is not a Covered Service under this Contract because it was determined by Us to be Experimental or Investigational or not Medically Necessary, except as expressly provided in this Contract. Directly related means that the service occurred as a direct result of the

Experimental or Investigational or not Medically Necessary service and would not have taken place in the absence of the Experimental or Investigational or not Medically Necessary service;

7. Services exceeding the amount of benefits available for a particular service;
8. Services for, or the treatment of complications of, non-covered procedures or Services;
9. Services, except for Emergency Care, relating to an Illness or Bodily Injury incurred as a result of the Covered Person;
    a. Being intoxicated, as defined by applicable state law in the state in which the loss occurred; or
    b. Being under the influence of illegal narcotics or controlled substance unless administered or prescribed by a Healthcare Practitioner;
10. Services relating to an Illness or Bodily Injury as a result of:
    a. Intentionally self-inflicted bodily harm or attempted suicide whether sane or insane, when not specifically the result of Mental Illness;
    b. War or an act of war, whether declared or not;
    c. Taking part in a riot;
    d. Engaging in an illegal occupation; or
    e. Any act of armed conflict, or any conflict involving armed forces or any authority.
11. Services:
    a. For charges which are not authorized, furnished or prescribed by a Participating Provider;
    b. For which no charge is made, or for which the Covered Person would not be required to pay if he/she did not have this coverage, unless charges are received from and reimbursable to the United States government, or any of its agencies as required by law;
    c. Furnished by or payable under any plan or law through a government or any political subdivision, except Medicaid, unless prohibited by law, which You or the Covered Person is not legally obligated to pay;
    d. Furnished while a Covered Person is Confined in a Hospital or institution owned or operated by the United States government or any of its agencies for any service-connected Illness or Bodily Injury;
    e. That are not rendered or not substantiated in the medical records;
    f. Provided by a Family Member or person who resides with the Covered Person;
    g. Performed in association with a non-covered service.
12. Except as otherwise provided in this Contract, Cosmetic Services, or any complication there from;
13. Custodial care and maintenance care;
14. Ambulance Services for routine transportation to, from or between medical facilities and/or a Healthcare Practitioner's office;
15. Elective medical or surgical abortion other than an abortion performed due to medical emergency. For purposes of this section, medical emergency means a life-threatening physical condition aggravated by, caused by, or arising from a pregnancy that, as certified by a Physician, places the Member in danger of death or a serious risk of substantial impairment of a major bodily function unless an abortion is performed;
16. Reversal of sterilization;

17. Infertility treatment;

18. Sexual dysfunction;

19. Vision examinations or testing for the purposes of prescribing corrective lenses; radial keratotomy; refractive keratoplasty; or any other Surgery or procedure to correct myopia, hyperopia or stigmatic error; orthoptic treatment (eye exercises); or the purchase or fitting of eyeglasses or contact lenses, unless specified in this Contract. See Schedule of Benefits for Limitations;

20. Dental services, including surgery or services provided to diagnose, prevent, or correct any ailments or defects of the teeth and supporting tissue and any related supplies or oral appliances or supplies for treatment of the teeth, gums, jaws or alveolar processes. This includes, but not limited to, excision of partially or completely un-erupted impacted teeth (other than complete bony impacted teeth), any oral or periodontal Surgery and preoperative and postoperative care, implants and related procedures, orthodontic procedures, and any dental services related to a Bodily Injury or Illness except as expressly provided in this Contract. Expenses for such treatment are considered dental services regardless of the reason for the services.

21. Pre-surgical/procedural testing duplicated during a Hospital Confinement;

22. Services or supplies solely for the purpose of weight reduction (including complications therefrom), including surgical procedures and Prescription Drugs, even if the Covered Person has other health conditions that might be helped by a reduction of weight, except for healthy diet counseling and obesity screening/counseling as may be provided under Preventive Services;

23. Surgical procedures for the removal of excess skin and/or fat in conjunction with or resulting from weight loss or a weight loss Surgery;

24. Foot-Care Services, in the absence of diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency, including but not limited to:

    a. Hygienic care, and the treatment of superficial lesions of the feet, such as corns, calluses or hyperkeratosis;

    b. Cutting of toenails, except removal of nail matrix; and

    c. Any Services or supplies in connection with foot care for flat feet, fallen arches or chronic foot strain including arch supports, heel wedges, lifts, shoe inserts, the fitting or provision of foot orthotics or orthopedic shoes, unless the orthopedic shoe is an integral part of a covered leg brace.

25. Hair prosthesis, hair transplants or implants, except as expressly provided in this Contract;

26. Services rendered in a premenstrual syndrome clinic or holistic medicine clinic;

27. Transplant Services except as expressly provided in this Contract;

28. Transplant or post-transplant care if the transplant was performed in China or another country known to have participated in forced organ harvesting.

29. A transplant in which the transplanted organ was procured by sale or donation in China or another country known to have participated in forced organ harvesting.

30. Over-the-counter medical items or supplies that may be prescribed by a Healthcare Practitioner but are also available without a written order or Prescription, except for Preventive Services;

31. Immunizations, including those required for foreign travel, except as expressly provided in this Contract; provided, however, that this exclusion does not apply to immunizations that are Covered Preventive Care Services, Preventive Services, or otherwise required to be covered under applicable federal or Texas law.

32. Genetic testing when not Medically Necessary including when:
    a. the diagnosis can be made clinically or by biochemical or another laboratory test;
    b. testing of Family Member not covered under this plan;
    c. testing for screening purposes or without a reasonable suspicion of genetic disorder, except to the extent the screening, genetic counseling, genetic testing, laboratory Services, imaging, medications, or related items or Services are Covered Preventive Care Services, Preventive Services, or otherwise required to be covered under applicable federal or Texas law;
    d. testing does not impact medical management;
    e. the test has not been established by clear and convincing evidence in the scientific literature to be reliably associated with a specific disease, disorder, or specific therapy

33. Expense for employment, school, sports or camp physical examinations or for the purpose of obtaining insurance, licensing, premarital tests/examinations or per court order or required for parole or probation;

34. Services received in an emergency room unless the Services constitute Emergency Care, are required as part of the medical screening examination or stabilization process, or are otherwise required to be covered under applicable law;

35. Any Expense Incurred for Services received outside of the United States except for Emergency Care Services or other Services required to be covered under applicable law;

36. Services received during an inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness;

37. Services and supplies which are:
    a. Rendered in connection with conditions, diagnoses, or services that are not covered under this Contract and are not required to be covered under applicable law. This provision will not be applied in a manner that imposes a treatment limitation on Mental Health or substance use disorder benefits that is more restrictive than the limitations applied to substantially all medical and surgical benefits in the same classification, to the extent prohibited by applicable law;
    b. Extended beyond the period necessary for evaluation and diagnosis of learning and behavioral disabilities, or for intellectual disability, except to the extent coverage for the particular Service is otherwise required under this Contract or applicable law;
    c. Specifically excluded as marriage counseling.

38. No benefits will be provided for:
    a. Immunotherapy for recurrent abortion;
    b. Chemonucleolysis;
    c. Biliary lithotripsy;
    d. Home uterine activity monitoring;
    e. Light treatment for Seasonal Affective Disorder (S.A.D.);
    f. Immunotherapy for food allergy;
    g. Prolotherapy;
    h. Cranial banding (orthosis);
    i. Hyperhidrosis Surgery;
    j. Sensory integration therapy; and

k. Weight loss programs.

39. Charges for alternative medicine, including medical diagnosis, treatment and therapy. Alternative medicine Services include, but are not limited to:

    a. Acupressure;

    b. Acupuncture;

    c. Aromatherapy;

    d. Ayurveda;

    e. Biofeedback (except to the extent it includes Neurofeedback Therapy that is Medically Necessary for the treatment of an Acquired Brain Injury);

    f. Faith healing;

    g. Guided mental imagery;

    h. Herbal medicine;

    i. Holistic medicine;

    j. Homeopathy;

    k. Hypnosis;

    l. Macrobiotic;

    m. Massage therapy;

    n. Naturopathy;

    o. Ozone therapy;

    p. Reflexology;

    q. Relaxation response;

    r. Rolfing;

    s. Shiatsu;

    t. Yoga;

    u. Movement therapies such as Tai Chi and Qi Gong;

    v. Healing touch;

    w. Music and expressive art therapies;

    x. Wilderness therapies; and

    y. Horse-assisted therapies.

40. Living expenses, travel, or transportation, except as expressly provided in the Transportation provision or the Transplants Transportation and Lodging provision in the "Your Contract Benefits Management" section of this Contract;

41. Charges for Services that are primarily and customarily used for a non-medical purpose or used for environmental control or enhancement (whether or not prescribed by a Healthcare Practitioner) including but not limited to:

    a. Common household items such as air conditioners, air purifiers, water purifiers, vacuum cleaners, waterbeds, hypoallergenic mattresses or pillows, or exercise equipment;

    b. Scooters or motorized transportation equipment, escalators, elevators, ambulance ramps, modifications or additions to living/working quarters or transportation vehicles;

    c. Personal comfort items including cervical pillows, gravity lumbar reduction chairs, swimming pools,

whirlpools or spas or saunas;

d. Medical equipment including blood-pressure monitoring devices, PUVA lights and stethoscopes;

e. Charges for any membership fees or program fees paid by a Covered Person, including but not limited to, health clubs, health spas, aerobic and strength conditioning, work-hardening programs and weight loss or similar programs and any related material or products related to these programs;

f. Communication systems, telephones, televisions or computer systems and related equipment or similar items or equipment; and

g. Communication devices except after surgical removal of the larynx or a diagnosis of permanent lack of function of the larynx.

42. Services for in vitro fertilization and promotion of fertility through extra-coital reproductive technologies including, but not limited to, artificial insemination, intrauterine insemination, super ovulation uterine capacitation enhancement, direct intra-peritoneal insemination, trans-uterine tubal insemination, gamete intra-fallopian transfer, pronuclear oocyte stage transfer, zygote intra-fallopian transfer, and tubal embryo transfer.

43. Medical transportation services such as air transportation, non-emergency ground transportation, facility-to-facility transfers, out-of-network transfers, and out-of-area transfers are subject to Prior Authorization.

6. Prescription Drug Exclusions

Except as expressly stated otherwise, no benefit will be provided for, or on account of, the following items:

1. Drugs that are not included on the Drug Formulary, except to the extent coverage is required under this Contract, an approved formulary exception or other exception process, continuation-of-benefits rules, or applicable law;

2. Nutritional products including formulas for any indication or route of administration;

3. Fluoride supplements except when prescribed to preschool children older than 6 months of age whose primary water source is deficient in fluoride;

4. Legend (Prescription) drugs that are not deemed Medically Necessary by Us;

5. Any drug prescribed for any Illness or Bodily Injury for which Services are not covered under this Contract;

6. Any drug prescribed for intended use other than for:

   a. Indications approved by the FDA; or

   b. Off-label indications recognized through peer-reviewed medical literature.

7. Any drug, medicine or medication that is either:

   a. Labeled “Caution-limited by Federal law to Investigational use”; or

   b. Experimental or Investigational, even though a charge is made to the Covered Person.

8. Allergy serum and allergy testing materials;

9. The administration or injection of any drugs;

10. Therapeutic devices or appliances, except as expressly provided in this Contract, including, but not limited to:

    a. Hypodermic needles and syringes except needles and syringes for use with insulin, and Self-Administered Injectable Drugs whose coverage is approved by Us;

    b. Support garments;

    c. Mechanical pumps for delivery of medication; and d. Other non-medical substances;

11. Prescription drugs prescribed solely for weight reduction or weight control are not Covered Services, except when:

    (i) the drug is required to be covered as a preventive service under applicable law; or

    (ii) the drug is prescribed for another covered medical indication and otherwise meets the terms of coverage

    Drugs with multiple indications will be evaluated based on the indication for which they are prescribed.

12. Abortifacients or drugs used to induce abortion, other than as expressly provided in this Contract or as required by applicable law; provided, however, that this exclusion does not apply to contraceptive drugs, devices, products, counseling, or related preventive items or Services that are Covered Preventive Care Services, Preventive Services, or otherwise required to be covered under applicable federal or Texas law.

13. Any drug used for cosmetic purposes, including, but not limited to:

    a. Tretinoin, e.g. Retin A, except if the Covered Person is under the age of 35 or is diagnosed as having adult acne;

    b. Dermatologicals or hair growth stimulants; or

    c. Pigmenting or de-pigmenting agents, e.g. Solaquin.

14. Newly approved drugs and newly approved indications for existing drugs will be reviewed and administered in accordance with Community's formulary review procedures, this Contract, and applicable federal and Texas law. Nothing in this provision permits Community to delay, deny, or exclude coverage in a manner inconsistent with applicable law, Essential Health Benefit requirements, exception-process requirements, or continuation-of-benefits protections.

15. Any drug or medicine that is:

    a. Lawfully obtainable without a Prescription (over the counter drugs), except insulin, drugs, medicines, medications, products, devices, or supplies that are Covered Preventative Care Services or Preventive Services, or other over-the-counter items required to be covered under applicable federal or Texas law, including when a Prescription is required for coverage under applicable law or this Contract; and

    b. Available in Prescription strength without a Prescription.

16. Compounded testosterone for the treatment of hormone replacement therapy;

17. Infertility and fertility treatment including medications;

18. Any drug prescribed for impotence and/or sexual dysfunction, e.g. Viagra;

19. Any drug, medicine or medication that is consumed, applied or injected at the place where the Prescription is given or dispensed by the Healthcare Practitioner;

20. Drug delivery implants;

21. Prescriptions that are to be taken by, applied or administered to the Covered Person, in whole or in part, while he/she is a patient in a facility where drugs are ordinarily provided by the facility on an inpatient basis. This includes drugs discharged with the Covered Person from the facility. Inpatient facilities include, but are not limited to:

    a. Hospital;

    b. Skilled-Nursing Facility; or

    c. Hospice facility.

22. Injectable drugs, including, but not limited to:

    a. Immunizing agents;

    b. Biological sera;

    c. Blood;

    d. Blood plasma; or platelet rich plasma injection;

    e. Adipose tissue derived stem cell injection; or

    f. Self-administered injectable drugs or Specialty Drugs for which we do not approve coverage.

23. Prescription refills:

    a. In excess of the number specified by the Healthcare Practitioner; or

    b. Dispensed more than one year from the date of the original order.

24. Any portion of a Prescription or refill that exceeds a 90-day supply when received from either a mail-order Pharmacy or from a retail Pharmacy that participates in Our program which allows a Covered Person to receive a 90-day supply of a Prescription or refill;

25. Any portion of a Prescription or refill that exceeds a 30-day supply when received from a retail Pharmacy that does not participate in Our program which allows a Covered Person to receive a 30-day supply of a Prescription or refill;

26. Any portion of a Specialty Drug or Self-Administered Injectable Drug that exceeds a 30-day supply;

27. Any portion of a drug for which Prior Authorization or Step Therapy is required and not obtained, except to the extent coverage is required under an approved exception, an Appeal or review outcome, continuity-of-benefits requirements, or applicable law;

28. Any drug for which a charge is customarily not made;

29. Any portion of a Prescription or refill that:

    a. Exceeds Our drug specific Dispensing Limit (i.e. IMITREX);

    b. Is dispensed to a Covered Person whose age is outside the drug specific age limits defined by Us;

    c. Is refilled early, as defined by Us; or

    d. Exceeds the duration-specific Dispensing Limit.

30. Any drug, medicine or medication received by the Covered Person:

    a. Before becoming covered under this benefit; or

    b. After the date the Covered Person's coverage under this Contract has ended

31. Any costs related to the mailing, sending or delivery of Prescription Drugs;

32. Any intentional misuse of this benefit, including Prescriptions purchased for consumption by someone other than the Covered Person;
33. Any Prescription or refill for drugs, medicines or medications that are lost, stolen, spilled, spoiled or damaged;
34. Any amount the Covered Person paid for a Prescription that has been filled, regardless of whether the Prescription is revoked or changed due to adverse reaction or change in dosage or Prescription;
35. Drugs that are repackaged by anyone other than the original manufacturer;
36. Covered drugs, devices, or other Pharmacy Services or supplies provided or available under the Workers' Compensation law; and
37. Athletic performance enhancement drugs.

7. Premium Payment

a. Your Duty to Pay the Premium

You must pay the premium required under this Contract when due. Initial enrollment will not become effective unless any required initial premium is paid in accordance with applicable law and Marketplace rules, if applicable. After coverage is in effect, any premium not paid when due will be subject to the grace period and termination provisions of this Contract and applicable law.

b. Cost-Sharing Reduction

You may qualify for a Cost-Sharing Reduction (CSR) if You are determined eligible by the Marketplace under applicable federal law and enroll in a plan for which CSR is available. CSR eligibility and amount are determined by the Marketplace.

c. Advance Premium Tax Credit

You may qualify for an Advance Premium Tax Credit (APTC) to help reduce Your premium if You are determined eligible by the Marketplace under applicable federal law. APTC eligibility, amount, and ongoing qualification are determined by the Marketplace and may change based on income, household information, access to other qualifying coverage, or changes in law.

If the Marketplace changes or ends Your APTC, You remain responsible for any premium owed under this Contract. If You have questions about APTC, contact the Marketplace or a qualified tax advisor.

d. Grace Period

If You do not receive APTC, a grace period of at least 30 days applies for payment of premiums after the initial premium, or any longer period required by applicable law. If the delinquent premium is not paid within the applicable grace period, coverage will terminate as provided in this Contract and applicable law. Claims incurred during the grace period may become Your responsibility to the extent permitted by applicable law.

e. Grace Period for Covered Persons Receiving Advance Premium Tax Credits

If You receive APTC and have paid at least one full month's premium, a three-month grace period applies in accordance with applicable federal law. Community may pend claims incurred in months two and three of the grace period as permitted by law and may deny Pharmacy claims during those months to the extent permitted by law. If premium delinquency is not cured, termination will be effective as required by applicable law, and You may remain responsible for claims for Services received during any period for which applicable law permits liability.

f. Changes to Your Premium

Your premium may change in accordance with applicable federal and Texas law, including because of changes in enrollment, rating factors permitted by law, geographic rating area, age, tobacco-use status if permitted by law, or other information that affects premium calculation. Community will provide any notice of premium change required by applicable law. Your continued payment of premium after an effective premium change constitutes acceptance of the new premium amount.

g. Return of the Premium

Any premium refund due under this Contract will be calculated in accordance with this Contract and applicable law. Premium may be refunded when coverage is rescinded as permitted by law, when coverage is terminated prospectively and premium has been paid for a period after the effective termination date, or in other circumstances required by law. Termination or cancellation will not affect claims incurred before the effective date of termination or cancellation.

8. Changes to Contract

a. Changes to Enrollment Information and Dependents

You must notify Community of any change in Your residential address, mailing address, telephone number, household information, or other enrollment information that may affect eligibility, premium, rating, or availability of coverage. If coverage was purchased through the Marketplace, You must also report changes to the Marketplace in accordance with applicable law and Marketplace rules. If You move outside the Service Area, coverage may terminate as provided in this Contract and applicable law.

If Community discontinues a particular type of individual coverage or ceases to do business in the applicable individual market, Community will provide the notices and options required by applicable federal and Texas law, including any required advance notice of discontinuation and any required offer of available replacement coverage.

If coverage was purchased through the Marketplace, You must request termination of the Contract through the Marketplace. The Marketplace will notify Us and termination will be processed accordingly.

If this Contract terminates and there is a break in coverage, Deductibles and Out-of-Pocket Maximums may restart in accordance with applicable law and the terms of any new coverage

b. Changes to Dependents

You may request a change to the persons covered under Your Contract due to certain changes in Your family.

1. Removing Dependents

   If You wish to remove a Covered Person from Your Contract, simply call or write Us at the address on Your Member Identification Card.

   If You purchased your coverage on the Marketplace, please contact the Marketplace to request a change to the persons Covered under Your Contract.

2. Adding Dependents

   If a child is born to a Contract Holder, or any Covered Person, a Contract Holder adopts a child, or a child is placed with the Contract Holder for the purpose of adoption, or the Contract Holder is a party in a suit in which adoption of a child is sought, We must be notified of the event verbally or in writing and receive any required premium on or before 60 days of the event. If We do not receive notice and the premium for the first 60 days and forward, the child will not be a Covered Person under this Contract.

If a Dependent child is the subject of a medical support order, coverage will be automatic for the first 31 days after receipt of the date of the medical support order or notice of the medical support order and any required premium.

A Dependent not falling under the previous paragraph must apply to be added as a Covered Person and be accepted by Us during the annual open enrollment period. A Dependent child is eligible to apply if they are under age 26. If accepted the Covered Person will be covered on the date We specify.

If You purchased Your coverage on the Marketplace, please contact the Marketplace to request a change to the persons Covered under Your Contract.

3. Effective Date of Dependent Changes
   a. Coverage for a newborn or adopted child will be effective for the first 60 days following the date of the birth, placement, adoption, or date the court grants the petition for adoption. To continue coverage for the newborn or adopted child beyond the initial period, You must provide notice to Us and remit the premium within 60 days of the child's date of birth or adoption;

   b. Coverage of a Dependent child who is the subject of a medical support order will be effective for the first 31 days after receipt of the medical support order or notice of the medical support order;

   c. If we receive the application or notification as applicable, and any required premium more than 60 days after the newborn's date of birth or the child's adoption, placement for adoption, or date the court grants the petition for adoption, such child will not be eligible; and

   d. For changes for other Dependents, the Dependent will not be eligible for coverage until receipt of premium and acceptance by Us, or until the next open annual enrollment period, qualifying event or special enrollment.

c. Changes to This Contract

This Contract may be amended only as permitted by applicable law. Any amendment, rider, endorsement, or change to this Contract will become effective only in the manner and on the date permitted by applicable law and stated by Community. No oral statement, representation, or promise will change this Contract.

If coverage is offered through the Marketplace, any change affecting Qualified Health Plan status, benefits, premium, or eligibility will also be subject to applicable Marketplace requirements.

9. Renewability and Termination

a. Reasons We Will Terminate or Nonrenew Your Contract

This Contract is guaranteed renewable at the option of the Contract Holder except as permitted by applicable federal and Texas law. Community may terminate or nonrenew this Contract only for reasons permitted by applicable law and this Contract, including nonpayment of premium, fraud or intentional misrepresentation of material fact, fraud in the use of benefits or Services, loss of eligibility or residence outside the Service Area when permitted by law, discontinuance of the product or market as permitted by law, or loss of Marketplace eligibility or decertification of the plan as a Qualified Health Plan when applicable.

If termination or nonrenewal is based on nonpayment of premium, coverage will end as provided in the grace period and termination provisions of this Contract and applicable law. If termination or nonrenewal is based on fraud or intentional misrepresentation of material fact, Community will provide any notice required by applicable law. If coverage is purchased through the Marketplace, termination requests, eligibility changes, and certain

termination events may be processed through the Marketplace in accordance with applicable law. If this Contract terminates and there is a break in coverage, accumulators such as Deductibles and Out-of-Pocket Maximums may restart as permitted by law and the terms of any new coverage.

b. Reasons We Will Terminate a Covered Person

Community may terminate coverage for a Covered Person when that person no longer satisfies eligibility requirements under this Contract or applicable law, commits fraud or intentionally misrepresents a material fact, loses eligibility for Marketplace coverage when applicable, or when the Contract terminates. If Community accepts premium for a Covered Person for a period beyond the date coverage would otherwise have ended, coverage will continue only for the period for which an identifiable premium was accepted, to the extent required by applicable law.

c. Your Duty to Notify Us

You must notify Community of events that affect eligibility, enrollment, rating, or premium under this Contract, including events that may cause termination of this Contract or a Covered Person's coverage. If coverage was purchased through the Marketplace, certain changes must also be reported to the Marketplace in accordance with applicable law.

d. Reinstatement

If this Contract terminates for nonpayment of premium after the initial premium and reinstatement is permitted by applicable law or Marketplace rules, You may request reinstatement within the timeframe allowed by Community's reinstatement procedures and applicable law. Reinstatement is not available when prohibited by applicable law, including after nonpayment of the initial premium or voluntary termination, and may require payment of all amounts due and satisfaction of any Marketplace requirements that apply.

e. Reasons You May Terminate Your Contract

You may terminate this Contract in accordance with applicable law and Community procedures. If coverage was purchased through the Marketplace, termination requests generally must be submitted through the Marketplace. Any termination will be effective on the date determined under this Contract, applicable law, and Marketplace rules, if applicable.

10. General Provisions

a. Appeals, Complaints, and External Review Rights

You have the right to file a Complaint, to Appeal an Adverse Determination or other Denial of Benefits, and, when applicable, to request review by an Independent Review Organization (IRO) or external review in accordance with applicable federal and Texas law. Community will not retaliate against You, a person acting on Your behalf, or Your Provider for filing a Complaint, requesting an Appeal, or seeking external review.

Adverse Determinations and Notice

If We issue an Adverse Determination, We will provide notice to You, any authorized representative, and the Provider of Record, as applicable, within the timeframes and in the manner required by applicable federal and Texas law. The notice will explain the principal reasons for the determination, the clinical basis for the determination, a description of or the source of the screening criteria or other guidelines used in making the determination when required by law, and Your rights to internal Appeal, expedited Appeal when available, and external review or Independent Review Organization review when available.

Notice of an Adverse Determination, including notice for urgent care, concurrent review, post-stabilization treatment, Prescription Drug or infusion-related determinations, and retrospective review, will be provided within the timeframes required by applicable federal and Texas law. If different laws could apply to the same request, Community will apply the shorter legally required timeframe.

Appeal of Adverse Determinations

You, an authorized representative, or the Provider of Record may request an internal Appeal of an Adverse Determination. In circumstances where applicable law permits direct access to external review or IRO review without completion of the full internal Appeal process, including certain urgent, life-threatening, formulary-exception, or timeline-failure situations, You may request that review in accordance with applicable law.

Expedited Appeal

An expedited Appeal is available when the request involves an emergency, urgent care, a life-threatening condition, continued hospitalization, post-stabilization treatment, or other circumstances for which applicable law requires expedited review, including certain Prescription Drug or infusion-related determinations. Expedited Appeals will be reviewed by an appropriate clinical reviewer who was not involved in the initial determination and will be decided within the timeframes required by applicable federal and Texas law.

Standard Appeals

When We receive a standard Appeal of an Adverse Determination, We will acknowledge receipt and resolve the Appeal within the timeframes required by applicable federal and Texas law. Community may request information reasonably necessary to review the Appeal. Appeals of Adverse Determinations will be reviewed by a physician or other appropriate reviewer who was not previously involved in the initial determination, and when applicable law requires specialty review, the Appeal will be reviewed by a provider in the same or similar specialty as typically manages the condition, procedure, or treatment at issue. Written notice of the Appeal decision will explain the outcome and any further rights available under applicable law.

External Review and Independent Review Organization Rights

If an Adverse Determination or other adverse benefit determination is eligible for external review or IRO review under applicable federal or Texas law, You may request that review within the timeframe required by applicable law. Community will provide the information required by law regarding how to request the review, where to send it, and whether completion of an internal Appeal is required or excused. External review and IRO review will be conducted within the timeframes required by applicable law, including expedited timeframes when applicable.

Appeal of Other Denials of Benefits

If We deny, reduce, terminate, or fail to provide or make payment for a benefit for reasons other than Medical Necessity or Experimental or Investigational status, including because of eligibility, enrollment, rescission, or another term of this Contract, You may request review in accordance with the Appeal or Complaint procedures required by applicable federal or Texas law, depending on the type of determination. Community will include information about the appropriate review process in the notice of determination.

Request for Additional Information

If You do not understand a denial or partial denial, You may request additional information, including the reason for the determination and, when required by law, the guideline, criteria, or clinical rationale used in making the decision. If a claim was denied because information was missing or incomplete, You or Your Provider may resubmit the claim with the information needed for review.

Complaint Process

If You file a Complaint orally or in writing, Community will acknowledge receipt and resolve the Complaint within the timeframes required by applicable Texas law. If a written Complaint form is required to complete processing of an oral Complaint, Community will provide the form or instructions. If a Complaint involves an emergency or denial of continued hospitalization, Community will investigate and resolve the Complaint within the timeframe required by applicable law.

Complaint Appeal Panel

If a Complaint is not resolved to Your satisfaction, You may request review by a Complaint Appeal Panel if and to the extent required by applicable Texas law. Community will acknowledge the request, schedule or process the review, provide the information required by law before the review, and issue a decision within the timeframes required by applicable law. No person who was previously involved in the matter may serve on the panel if prohibited by applicable law.

Where to Send Appeals and Complaints

Information about how to submit an Appeal, Complaint, or eligible request for external review or IRO review is available from Member Services and in the notices Community sends regarding determinations. Community will provide the applicable mailing address, fax number, telephone number, electronic submission options, and any required forms or instructions in accordance with applicable law.

You may also file a Complaint with the Texas Department of Insurance. Information about how to contact the Texas Department of Insurance is available from Member Services and on the Texas Department of Insurance website. Filing a Complaint with Community does not limit any right You may have to contact the Texas Department of Insurance or to seek any review available under applicable law.

Exhaustion of Remedies

You must complete the internal Appeal, Complaint, external review, IRO review, or other review procedures that apply to Your type of determination to the extent required by applicable law before filing legal action, except where applicable law permits earlier action or excuse from exhaustion.

No legal action regarding benefits under this Contract may be brought until the review procedures required by applicable law for the type of determination at issue have been completed, deemed exhausted, or excused. Any legal action must be brought within the time permitted by this Contract and applicable law.

b. Coordination of Benefits

For purposes of this Coordination of Benefits provision, "allowable amount" means the amount of a billed charge that a plan determines to be covered for Services, including any applicable Deductible, Copayment, or Coinsurance for which the Covered Person is responsible. If a Covered Person receives Services from a Non-Participating Provider in a circumstance protected by applicable law, any applicable cost-sharing and protections against additional billing will be determined in accordance with applicable law.

If a Covered Person is confined as an inpatient on the Effective Date of this Contract and prior coverage continues benefits for that confinement after termination of the prior coverage, benefits under this Contract will apply as required by this Coordination of Benefits provision, this Contract, and applicable law. If prior coverage does not continue benefits, coverage under this Contract will apply for covered benefits incurred on or after the Effective Date, subject to Medical Necessity review, Prior Authorization requirements to the extent permitted by law, and the terms of this Contract. If inpatient Services are provided at a Non-Participating Provider or facility, Community may require transfer to a Participating Provider or facility when the Covered Person is medically stable for transfer and the transfer is permitted by applicable law. Covered Person cost-sharing and any protection from additional billing in protected circumstances will be determined in accordance with applicable law.

The order of benefit determination and payment under this section will be administered in accordance with applicable Texas law governing Coordination of Benefits. To the extent required by law, Community will apply the order-of-benefit rules, calculation of secondary payment, and related Coordination of Benefits standards required for health benefit plans in Texas.

c. Effect on the Benefits of This Contract

This section applies when this Contract is secondary in accordance with the order of benefit determination outlined above. In this event, the benefits of this Contract may be reduced so that the total benefits paid or provided by all plans are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary

plan. The secondary plan may then reduce its payment so that, when combined with the amount paid by the primary plan the total benefits paid or provided by all plans for the claim equal 100 percent of the total allowable expense for that claim, to the extent permitted by applicable law. In addition, the secondary plan must credit to its Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage, if required by applicable law.

d. Facility of Payment

A payment made under another plan may include an amount that should have been paid under this Contract. If it does, Community may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this Contract. Community will not have to pay that amount again. The term "payment made" includes providing benefits in the form of Services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of Services.

e. Release of Information

For purposes of this Contract, Community may, subject to applicable confidentiality requirements set forth in this Contract and applicable law, release to or obtain from any insurance company or other organization information reasonably necessary to implement these Coordination of Benefits provisions. Any Covered Person claiming benefits under this Contract must furnish to Community all information reasonably necessary to implement these Coordination of Benefits provisions.

f. Right of Recovery

If the amount of payment made by Us is more than should have been paid under this Coordination of Benefits provision, We may recover the excess from one or more of the persons We have paid, or for whom We have paid, or any other person or organization that may be responsible for the benefits or Services provided for the Covered Person. The "amount of payments made" includes the reasonable cash value of any benefits provided in the form of Services.

g. Right of Reimbursement

If We pay benefits and You recover or are entitled to recover benefits from other coverage or from any legally responsible party, We have the right to recover from You the amount We paid, to the extent permitted by applicable law.

You must notify Us, in writing, within 31 days of any benefit payment, settlement, compromise, or judgment. If You waive or impair Our right to reimbursement, We may suspend payment of past or future Services to the extent permitted by applicable law until all outstanding lien or reimbursement interests are resolved.

If You recover payment from and release any legally responsible party for future medical expenses relating to an Illness or Bodily Injury, We shall have a continuing right to seek reimbursement from You, but only to the extent allowed by law.

This reimbursement obligation exists only to the extent permitted by applicable law and regardless of whether the settlement, compromise, or judgment designates the recovery as including or excluding medical expenses.

h. Our Right of Subrogation

To the extent allowed by Texas law, We have the right to recover payments acquired by You against any person or organization for negligence or any willful act resulting in Illness or Bodily Injury to the extent We have paid for Services. As a condition of receiving benefits from Us, You agree to assign to Us any rights You may have to make a claim, take legal action, or recover any expenses paid for benefits covered under this Contract, to the extent permitted by applicable law.

If We are precluded from exercising Our right of subrogation, We may exercise Our right of reimbursement to the extent allowed by law. Rescission is subject to 30 days' prior notification and is retroactive to the Effective Date. In the event of such cancellation, We may deduct from the Premium refund any amounts made in claim payments

during this period and You may be liable for any claim payment amount greater than the total amount of Premiums paid during the period for which cancellation is affected.

i. Assignment of Recovery Rights

If Your claim against another insurer is denied or partially paid, We will process that claim according to the terms and conditions of this Contract. If payment is made by Us on behalf of You, You agree that any right You have against the other insurer for medical expenses We pay will be assigned to Us to the extent permitted by applicable law.

j. Right to Request Overpayments

We reserve the right to recover any payments made by Us that were:

1. Made in error;
2. Made to You or any party on Your behalf where We determine that the payment is greater than the amount payable under this Contract;
3. Made to You or any party on Your behalf based on fraudulent or intentional misrepresentation of material fact; or
4. Made to You or any part on Your behalf for changes that were discounted, waived, or rebated.

We reserve the right to adjust any amount applied in error to any Deductible or Out-of-Pocket Maximum.

k. Right to Require Medical Examinations

We have the right to have the Covered Person examined or, when permitted by law, autopsied during the pendency of a claim. These procedures will be conducted as often as We deem reasonably necessary to determine Contract benefits, at Our expense.

l. State Public Medical Assistance

If a Covered Person received medical assistance from a program under the Texas Health and Human Services Commission while insured under this Contract, We will reimburse the program for the actual cost of medical expenses the program pays through medical assistance, if that assistance was paid for a Covered Service for which benefits are payable under this Contract and if We received timely notice from the Commission, or its designated health plan, of payment of that assistance. Any reimbursement to the Commission or its designated health plan made by Us will discharge Us to the extent of the reimbursement. This provision applies only to the extent We have not already made payment of the claim to You or to the Provider.

If the Texas Health and Human Services Commission is paying financial and medical assistance for a child, and You are a parent who purchased this Contract or a parent covered by this Contract and have possession or access to the child, or are not entitled to access or possession of the child but are required by court order to pay child support, all benefits paid on behalf of the child or children under this Contract must be paid to the Texas Health and Human Services Commission to the extent required by applicable law.

We must receive written notice affixed to the claim when first submitted that benefits must be paid directly to the Texas Health and Human Services Commission.

m. Time of Payment of Claims

Payment due under this Contract to Participating Physicians and Participating Providers will be paid in accordance with applicable Texas prompt-payment laws.

n. Workers' Compensation

This Contract is not in lieu of any Workers' Compensation or Occupational Disease coverage.

Schedule of Benefits – Community Premier Bronze 003 HSA

This Schedule of Benefits summarizes benefit information for Covered Services that are fully described in the "Contract Benefit Management" section of this Contract. Please read Your entire Contract carefully to fully understand all terms, conditions, exclusions, and limitations that apply.

Medical and Pharmacy (Combined) Deductible	
Deductible, per individual, per Plan Year	$8,500
Deductible, per family, per Plan Year	$17,000
Out-of-Pocket Maximum	
Out-of-Pocket Maximum, per individual, per Plan Year	$12,000
Out-of-Pocket Maximum, per family, per Plan Year	$24,000

Benefit	Description	Copayment/ Percentage of Allowed Amount
Primary Care Office Visit	Physician Office Visit not for	$35 copay (Deductible does not apply)
Specialist Visit	Preventive Care Services. See Section 4(p).	$70 copay after Deductible
Outpatient Services	See Section 4(i).	
Outpatient Surgery Facility Fee	Outpatient Services and Habilitation Services are subject to different cost-sharing depending on whether the Service is an Office Visit or other Outpatient Service. Office visits are subject to Copays, while facility-based Services are subject to coinsurance.	40% coinsurance after Deductible
Outpatient Surgery Physician/Surgical Services	Outpatient Hospital Services performed in an Outpatient Facility or in a Hospital without admission. See Section 4(h).	40% coinsurance after Deductible
Outpatient Laboratory	Professional fees for outpatient or Ambulatory Surgical Procedures. See Section 4(h).	$40 copay after Deductible
Outpatient X-rays and Diagnostic Imaging	See Section 4(g) and 4(h).	$40 copay after Deductible
Outpatient CT/PET/MRI and Other Outpatient Diagnostic Procedures	See Section 4(g) and 4(h).	40% after Deductible
Dialysis	See Section 4(g) and 4(h).	$70 copay after Deductible
Allergy Testing and Treatments	Per Visit for Dialysis. See Section 4(g).	$35 copay after Deductible
Chemotherapy, Radiation, and Infusion Therapy	See Section 4(h).	$70 after Deductible

Benefit	Description	Copayment/ Percentage of Allowed Amount
Preventive Care Services		
Preventive Care Services	Preventive Care Services are covered by the Plan at 100%, with no Deductible. Refer to https://www.healthcare.gov/what-are-my-preventive-care-benefits/ for current list of covered Preventive Care Services. See Section 4(p).	$0
Immunizations	Age appropriate immunizations are covered by the Plan at 100%, with no Deductible. Refer to https://www.healthcare.gov/what-are-my-preventive-care-benefits/ for current list of covered Preventive Care. See Section 4(p).	$0
Hospital Services		
Inpatient Hospital Services	Section 4(h).	$1,000 copay, plus 40% coinsurance after Deductible
Inpatient Physician and Surgical Services	Professional fees for inpatient surgery and other inpatient Physician Services. See Section 4(h).	40% coinsurance after Deductible
Emergency Services		
Emergency Room Services	Per episode of Emergency Room Services. See Section 4(g). Copay waived if admitted to the Hospital (Inpatient Hospital expenses apply).	$700 copay, plus 40% coinsurance after Deductible
Emergency Transportation Services	See Section 4(v).	$70 copay after Deductible
Urgent Care Services		
Urgent Care Facility	See Section 4(w).	$70 copay (Deductible does not apply)
Outpatient Mental Health Care and Substance Abuse Disorder Treatment	Mental/Behavioral Health Outpatient Services, Substance Abuse Disorder Outpatient Services, and Habilitation Services are subject to different cost-sharing depending on whether the Service is an Office Visit or other Outpatient Service. Office visits are subject to Copays, while facility-based Services are subject to coinsurance.	
Outpatient Mental Health Services	Outpatient mental health care visit to or by a Health Professional. See Section 4(l).	40% coinsurance after Deductible $35 copay for Office Visits (Deductible does not apply)
Outpatient Substance Abuse Disorder Services	Outpatient Substance Abuse Disorder visit to or by a Health Professional. See Section 4(l).	40% coinsurance after Deductible $35 copay for Office Visits (Deductible does not apply)

Benefit	Description	Copayment/ Percentage of Allowed Amount
Inpatient Mental Health Care		
Inpatient Mental Health Care Services	See Section 4(l).	$1,000 copay, plus 40% coinsurance after Deductible
Inpatient Mental Health Physician Services	Professional fees for Inpatient Mental Health Physician Services. See Section 4(l).	40% coinsurance after Deductible
Inpatient Substance Abuse Disorder Services	See Section 4(l).	$1,000 copay, plus 40% coinsurance after Deductible
Inpatient Substance Abuse Disorder Physician Services	Professional fees for Inpatient Substance Abuse Disorder Physician Services. See Section 4(l).	40% coinsurance after Deductible$0 after Deductible
Rehabilitative Therapy Outpatient Rehabilitative Therapy	Limited to Medically Necessary outpatient Rehabilitative Therapy visits to or by a Participating Provider other than a Primary	$70 after Deductible
Habilitation Services	See Section 4(s).	$70 copay after Deductible
Speech Therapy	Limited to Medically Necessary.	$70 copay after Deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	Limited to Medically Necessary Rehabilitative Therapy, including Occupational and Physical Therapy.	$70 copay after Deductible
Chiropractic Care		
Chiropractic Care Visit	Chiropractic Care is limited to 35 visits per year. See Section 4(n).	$70 copay after Deductible
Home Healthcare		
Home Health Visit	Home health visit to or by a Participating Provider other than a Primary Care Physician. Coverage for all Home Health Services is limited to 60 visits per Plan Year. See Section 4(j).	$70 copay after Deductible
Skilled Nursing Facility		
Skilled Nursing Facility	Coverage is limited to 25 days per Plan Year. See Section 4(s).	$1,000 copay, plus 40% coinsurance after Deductible
Hospice Services		
Hospice Services	Cost sharing and limitations depends on type and site of Service. See Section 4(k).	$70 copay after Deductible
Inpatient Hospice Services	Cost sharing and limitations depends on type and site of Service. See Section 4(k).	$1,000 copay, plus 40% coinsurance after Deductible
Maternity Services		
Professional Services for Prenatal and Postnatal care	Copayment for Maternity Care by a Participating Provider. See Section 4(m).	$70 copay after Deductible per occurrence
Delivery and all Inpatient Facility Services for Maternity Care	See Section 4(m).	$1,000 copay, plus 40% coinsurance after Deductible

Benefit	Description	Copayment/ Percentage of Allowed Amount
Pediatric Vision Services		
Routine Eye Exam for Children 18 (until child turns 19) and under	See Section 4(x).	$70 copay after Deductible
Eyeglasses for Children 18 (until child turns 19) and under	See Section 4(x).	$70 copay after Deductible
DME/Orthotics/Prosthetic Medical Appliances and Hearing Aids		
Durable Medical Equipment	See Section 4(f).	30% coinsurance after Deductible
Hearing Aids	See Section 4(f).	30% coinsurance after Deductible
Diabetic Services and Education		
Diabetes Education	See Section 4(e).	$35 copay after Deductible
Diabetes Care Management	See Section 4(e).	$35 copay after Deductible
Transplant Services		
Inpatient Transplant Services	For other covered Transplant Services, Copayments for other benefits will apply, as appropriate. See Section 4(t).	$1,000 copay, plus 40% coinsurance after Deductible
Prescription Drugs		
Preventive Drugs	Certain Preventive Drugs are covered by the Plan at 100%, with no Deductible. Refer to https://www.healthcare.gov/what-are-my-preventive-care- benefits/ for current covered preventive drugs. See Section 4(o).	$0
Generic Drugs	See Section 4(o).	$15 copay 20 (Deductible does not apply)
Preferred Brand Drugs	See Section 4(o).	$80 copay after Deductible
Non-Preferred Brand Drugs	See Section 4(o).	$150 copay after Deductible
Specialty Drugs	See Section 4(o).	45% coinsurance after Deductible
Mail Order Prescription Drugs		
Generic drugs	Formulary Generic Drugs obtained through Mail Order Service. See Section 4(o).	$15 copay (30-day supply) $37.50 copay (90-day supply) Deductible does not apply
Preferred Brand Drugs	Formulary Preferred Brand Drugs obtained through Mail Order Service. See Section 4(0).	$80 copay (30-day supply after Deductible) $200 copay (90-day supply after Deductible)

Benefit	Description	Copayment/ Percentage of Allowed Amount
Non-Preferred Brand Drugs	Formulary Non-Preferred Brand Drugs obtained through Mail Order Service. See Section 4(o).	$150 copay (30-day supply after Deductible) $375 copay (90-day supply after Deductible)
Not Covered Services		
Services Your Plan Does NOT Cover	- Acupuncture - Bariatric Surgery - Dental Care (Adult and Child) - Vision (Adult) - Long-Term Care - Non-Emergency Care when traveling outside the U.S. - Routine Eye Care (Adult) - Weight Loss Programs - Infertility Treatment - Cosmetic Surgery	Review Evidence of Coverage for complete list under "General Exclusions and Limitations." See Section 5.

Schedule of Benefits – Community Select Bronze 016 HSA

This Schedule of Benefits summarizes benefit information for Covered Services that are fully described in the "Contract Benefit Management" section of this Contract. Please read Your entire Contract carefully to fully understand all terms, conditions, exclusions, and limitations that apply.

Medical and Pharmacy (Combined) Deductible	
Deductible, per individual, per Plan Year	$11,000
Deductible, per family, per Plan Year	$22,000
Out-of-Pocket Maximum	
Out-of-Pocket Maximum, per individual, per Plan Year	$12,000
Out-of-Pocket Maximum, per family, per Plan Year	$24,000

Benefit	Description	Copayment/ Percentage of Allowed Amount
Primary Care Office Visit	Physician Office Visit not for Preventive Care Services. See Section 4(p).	$35 copay (Deductible does not apply)
Specialist Visit	See Section 4(i).	$90 copay after Deductible
Outpatient Services	Outpatient Services and Habilitation Services are subject to different cost-sharing depending on whether the Service is an Office Visit or other Outpatient Service. Office visits are subject to Copays, while facility-based Services are subject to coinsurance.	
Outpatient Surgery Facility Fee	Outpatient Hospital Services performed in an Outpatient Facility or in a Hospital without admission. See Section 4(h).	50% coinsurance after Deductible
Outpatient Surgery Physician/ Surgical Services	Professional fees for outpatient or Ambulatory Surgical Procedures. See Section 4(h).	50% coinsurance after Deductible
Outpatient Laboratory	See Section 4(g) and 4(h).	$35 copay after Deductible
Outpatient X-rays and Diagnostic Imaging	See Section 4(g) and 4(h).	$35 copay after Deductible
Outpatient CT/PET/MRI and Other Outpatient Diagnostic Procedures	See Section 4(g) and 4(h).	50% after Deductible
Dialysis	Per Visit for Dialysis. See Section 4(h).	$90 copay after Deductible
Allergy Testing and Treatments	Per Visit for Allergy Treatments. See Section 4(h).	$35 copay after Deductible
Chemotherapy, Radiation, and Infusion Therapy	See Section 4(h).	$90 copay after Deductible

Benefit	Description	Copayment/ Percentage of Allowed Amount
Preventive Care Services		
Preventive Care Services	Preventive Care Services are covered by the Plan at 100%, with no Deductible. Refer to https://www.healthcare.gov/what-are-my-preventive- care-benefits/ for current list of covered Preventive Care Services. See Section 4(p).	$0
Immunizations	Age appropriate immunizations are covered by the Plan at 100%, with no Deductible. Refer to https://www.healthcare.gov/what-are-my-preventive- care-benefits/ for current list of covered Preventive Care. See Section 4(p).	$0
Hospital Services		
Inpatient Hospital Services	Section 4(h).	$1,000 copay, plus 50% coinsurance after Deductible
Inpatient Physician and Surgical Services	Professional fees for inpatient surgery and other inpatient Physician Services. See Section 4(h).	50% coinsurance after Deductible
Emergency Services		
Emergency Room Services	Per episode of Emergency Room Services. See Section 4(g). Copay waived if admitted to the Hospital (Inpatient Hospital expenses apply).	$700 copay, plus 50% coinsurance after Deductible
Emergency Transportation Services	See Section 4(v).	$90 copay after Deductible
Urgent Care Services		
Urgent Care Facility	See Section 4(w).	$90 copay (Deductible does not apply)
Outpatient Mental Health Care and Substance Abuse Disorder Treatment	Mental/Behavioral Health Outpatient Services, Substance Abuse Disorder Outpatient Services, and Habilitation Services are subject to different cost-sharing depending on whether the Service is an Office Visit or other Outpatient Service. Office visits are subject to Copays, while facility-based Services are subject to coinsurance.	
Outpatient Mental Health Services	Outpatient mental health care visit to or by a Health Professional. See Section 4(l).	50% coinsurance after Deductible $35 copay for Office Visits (Deductible does not apply)
Outpatient Substance Abuse Disorder Services	Outpatient Substance Abuse Disorder visit to or by a Health Professional. 4(l).	50% coinsurance after Deductible $35 copay for Office Visits (Deductible does not apply)

Benefit	Description	Copayment/ Percentage of Allowed Amount
Inpatient Mental Health Care		
Inpatient Mental Health Care Services	See Section 4(l).	$1,000 copay, plus 50% coinsurance after Deductible
Inpatient Mental Health Physician Services	Professional fees for Inpatient Mental Health Physician Services. See Section 4(l).	50% coinsurance after Deductible
Inpatient Substance Abuse Disorder Services	See Section 4(l).	$1,000 copay, plus 50% coinsurance after Deductible
Inpatient Substance Abuse Disorder Physician Services	Professional fees for Inpatient Substance Abuse Disorder Physician Services. See Section 4(l).	50% coinsurance after Deductible
Rehabilitative Therapy Outpatient Rehabilitative Therapy	Limited to Medically Necessary outpatient Rehabilitative Therapy visits to or by a Participating Provider other than a Primary Care Physician.	$75 copay (Deductible does not apply)
Habilitation Services	See Section 4(s).	$90 copay after Deductible
Speech Therapy	Limited to Medically Necessary.	$90 copay after Deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	Limited to Medically Necessary Rehabilitative Therapy, including Occupational and Physical Therapy.	$90 copay after Deductible
Chiropractic Care		
Chiropractic Care Visit	Chiropractic Care is limited to 35 visits per year. See Section 4(n).	$90 copay after Deductible
Home Healthcare		
Home Health Visit	Home health visit to or by a Participating Provider other than a Primary Care Physician. Coverage for all Home Health Services is limited to 60 visits per Plan Year. See Section 4(j).	$90 copay after Deductible
Skilled Nursing Facility		
Skilled Nursing Facility	Coverage is limited to 25 days per Plan Year. See Section 4(s).	1,000 copay, plus 50% coinsurance after Deductible
Hospice Services		
Hospice Services	Cost sharing and limitations depends on type and site of Service. See Section 4(k).	$90 copay after Deductible
Inpatient Hospice Services	Cost sharing and limitations depends on type and site of Service. See Section 4(k).	$1,000 copay, plus 50% coinsurance after Deductible
Maternity Services		
Professional Services for Prenatal and Postnatal care	Copayment for Maternity Care by a Participating Provider. See Section 4(m).	$90 copay after Deductible per occurrence

Benefit	Description	Copayment/ Percentage of Allowed Amount
Delivery and all Inpatient Facility Services for Maternity Care	See Section 4(m).	$1,000 copay, plus 50% coinsurance after Deductible
Pediatric Vision Services		
Routine Eye Exam for Children 18 (until child turns 19) and under	See Section 4(x).	$90 copay after Deductible
Eyeglasses for Children 18 (until child turns 19) and under	See Section 4(x).	$90 copay after Deductible
DME/Orthotics/Prosthetic Medical Appliances and Hearing Aids		
Durable Medical Equipment	See Section 4(f).	30% coinsurance after Deductible
Hearing Aids	See Section 4(f).	30% coinsurance after Deductible
Diabetic Services and Education		
Diabetes Education	See Section 4(e).	$35 copay after Deductible
Diabetes Care Management	See Section 4(e).	$35 copay after Deductible
Transplant Services		
Inpatient Transplant Services	For other covered Transplant Services, Copayments for other benefits will apply, as appropriate. See Section 4(t).	$1,000 copay, plus 50% coinsurance after Deductible
Prescription Drugs		
Preventive Drugs	Certain Preventive Drugs are covered by the Plan at 100%, with no Deductible. Refer tohttps://www.healthcare.gov/what-are-my-preventive- care-benefits/ for current covered preventive drugs. See Section 4(o).	$0
Generic Drugs	See Section 4(o).	$15 copay (Deductible does not apply)
Preferred Brand Drugs	See Section 4(o).	$60 copay after Deductible
Non-Preferred Brand Drugs	See Section 4(o).	$130 copay after Deductible
Specialty Drugs	See Section 4(o).	50% coinsurance after Deductible
Mail Order Prescription Drugs		
Generic drugs	Formulary Generic Drugs obtained through Mail Order Service. See Section 4(o).	$15 copay (30-day supply) $37.50 copay (90-day supply) Deductible does not apply

Benefit	Description	Copayment/ Percentage of Allowed Amount
Preferred Brand Drugs	Formulary Preferred Brand Drugs obtained through Mail Order Service. See Section 4(o).	$60 copay (30-day supply after Deductible) $150 copay (90-day supply after Deductible)
Non-Preferred Brand Drugs	Formulary Non-Preferred Brand Drugs obtained through Mail Order Service. See Section 3(n).	$130 copay (30-day supply after Deductible) $325 copay (90-day supply after Deductible)
Not Covered Services		
Services Your Plan Does NOT Cover	- Acupuncture - Bariatric Surgery - Dental Care (Adult and Child) - Vision (Adult) - Long-Term Care - Non-Emergency Care when traveling outside the U.S. - Routine Eye Care (Adult) - Weight Loss Programs - Infertility Treatment - Cosmetic Surgery	Review Evidence of Coverage for complete list under “General Exclusions and Limitations.” See Section 5.

Schedule of Benefits – Community Premier Bronze 018 HSA

This Schedule of Benefits summarizes benefit information for Covered Services that are fully described in the "Contract Benefit Management" section of this Contract. Please read Your entire Contract carefully to fully understand all terms, conditions, exclusions, and limitations that apply.

Medical and Pharmacy (Combined) Deductible	
Deductible, per individual, per Plan Year	$7,500
Deductible, per family, per Plan Year	$15,000
Out-of-Pocket Maximum	
Out-of-Pocket Maximum, per individual, per Plan Year	$12,000
Out-of-Pocket Maximum, per family, per Plan Year	$24,000

Benefit	Description	Copayment/ Percentage of Allowed Amount
Primary Care Office Visit	Physician Office Visit not for Preventive Care Services. See Section 4(p).	$50 copay (Deductible does not apply)
Specialist Visit	See Section 4(i).	$100 copay (Deductible does not apply)
Outpatient Services	Outpatient Services and Habilitation Services are subject to different cost-sharing depending on whether the Service is an Office Visit or other Outpatient Service. Office visits are subject to Copays, while facility-based Services are subject to coinsurance.	
Outpatient Surgery Facility Fee	Outpatient Hospital Services performed in an Outpatient Facility or in a Hospital without admission. See Section 4(h).	50% coinsurance after Deductible
Outpatient Surgery Physician/ Surgical Services	Professional fees for outpatient or Ambulatory Surgical Procedures. See Section 4(h).	50% coinsurance after Deductible
Outpatient Laboratory	See Section 4(g) and 4(h).	50% coinsurance after Deductible
Outpatient X-rays and Diagnostic Imaging	See Section 4(g) and 4(h).	50% coinsurance after Deductible
Outpatient CT/PET/MRI and Other Outpatient Diagnostic Procedures	See Section 4(g) and 4(h).	50% coinsurance after Deductible
Dialysis	Per Visit for Dialysis. See Section 4(h).	$100 copay after Deductible
Allergy Testing and Treatments	Per Visit for Allergy Treatments. See Section 4(h).	$50 copay after Deductible
Chemotherapy, Radiation, and Infusion Therapy	See Section 4(h).	$100 copay after Deductible

Benefit	Description	Copayment/ Percentage of Allowed Amount
Preventive Care Services		
Preventive Care Services	Preventive Care Services are covered by the Plan at 100%, with no Deductible. Refer to https://www.healthcare.gov/what-are-my-preventive-care-benefits/ for current list of covered Preventive Care Services. See Section 4(p).	$0
Immunizations	Age appropriate immunizations are covered by the Plan at 100%, with no Deductible. Refer tohttps://www.healthcare.gov/what-are-my-preventive-care-benefits/ for current list of covered Preventive Care. See Section 4(p).	$0
Hospital Services		
Inpatient Hospital Services	Section 4(h).	50% coinsurance after Deductible
Inpatient Physician and Surgical Services	Professional fees for inpatient surgery and other inpatient Physician Services. See Section 4(h).	50% coinsurance after Deductible
Emergency Services		
Emergency Room Services	Per episode of Emergency Room Services. See Section 4(g). Copay waived if admitted to the Hospital (Inpatient Hospital expenses apply).	50% coinsurance after Deductible
Emergency Transportation Services	See Section 4(v).	$100 copay after Deductible
Urgent Care Services		
Urgent Care Facility	See Section 4(w).	$75 copay (Deductible does not apply)
Outpatient Mental Health Care and Substance Abuse Disorder Treatment	Mental/Behavioral Health Outpatient Services, Substance Abuse Disorder Outpatient Services, and Habilitation Services are subject to different cost-sharing depending on whether the Service is an Office Visit or other Outpatient Service. Office visits are subject to Copays, while facility-based Services are subject to coinsurance.	
Outpatient Mental Health Services	Outpatient mental health care visit to or by a Health Professional. See Section 4(l).	50% coinsurance after Deductible $50 for Office Visits (Deductible does not apply)
Outpatient Substance Abuse Disorder Services	Outpatient Substance Abuse Disorder visit to or by a Health Professional. See Section 4(l).	50% coinsurance after Deductible $50 for Office Visits (Deductible does not apply)

Benefit	Description	Copayment/ Percentage of Allowed Amount
Inpatient Mental Health Care		
Inpatient Mental Health Care Services	See Section 4(l).	50% coinsurance after Deductible
Inpatient Mental Health Physician Services	Professional fees for Inpatient Mental Health Physician Services. See Section 4(l).	50% coinsurance after Deductible
Inpatient Substance Abuse Disorder Services	See Section 4(l).	50% coinsurance after Deductible
Inpatient Substance Abuse Disorder Physician Services	Professional fees for Inpatient Substance Abuse Disorder Physician Services. See Section 4(l).	50% coinsurance after Deductible
Rehabilitative Therapy Outpatient Rehabilitative Therapy	Limited to Medically Necessary outpatient Rehabilitative Therapy visits to or by a Participating Provider other than a Primary Care Physician.	$75 copay (Deductible does not apply)
Habilitation Services	See Section 4(s).	$50 copay (Deductible does not apply)
Speech Therapy	Limited to Medically Necessary.	$50 copay (Deductible does not apply)
Rehabilitative Occupational and Rehabilitative Physical Therapy	Limited to Medically Necessary Rehabilitative Therapy, including Occupational and Physical Therapy.	$50 copay (Deductible does not apply)
Chiropractic Care		
Chiropractic Care Visit	Chiropractic Care is limited to 35 visits per year. See Section 4(n).	$100 copay after Deductible
Home Healthcare		
Home Health Visit	Home health visit to or by a Participating Provider other than a Primary Care Physician. Coverage for all Home Health Services is limited to 60 visits per Plan Year. See Section 4(j).	$100 copay after Deductible
Skilled Nursing Facility		
Skilled Nursing Facility	Coverage is limited to 25 days per Plan Year. See Section 4(s).	50% coinsurance after Deductible
Hospice Services		
Hospice Services	Cost sharing and limitations depends on type and site of Service. See Section 4(k).	$100 copay after Deductible
Inpatient Hospice Services	Cost sharing and limitations depends on type and site of Service. See Section 4(k).	50% coinsurance after Deductible
Maternity Services		
Professional Services for Prenatal and Postnatal care	Copayment for Maternity Care by a Participating Provider. See Section 4(m).	$100 copay after Deductible per occurrence
Delivery and all Inpatient Facility Services for Maternity Care	See Section 4(m).	50% coinsurance after Deductible

Benefit	Description	Copayment/ Percentage of Allowed Amount
Pediatric Vision Services		
Routine Eye Exam for Children 18 (until child turns 19) and	See Section 4(x).	$100 copay after Deductible
Eyeglasses for Children 18 (until child turns 19) and under	See Section 4(x).	$100 copay after Deductible
DME/Orthotics/Prosthetic Medical Appliances and Hearing Aids		
Durable Medical Equipment	See Section 4(f).	30% coinsurance after Deductible
Hearing Aids	See Section 4(f).	30% coinsurance after Deductible
Diabetic Services and Education		
Diabetes Education	See Section 4(e).	$50 copay after Deductible
Diabetes Care Management	See Section 4(e).	$50 copay after Deductible
Transplant Services		
Inpatient Transplant Services	For other covered Transplant Services, Copayments for other benefits will apply, as appropriate. See Section 4(o).	50% coinsurance after Deductible
Prescription Drugs		
Preventive Drugs	Certain Preventive Drugs are covered by the Plan at 100%, with no Deductible. Refer to https://www.healthcare.gov/what-are-my-preventive- care-benefits/ for current covered preventive drugs. See Section 4(o).	$0
Generic Drugs	See Section 4(o).	$25 copay (Deductible does not apply)
Preferred Brand Drugs	See Section 4(o).	$50 copay after Deductible
Non-Preferred Brand Drugs	See Section 4(o).	$100 copay after Deductible
Specialty Drugs	See Section 4(o).	$500 copay after Deductible
Mail Order Prescription Drugs		
Generic drugs	Formulary Generic Drugs obtained through Mail Order Service. See Section 4(o).	$25 copay (30-day supply) $62.50 copay (90-day supply) Deductible does not apply

Benefit	Description	Copayment/ Percentage of Allowed Amount
Preferred Brand Drugs	Formulary Preferred Brand Drugs obtained through Mail Order Service. See Section 4(o).	$50 copay (30-day supply after Deductible) $125 copay (90-day supply after Deductible)
Non-Preferred Brand Drugs	Formulary Non-Preferred Brand Drugs obtained through Mail Order Service. See Section 4(o).	$100 copay (30-day supply after Deductible) $250 copay (90-day supply after Deductible)
Not Covered Services		
Services Your Plan Does NOT Cover	- Acupuncture - Bariatric Surgery - Dental Care (Adult and Child) - Vision (Adult) - Long-Term Care - Non-Emergency Care when traveling outside the U.S. - Routine Eye Care (Adult) - Weight Loss Programs - Infertility Treatment - Cosmetic Surgery	Review Evidence of Coverage for complete list under “General Exclusions and Limitations.” See Section 5.

Schedule of Benefits – Community Premier Silver 12

This Schedule of Benefits summarizes benefit information for Covered Services that are fully described in the "Contract Benefit Management" section of this Contract. Please read Your entire Contract carefully to fully understand all terms, conditions, exclusions, and limitations that apply.

Medical and Pharmacy (Combined) Deductible	
Deductible, per individual, per Plan Year	Silver / Silver 73 / Silver 87 / Silver 94 [$2,800 / $2,600 / $600 / $0]
Deductible, per family, per Plan Year	Silver / Silver 73 / Silver 87 / Silver 94 [$5,600 / $5,200 / $1,200 / $0]
Out-of-Pocket Maximum	
Out-of-Pocket Maximum, per individual, per Plan Year	Silver / Silver 73 / Silver 87 / Silver 94 [$12,000 / $9,600 / $3,600 / $3,400]
Out-of-Pocket Maximum, per family, per Plan Year	Silver / Silver 73 / Silver 87 / Silver 94 [$24,000 / $19,200 / $7,200 / $6,800]

Benefit	Description	Copayment/ Percentage of Allowed Amount
Ambulatory Patient Services		Silver / 73 / 87 / 94
Primary Care Office Visit	Physician Office Visit not for Preventive Care Services. See Section 4(p).	[$10 / $10 / $5 / $5] copay (Deductible does not apply)
Specialist Visit	See Section 4(i).	[$60 / $60 / $50 / $30] copay after Deductible
Outpatient Services	Outpatient Services and Habilitation Services are subject to different cost-sharing depending on whether the Service is an Office Visit or other Outpatient Service. Office visits are subject to Copays, while facility-based Services are subject to coinsurance.	
Outpatient Surgery Facility Fee	Outpatient Hospital Services performed in an Outpatient Facility or in a Hospital without admission. See Section 4(h).	[50% / 50% / 40% / 10%]
Outpatient Surgery Physician/ Surgical Services	Professional fees for outpatient or Ambulatory Surgical Procedures. See Section 4(h).	[50% / 50% / 40% / 10%] Coinsurance after Deductible
Outpatient Laboratory	See Section 4(g) and 4(h).	[$30 / $30 / $25 / $10] copay after Deductible
Outpatient X-rays and Diagnostic Imaging	See Section 4(g) and 4(h).	[$30 / $30 / $25 / $10] copay after Deductible
Outpatient CT/PET/MRI and other Outpatient Diagnostic Procedures	See Section 4(g) and 4(h).	[50% / 50% / 40% / 10%] coinsurance after Deductible
Dialysis	Per Visit for Dialysis. See Section 4(h).	[$60 / $60 / $50 / $30] copay after Deductible
Allergy Testing and Treatments	Per Visit for Allergy Treatments. See Section 4(h).	[$10 / $10 / $5 / $5] copay after Deductible

Benefit	Description	Copayment/ Percentage of Allowed Amount
Chemotherapy, Radiation, and Infusion Therapy	See Section 4(h).	[$60 / $60 / $50 / $30] copay after Deductible
Preventive Care Services		
Preventive Care Services	Preventive Care Services are covered by the Plan at 100%, with no Deductible. Refer to https://www.healthcare.gov/what-are-my-preventive- care-benefits/ for current list of covered Preventive Care Services. See Section 4(p).	[$0 / $0 / $0 / $0]
Immunizations	Age appropriate immunizations are covered by the Plan at 100%, with no Deductible. Refer to https://www.healthcare.gov/what-are-my-preventive-care-benefits/ for current list of covered Preventive Care. See Section 4(p).	[$0 / $0 / $0 / $0]
Hospital Services		
Inpatient Hospital Services	See Section 4(h).	[$900, $900, $800, $500] copay, plus [50% / 50% / 40% / 10%] coinsurance after Deductible
Inpatient Physician and Surgical Services	Professional fees for inpatient surgery and other inpatient Physician Services. See Section 4(h).	[50% / 50% / 40% / 10%] coinsurance after Deductible
Emergency Services		
Emergency Room Services	Per episode of Emergency Room Services. See Section 4(g). Copay waived if admitted to the Hospital (Inpatient Hospital expenses apply).	[$600, $600, $500, $300] copay, plus [50% / 50% / 40% / 10%] coinsurance after Deductible
Emergency Transportation Services	See Section 4(v).	[$60 / $60 / $50 / $30] copay after Deductible
Urgent Care Services		
Urgent Care Facility	See Section 4(w).	[$60 / $60 / $50 / $30] copay (Deductible does not apply)
Outpatient Mental Health Care and Substance Abuse Disorder Treatment	Mental/Behavioral Health Outpatient Services, Substance Abuse Disorder Outpatient Services, and Habilitation Services are subject to different cost-sharing depending on whether the Service is an Office Visit or other Outpatient Service. Office visits are subject to Copays, while facility-based Services are subject to coinsurance.	
Outpatient Mental Health Services	Outpatient mental health care visit to or by a Health Professional. See Section 4(l).	Office Visits: [$10 / $10 / $5 / $5] copay (Deductible does not apply) Outpatient Services: [50% / 50% / 40% / 10%] coinsurance after Deductible
Outpatient Substance Abuse Disorder Services	Outpatient Substance Abuse Disorder visit to or by a Health Professional. See Section 4(l).	Office Visits: [$10 / $10 / $5 / $5] copay (Deductible does not apply) Outpatient Services: [50% / 50% / 40% / 10%] coinsurance after Deductible

Benefit	Description	Copayment/ Percentage of Allowed Amount
Inpatient Mental Health Care		
Inpatient Mental Health Care Services	See Section 4(l).	[$900, $900, $800, $500] copay, plus [50% / 50% / 40% / 10%] Coinsurance after Deductible
Inpatient Mental Health Physician Services	Professional fees for Inpatient Mental Health Physician Services. See Section 4(l).	[50% / 50% / 40% / 10%] Coinsurance after Deductible
Inpatient Substance Abuse Disorder Services	See Section 4(l).	[$900, $900, $800, $500] copay, plus [50% / 50% / 40% / 10%] Coinsurance after Deductible
Inpatient Substance Abuse Disorder Physician Services	Professional fees for Inpatient Substance Abuse Disorder Physician Services. See Section 4(l).	[50% / 50% / 40% / 10%] Coinsurance after Deductible
Rehabilitative Therapy		
Outpatient Rehabilitative Therapy	Limited to Medically Necessary Outpatient Rehabilitative Therapy visits to or by a Participating Provider other than a Primary Care Physician.	[$60 / $60 / $50 / $30] copay after Deductible
Habilitation Services	See Section 4(s).	[$60 / $60 / $50 / $30] copay after Deductible
Speech Therapy	Limited to Medically Necessary.	[$60 / $60 / $50 / $30] copay after Deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	Limited to Medically Necessary Rehabilitative Therapy, including Occupational and Physical Therapy.	[$60 / $60 / $50 / $30] copay after Deductible
Chiropractic Care		
Chiropractic Care Visit	Chiropractic Care is limited to 35 visits per year. See Section 4(n).	[$60 / $60 / $50 / $30] copay after Deductible
Home Healthcare		
Home Health Visit	Home health visit to or by a Participating Provider other than a Primary Care Physician. Coverage for all Home Health Services is limited to 60 visits per Plan Year. See Section 4(j).	[$60 / $60 / $50 / $30] copay after Deductible
Skilled Nursing Facility		
Skilled Nursing Facility	Coverage is limited to 25 days per Plan Year. See Section 4(s).	[$900, $900, $800, $500] copay, plus [50% / 50% / 40% / 10%] coinsurance after Deductible
Hospice Services		
Hospice Services	Cost sharing and limitations depends on type and site of Service. See Section 4(k).	[$60 / $60 / $50 / $30] copay after Deductible
Inpatient Hospice Services	Cost sharing and limitations depends on type and site of Service. See Section 4(k).	[$900, $900, $800, $500] copay, plus [50% / 50% / 40% / 10%] coinsurance after Deductible

Benefit	Description	Copayment/ Percentage of Allowed Amount
Maternity Services		
Professional Services for Prenatal and Postnatal care	Copayment for Maternity Care by a Participating Provider. See Section 4(m).	[$60 / $60 / $50 / $30] copay after Deductible per occurrence
Delivery and all Inpatient Facility Services for Maternity Care	Copayment for each day of inpatient Services. See Section 4(m).	[$900, $900, $800, $500] copay, plus [50% / 50% / 40% / 10%] coinsurance after Deductible
Pediatric Vision Services		
Routine Eye Exam for Children 18 (until child turns 19) and under	See Section 4(x).	[$60 / $60 / $50 / $30] copay after Deductible
Eyeglasses for Children 18 (until child turns 19) and under	See Section 4(x).	[$60 / $60 / $50 / $30] copay after Deductible
DME/Orthotics/Prosthetic Medical Appliances and Hearing Aids		
Durable Medical Equipment	See Section 4(f).	[30% / 20% / 15% / 10%] coinsurance after Deductible
Hearing Aids	See Section 4(f).	[30% / 20% / 15% / 10%] after coinsurance Deductible
Diabetic Services and Education		
Diabetes Education	See Section 4(e).	[$10 / $10 / $5 / $5] copay after Deductible
Diabetes Care Management	See Section 4(e).	[$10 / $10 / $5 / $5] copay after Deductible
Transplant Services		
Inpatient Transplant Services	For other covered Transplant Services, Copayments for other benefits will apply, as appropriate. See Section 4(t).	[$900, $900, $800, $500] copay, plus [50% / 50% / 40% / 10%] coinsurance after Deductible
Prescription Drugs		
Preventive Drugs	Certain Preventive Drugs are covered by the Plan at 100%, with no Deductible. Refer to https://www.healthcare.gov/what-are-my-preventive-care-benefits/ for current covered preventive drugs. See Section 4(o).	[$0 / $0 / $0 / $0]
Generic Drugs	See Section 4(o).	[$5 / $5 / $5 / $5] copay (Deductible does not apply)
Preferred Brand Drugs	See Section 4(o).	[$80 / $80 / $70 / $25] copay after Deductible
Non-Preferred Brand Drugs	See Section 4(o).	[$120 / $120 / $100 / $55] copay after Deductible
Specialty Drugs	See Section 4(o).	[50% / 50% / 40% / 30%] coinsurance after Deductible

Benefit	Description	Copayment/ Percentage of Allowed Amount
Mail Order Prescription Drugs		
Generic drugs	Formulary Generic Drugs obtained through Mail Order Service. See Section 4(0).	[$5 / $5 / $5 / $5] copay (30-day supply) [$12.50 / $12.50 / $12.50 / $12.50] copay (90-day supply) (Deductible does not apply)
Preferred Brand Drugs	Formulary Preferred Brand Drugs obtained through Mail Order Service. See Section 4(0).	[$80 / $80 / $70 / $25] copay (30-day supply) [$200 / $200 / $175 / $62.50] copay (90-day supply) Deductible applies
Non-Preferred Brand Drugs	Formulary Non-Preferred Brand Drugs obtained through Mail Order Service. See Section 4(0).	[$120 / $120 / $100 / $55] copay (30-day supply) [$300/$300/$250/$110] copay (90-day supply) Deductible applies
Not Covered Services		
Services Your Plan Does NOT Cover	- Acupuncture - Bariatric Surgery - Dental Care (Adult and Child) - Vision (Adult) - Long-Term Care - Non-Emergency Care when traveling outside the U.S. - Routine Eye Care (Adult) - Weight Loss Programs - Infertility Treatment - Cosmetic Surgery	Review Evidence of Coverage for complete list under “General Exclusions and Limitations.” See Section 5.

Schedule of Benefits – Community Select Silver 019

This Schedule of Benefits summarizes benefit information for Covered Services that are fully described in the "Contract Benefit Management" section of this Contract. Please read Your entire Contract carefully to fully understand all terms, conditions, exclusions, and limitations that apply.

Medical and Pharmacy (Combined) Deductible	
Deductible, per individual, per Plan Year	Silver / Silver 73 / Silver 87 / Silver 94 [$5,000 / $4,000 / $800 / $0]
Deductible, per family, per Plan Year	Silver / Silver 73 / Silver 87 / Silver 94 [$10,000 / $8,000 / $1,600 / $0]
Out-of-Pocket Maximum	
Out-of-Pocket Maximum, per individual, per Plan Year	Silver / Silver 73 / Silver 87 / Silver 94 [$10,000 / $8,200 / $3,700 / $3,400]
Out-of-Pocket Maximum, per family, per Plan Year	Silver / Silver 73 / Silver 87 / Silver 94 [$20,000 / $16,400 / $7,400 / $6,800]

Benefit	Description	Copayment/ Percentage of Allowed Amount
Ambulatory Patient Services		Silver / 73 / 87 / 94
Primary Care Office Visit	Physician Office Visit not for Preventive Care Services. See Section 4(p).	[$15 / $15 / $5 / $5] copay (Deductible does not apply)
Specialist Visit	See Section 4(i).	[$80 / $80 / $40 / $30] copay (Deductible does not apply)
Outpatient Services	Outpatient Services and Habilitation Services are subject to different cost-sharing depending on whether the Service is an Office Visit or other Outpatient Service. Office visits are subject to Copays, while facility-based Services are subject to coinsurance.	
Outpatient Surgery Facility Fee	Outpatient Hospital Services performed in an Outpatient Facility or in a Hospital without admission. See Section 4(h).	[40% / 40% / 30% / 10%] coinsurance after Deductible
Outpatient Surgery Physician/ Surgical Services	Professional fees for outpatient or Ambulatory Surgical Procedures. See Section 4(h).	[40% / 40% / 30% / 10%] coinsurance after Deductible
Outpatient Laboratory	See Section 4(g) and 4(h).	[$40 / $40 / $20 / $10] copay after Deductible
Outpatient X-rays and Diagnostic Imaging	See Section 4(g) and 4(h).	[$40 / $40 / $20 / $10] copay after Deductible
Outpatient CT/PET/MRI and other Outpatient Diagnostic Procedures	See Section 4(g) and 4(h).	[40% / 40% / 30% / 10%] coinsurance after Deductible

Benefit	Description	Copayment/ Percentage of Allowed Amount
Dialysis	Per Visit for Dialysis. See Section 4(h).	[$80 / $80 / $40 / $30] copay after Deductible
Allergy Testing and Treatments	Per Visit for Allergy Treatments. See Section 4(h).	[$15 / $15 / $5 / $5] copay after Deductible
Chemotherapy, Radiation, and Infusion Therapy	See Section 4(h).	[$80 / $80 / $40 / $30] copay after Deductible
Preventive Care Services		
Preventive Care Services	Preventive Care Services are covered by the Plan at 100%, with no Deductible. Refer to https://www.healthcare.gov/what-are-my-preventive-care-benefits/ for current list of covered Preventive Care Services. See Section 4(p).	[$0 / $0 / $0 / $0]
Immunizations	Age appropriate immunizations are covered by the Plan at 100%, with no Deductible. Refer to https://www.healthcare.gov/what-are-my-preventive-care-benefits/ for current list of covered Preventive Care. See Section 4(p).	[$0 / $0 / $0 / $0]
Hospital Services		
Inpatient Hospital Services	See Section 4(h).	[$900, $900, $800, $500] copay, plus [40% / 40% / 30% / 10%] coinsurance after Deductible
Inpatient Physician and Surgical Services	Professional fees for inpatient surgery and other inpatient Physician Services. See Section 4(h).	[40% / 40% / 30% / 10%] coinsurance after Deductible
Emergency Services		
Emergency Room Services	Per episode of Emergency Room Services. See Section 4(g). Copay waived if admitted to the Hospital (Inpatient Hospital expenses apply).	[$600, $600, $500, $300] copay, plus [40% / 40% / 30% / 10%] coinsurance after Deductible
Emergency Transportation Services	See Section 4(v).	[$80 / $80 / $40 / $30] copay after Deductible
Urgent Care Services		
Urgent Care Facility	See Section 4(w).	[[$80 / $80 / $40 / $30] copay (Deductible does not apply)
Outpatient Mental Health Care and Substance Abuse Disorder Treatment	Mental/Behavioral Health Outpatient Services, Substance Abuse Disorder Outpatient Services, and Habilitation Services are subject to different cost-sharing depending on whether the Service is an Office Visit or other Outpatient Service. Office visits are subject to Copays, while facility-based Services are subject to coinsurance	

Benefit	Description	Copayment/ Percentage of Allowed Amount
Outpatient Mental Health Services	Outpatient mental health care visit to or by a Health Professional. See Section 4(l).	[$15 / $15 / $5 / $5] copay per Office Visit (Deductible does not apply) Outpatient Services: [40%/ 40% / 30% / 10%] coinsurance after Deductible
Outpatient Substance Abuse Disorder Services	Outpatient Substance Abuse Disorder visit to or by a Health Professional. See Section 4(l).	[$15 / $15 / $5 / $5] copay per Office Visit (Deductible does not apply) Outpatient Services: [40%/ 40% / 30% / 10%] coinsurance after Deductible
Inpatient Mental Health Care		
Inpatient Mental Health Care Services	See Section 4(l).	[$900, $900, $800, $500] copay, plus [40% / 40% / 30% / 10%] coinsurance after Deductible
Inpatient Mental Health Physician Services	Professional fees for Inpatient Mental Health Physician Services. See Section 4(l).	[40% / 40% / 30% / 10%] coinsurance after Deductible
Inpatient Substance Abuse Disorder Services	See Section 4(l).	[$900, $900, $800, $500] copay, plus [40% / 40% / 30% / 10%] coinsurance after Deductible
Inpatient Substance Abuse Disorder Physician Services	Professional fees for Inpatient Substance Abuse Disorder Physician Services. See Section 4(l).	[40% / 40% / 30% / 10%] coinsurance after Deductible
Rehabilitative Therapy		
Outpatient Rehabilitative Therapy	Limited to Medically Necessary Outpatient Rehabilitative Therapy visits to or by a Participating Provider other than a Primary Care Physician.	[$65 / $65 / $25 / $10] copay (Deductible does not apply)
Habilitation Services	See Section 4(s).	[$80 / $80 / $40 / $30] copay after Deductible
Speech Therapy	Limited to Medically Necessary.	[$80 / $80 / $40 / $30] copay after Deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	Limited to Medically Necessary Rehabilitative Therapy, including Occupational and Physical Therapy.	[$80 / $80 / $40 / $30] copay after Deductible
Chiropractic Care		
Chiropractic Care Visit	Chiropractic Care is limited to 35 visits per year. See Section 4(n).	[$80 / $80 / $40 / $30] copay after Deductible
Home Healthcare		
Home Health Visit	Home health visit to or by a Participating Provider other than a Primary Care Physician. Coverage for all Home Health Services is limited to 60 visits per Plan Year. See Section 4(j).	[$80 / $80 / $40 / $30] copay after Deductible

Benefit	Description	Copayment/ Percentage of Allowed Amount
Skilled Nursing Facility		
Skilled Nursing Facility	Coverage is limited to 25 days per Plan Year. See Section 4(s).	[$900, $900, $800, $500] copay, plus [40% / 40% / 30% / 10%] coinsurance after Deductible
Hospice Services		
Hospice Services	Cost sharing and limitations depends on type and site of Service. See Section 4(k).	[$80 / $80 / $40 / $30] copay per day after Deductible
Inpatient Hospice Services	Cost sharing and limitations depends on type and site of Service. See Section 4(k).	[$900, $900, $800, $500] copay, plus [40% / 40% / 30% / 10%] coinsurance after Deductible
Maternity Services		
Professional Services for Prenatal and Postnatal care	Copayment for Maternity Care by a Participating Provider. See Section 4(m).	[$80 / $80 / $40 / $30] copay after Deductible per occurrence
Delivery and all Inpatient Facility Services for Maternity Care	See Section 4(m).	[$900, $900, $800, $500] copay, plus [40% / 40% / 30% / 10%] coinsurance after Deductible
Pediatric Vision Services		
Routine Eye Exam for Children 18 (until child turns 19) and under	See Section 4(x).	[$80 / $80 / $40 / $30] copay after Deductible
Eyeglasses for Children 18 (until child turns 19) and under	See Section 4(x).	[$80 / $80 / $40 / $30] copay after Deductible
DME/Orthotics/Prosthetic Medical Appliances and Hearing Aids		
Durable Medical Equipment	See Section 4(f).	[30% / 20% / 15% / 10%] coinsurance after Deductible
Hearing Aids	See Section 4(f).	[30% / 20% / 15% / 10%] coinsurance after Deductible
Diabetic Services and Education		
Diabetes Education	See Section 4(e).	[$15 / $15 / $5 / $5] copay after Deductible
Diabetes Care Management	See Section 4(e).	[$15 / $15 / $5 / $5] copay after Deductible
Transplant Services		
Inpatient Transplant Services	For other covered Transplant Services, Copayments for other benefits will apply, as appropriate. See Section 4(t).	[$900, $900, $800, $500] copay, plus [40% / 40% / 30% / 10%] coinsurance after Deductible

Benefit	Description	Copayment/ Percentage of Allowed Amount
Prescription Drugs		
Preventive Drugs	Certain Preventive Drugs are covered by the Plan at 100%, with no Deductible. Refer to https://www.healthcare.gov/what-are-my-preventive-care-benefits/ for current covered preventive drugs. See Section 4(o).	[$0 / $0 / $0 / $0]
Generic Drugs	See Section 4(o).	[$10 / $10 / $10 / $5] copay Deductible does not apply
Preferred Brand Drugs	See Section 4(o).	[$45 / $45 / $25 / $25] copay after Deductible
Non-Preferred Brand Drugs	See Section 4(o).	[$100 / $100 / $60 / $40] copay after Deductible
Specialty Drugs	See Section 4(o).	[50% / 50% / 50% / 30%] coinsurance after Deductible
Mail Order Prescription Drugs		
Generic drugs	Formulary Generic Drugs obtained through Mail Order Service. See Section 4(0).	[$10 / $10 / $10 / $5] copay (30-day supply) [$25 / $25 / $25 / $12.50] copay (90-day supply) (Deductible does not apply)
Preferred Brand Drugs	Formulary Preferred Brand Drugs obtained through Mail Order Service. See Section 4(0).	[$45 / $45 / $25 / $25] copay (30-day supply) [$112.50 / $112.50 / $62.50 / $62.50] copay (90-day supply) Deductible applies
Non-Preferred Brand Drugs	Formulary Non-Preferred Brand Drugs obtained through Mail Order Service. See Section 4(0).	[$100 / $100 / $60 / $40] copay (30- day supply) [$250 / $250 / $150 / $100] copay (90-day supply) Deductible applies
Not Covered Services		
Services Your Plan Does NOT Cover	- Acupuncture - Bariatric Surgery - Dental Care (Adult and Child) - Vision (Adult) - Long-Term Care - Non-Emergency Care when traveling outside the U.S. - Routine Eye Care (Adult) - Weight Loss Programs - Infertility Treatment - Cosmetic Surgery	Review Evidence of Coverage for complete list under “General Exclusions and Limitations.” See Section 5.

Schedule of Benefits – Community Premier Silver 020

This Schedule of Benefits summarizes benefit information for Covered Services that are fully described in the "Contract Benefit Management" section of this Contract. Please read Your entire Contract carefully to fully understand all terms, conditions, exclusions, and limitations that apply.

Medical and Pharmacy (Combined) Deductible	
Deductible, per individual, per Plan Year	Silver / Silver 73 / Silver 87 / Silver 94 [$6,400 / $2,900 / $800 / $0]
Deductible, per family, per Plan Year	Silver / Silver 73 / Silver 87 / Silver 94 [$12,800 / $5,800 / $1,600 / $0]
Out-of-Pocket Maximum	
Out-of-Pocket Maximum, per individual, per Plan Year	Silver / Silver 73 / Silver 87 / Silver 94 [$10,300 / $9,000 / $3,600 / $3,500]
Out-of-Pocket Maximum, per family, per Plan Year	Silver / Silver 73 / Silver 87 / Silver 94 [$20,600 / $18,000 / $7,200 / $7,000]

Benefit	Description	Copayment/ Percentage of Allowed Amount
Ambulatory Patient Services		Silver / 73 / 87 / 94
Primary Care Office Visit	Physician Office Visit not for Preventive Care Services. See Section 4(p).	[$40 / $40 / $20 / $0] copay (Deductible does not Apply)
Specialist Visit	See Section 4(i).	[$80 / $80 / $40 / $10] copay (Deductible does not Apply)
Outpatient Services	Outpatient Services and Habilitation Services are subject to different cost-sharing depending on whether the Service is an Office Visit or other Outpatient Service. Office visits are subject to Copays, while facility-based Services are subject to coinsurance.	
Outpatient Surgery Facility Fee	Outpatient Hospital Services performed in an Outpatient Facility or in a Hospital without admission. See Section 4(h).	[40% / 40% / 30% / 25%] coinsurance after Deductible
Outpatient Surgery Physician/ Surgical Services	Professional fees for outpatient or Ambulatory Surgical Procedures. See Section 4(h).	[40% / 40% / 30% / 25%] coinsurance after Deductible
Outpatient Laboratory	See Section 4(g) and 4(h).	[40% / 40% / 30% / 25%] coinsurance after Deductible
Outpatient X-rays and Diagnostic Imaging	See Section 4(g) and 4(h).	[40% / 40% / 30% / 25%] coinsurance after Deductible
Outpatient CT/PET/MRI and other Outpatient Diagnostic Procedures	See Section 4(g) and 4(h).	[40% / 40% / 30% / 25%] coinsurance after Deductible
Dialysis	Per Visit for Dialysis. See Section 4(h).	[$80 / $80 / $40 / $10] copay after Deductible

Benefit	Description	Copayment/ Percentage of Allowed Amount
Allergy Testing and Treatments	Per Visit for Allergy Treatments. See Section 4(h).	[$40 / $40 / $20 / $0] copay after Deductible
Chemotherapy, Radiation, and Infusion Therapy	See Section 4(h).	[$80 / $80 / $40 / $10] copay after Deductible
Preventive Care Services		
Preventive Care Services	Preventive Care Services are covered by the Plan at 100%, with no Deductible. Refer to https://www.healthcare.gov/what-are-my-preventive-care-benefits/ for current list of covered Preventive Care Services. See Section 4(p).	[$0 / $0 / $0 / $0]
Immunizations	the Plan at 100%, with no Deductible. Refer to https://www.healthcare.gov/what-are-my-preventive- care-benefits/ for current list of covered Preventive Care. See Section 4(p).	[$0 / $0 / $0 / $0]
Hospital Services		
Inpatient Hospital Services	See Section 4(h).	[40% / 40% / 30% / 25%] coinsurance after Deductible
Inpatient Physician and Surgical Services	Professional fees for inpatient surgery and other inpatient Physician Services. See Section 4(h).	[40% / 40% / 30% / 25%] coinsurance after Deductible
Emergency Services		
Emergency Room Services	Per episode of Emergency Room Services. See Section 4(g). Copay waived if admitted to the Hospital (Inpatient Hospital expenses apply).	[40% / 40% / 30% / 25%] coinsurance after Deductible
Emergency Transportation Services	See Section 4(v).	[$80 / $80 / $40 / $10] copay after Deductible
Urgent Care Services		
Urgent Care Facility	See Section 4(w).	[$60 / $60 / $30 / $5] copay (Deductible does not apply)
Outpatient Mental Health Care and Substance Abuse Disorder Treatment	Mental/Behavioral Health Outpatient Services, Substance Abuse Disorder Outpatient Services, and Habilitation Services are subject to different cost-sharing depending on whether the Service is an Office Visit or other Outpatient Service. Office visits are subject to Copays, while facility-based Services are subject to coinsurance.	
Outpatient Mental Health Services	Outpatient mental health care visit to or by a Health Professional. See Section 4(l).	[$40 / $40 / $20 / $0] copay per Office Visit (Deductible does not apply) Outpatient Services: [40% / 40% / 30% / 25%] coinsurance after Deductible

Benefit	Description	Copayment/ Percentage of Allowed Amount
Outpatient Substance Abuse Disorder Services	Outpatient Substance Abuse Disorder visit to or by a Health Professional. See Section 4(l).	[$40 / $40 / $20 / $0] copay per Office Visit (Deductible does not apply) Outpatient Services: [40% / 40% / 30% / 25%] coinsurance after Deductible
Inpatient Mental Health Care		
Inpatient Mental Health Care Services	See Section 4(l).	[40% / 40% / 30% / 25%] coinsurance after Deductible
Inpatient Mental Health Physician Services	Professional fees for Inpatient Mental Health Physician Services. See Section 4(l).	[40% / 40% / 30% / 25%] coinsurance after Deductible
Inpatient Substance Abuse Disorder Services	See Section 4(l).	[40% / 40% / 30% / 25%] coinsurance after Deductible
Inpatient Substance Abuse Disorder Physician Services	Professional fees for Inpatient Substance Abuse Disorder Physician Services. See Section 4(l).	[40% / 40% / 30% / 25%] coinsurance after Deductible
Rehabilitative Therapy		
Outpatient Rehabilitative Therapy	Limited to Medically Necessary Outpatient Rehabilitative Therapy visits to or by a Participating Provider other than a Primary Care Physician.	[$40 / $40 / $20 / $0] copay (Deductible does not apply)
Habilitation Services	See Section 4(s).	[$40 / $40 / $20 / $0] copay (Deductible does not apply)
Speech Therapy	Limited to Medically Necessary.	[$40 / $40 / $20 / $0] copay (Deductible does not apply)
Rehabilitative Occupational and Rehabilitative Physical Therapy	Limited to Medically Necessary Rehabilitative Therapy, including Occupational and Physical Therapy.	[$40 / $40 / $20 / $0] copay (Deductible does not apply)
Chiropractic Care		
Chiropractic Care Visit	Chiropractic Care is limited to 35 visits per year. See Section 4(n).	[$80, $80, $40, $10] copay after Deductible
Home Healthcare		
Home Health Visit	Home health visit to or by a Participating Provider other than a Primary Care Physician. Coverage for all Home Health Services is limited to 60 visits per Plan Year. See Section 4(j).	[$80, $80, $40, $10] copay after Deductible
Skilled Nursing Facility		
Skilled Nursing Facility	Coverage is limited to 25 days per Plan Year. See Section 4(s).	[40% / 40% / 30% / 25%] coinsurance after Deductible
Hospice Services		
Hospice Services	Cost sharing and limitations depends on type and site of Service. See Section 4(k).	[$80, $80, $40, $10] copay after Deductible
Inpatient Hospice Services	Cost sharing and limitations depends on type and site of Service. See Section 4(k).	[40% / 40% / 30% / 25%] coinsurance after Deductible

Benefit	Description	Copayment/ Percentage of Allowed Amount
Maternity Services		
Professional Services for Prenatal and Postnatal care	Copayment for Maternity Care by a Participating Provider. See Section 4(m).	[$80, $80, $40, $10] copay after Deductible
Delivery and all Inpatient Facility Services for Maternity Care	See Section 4(m).	[40% / 40% / 30% / 25%] coinsurance after Deductible
Pediatric Vision Services		
Routine Eye Exam for Children 18 (until child turns 19) and under	See Section 4(x).	[$80, $80, $40, $10] copay after Deductible
Eyeglasses for Children 18 (until child turns 19) and under	See Section 4(x).	[$80, $80, $40, $10] copay after Deductible
DME/Orthotics/Prosthetic Medical Appliances and Hearing Aids		
Durable Medical Equipment	See Section 4(f).	[30% / 20% / 15% / 10%] coinsurance after Deductible
Hearing Aids	See Section 4(f).	[30% / 20% / 15% / 10%] coinsurance after Deductible
Diabetic Services and Education		
Diabetes Education	See Section 4(e).	[$40 / $40 / $20 / $0] copay after Deductible
Diabetes Care Management	See Section 4(e).	[$40 / $40 / $20 / $0] copay after Deductible
Transplant Services		
Inpatient Transplant Services	For other covered Transplant Services, Copayments for other benefits will apply, as appropriate. See Section 4(t).	[40% / 40% / 30% / 25%] coinsurance after Deductible
Prescription Drugs		
Preventive Drugs	Certain Preventive Drugs are covered by the Plan at 100%, with no Deductible. Refer to https://www.healthcare.gov/what-are-my-preventive- care-benefits/ for current covered preventive drugs. See Section 4(o).	[$0 / $0 / $0 / $0]
Generic Drugs	See Section 4(o).	[$20 / $20 / $10 / $0] copay (Deductible does not apply)
Preferred Brand Drugs	See Section 4(o).	[$40 / $40 / $20 / $15] copay (Deductible does not apply)
Non-Preferred Brand Drugs	See Section 4(o).	[$80 / $80 / $60 / $50] copay after Deductible
Specialty Drugs	See Section 4(o).	[$350 / $350 / $250 / $150] copay after Deductible

Benefit	Description	Copayment/ Percentage of Allowed Amount
Mail Order Prescription Drugs		
Generic drugs	Formulary Generic Drugs obtained through Mail Order Service. See Section 4(o).	[$20 / $20 / $10 / $0] (30-day supply) [$50 / $50 / $25 / $0] (90-day supply) (Deductible does not apply)
Preferred Brand Drugs	Formulary Preferred Brand Drugs obtained through Mail Order Service. See Section 4(o).	[$40 / $40 / $20 / $15] (30-day supply) [$100 / $100 / $50 / $37.50] (90-day supply) (Deductible does not apply)
Non-Preferred Brand Drugs	Formulary Non-Preferred Brand Drugs obtained through Mail Order Service. See Section 4(o).	[$80 / $80 / $60 / $50] (30-day supply) [$200 / $200 / $150 / $125] (90-day supply) Deductible applies
Not Covered Services		
Services Your Plan Does NOT Cover	- Acupuncture - Bariatric Surgery - Dental Care (Adult and Child) - Vision (Adult) - Long-Term Care - Non-Emergency Care when traveling outside the U.S. - Routine Eye Care (Adult) - Weight Loss Programs - Infertility Treatment - Cosmetic Surgery	Review Evidence of Coverage for complete list under "General Exclusions and Limitations." See Section 5.

Schedule of Benefits – Community Premier Gold 005

This Schedule of Benefits summarizes benefit information for Covered Services that are fully described in the "Contract Benefit Management" section of this Contract. Please read Your entire Contract carefully to fully understand all terms, conditions, exclusions, and limitations that apply.

Medical and Pharmacy (Combined) Deductible	
Deductible, per individual, per Plan Year	$2,500
Deductible, per family, per Plan Year	$5,000
Out-of-Pocket Maximum	
Out-of-Pocket Maximum, per individual, per Plan Year	$8,500
Out-of-Pocket Maximum, per family, per Plan Year	$17,000

Benefit	Description	Copayment/ Percentage of Allowed Amount
Ambulatory Patient Services		
Primary Care Office Visit	Physician Office Visit not for Preventive Care Services. See Section 4(p).	$15 copay (Deductible does not apply)
Specialist Visit	See Section 4(i).	$40 copay (Deductible does not apply)
Outpatient Services	Outpatient Services and Habilitation Services are subject to different cost-sharing depending on whether the Service is an Office Visit or other Outpatient Service. Office visits are subject to Copays, while facility-based Services are subject to coinsurance.	
Outpatient Surgery Facility Fee	Outpatient Hospital Services performed in an Outpatient Facility or in a Hospital without admission. See Section 4(h).	25% after Deductible
Outpatient Surgery Physician/ Surgical Services	Professional fees for outpatient or Ambulatory Surgical Procedures. See Section 4(h).	25% coinsurance after Deductible
Outpatient Laboratory	See Section 4(g) and 4(h).	$20 copay after Deductible
Outpatient X-rays and Diagnostic Imaging	See Section 4(g) and 4(h).	$20 copay after Deductible
Outpatient CT/PET/MRI and other Outpatient Diagnostic Procedures	See Section 4(g) and 4(h).	25% coinsurance after Deductible
Dialysis	Per Visit for Dialysis. See Section 4(g).	$40 copay after Deductible
Allergy Testing and Treatments	Per Visit for Allergy Treatments. See Section 4(h).	$15 copay after Deductible
Chemotherapy, Radiation, and Infusion Therapy	See Section 4(h).	$40 copay after Deductible

Benefit	Description	Copayment/ Percentage of Allowed Amount
Preventive Care Services		
Preventive Care Services	Preventive Care Services are covered by the Plan at 100%, with no Deductible. Refer to https://www.healthcare.gov/what-are-my-preventive-care-benefits/ for current list of covered Preventive Care Services. See Section 4(p).	$0
Immunizations	Age appropriate immunizations are covered by the Plan at 100%, with no Deductible. Refer to https://www.h ealthcare.gov/what- are-my-preventive-care-benefits/ for current list of covered Preventive Care. See Section 4(p).	$0
Hospital Services		
Inpatient Hospital Services	See Section 4(h).	$800 copay, plus 25% coinsurance after Deductible
Inpatient Physician and Surgical Services	Professional fees for inpatient surge and other inpatient Physician Services. See Section 4(h).	25% coinsurance after Deductible
Emergency Services		
Emergency Room Services	Per episode of Emergency Room Services. See Section 4(g).	$500 copay, plus 25% coinsurance after Deductible
Emergency Transportation Services	See Section 4(v).	$40 copay after Deductible
Urgent Care Services		
Urgent Care Facility	See Section 4(w).	$40 copay (Deductible does not apply)
Outpatient Mental Health Care and Substance Abuse Disorder Treatment	Mental/Behavioral Health Outpatient Services, Substance Abuse Disorder Outpatient Services, and Habilitation Services are subject to different cost-sharing depending on whether the Service is an Office Visit or other Outpatient Service. Office visits are subject to Copays, while facility-based Services are subject to coinsurance.	
Outpatient Mental Health Services	Outpatient mental health care visit to or by a Health Professional. See Section 4(l).	$15 copay for Office Visits (Deductible does not apply) 25% coinsurance for Outpatient Services after Deductible
Outpatient Substance Abuse Disorder Services	Outpatient Substance Abuse Disorder visit to or by a Health Professional. See Section 4(l).	$15 copay for Office Visits (Deductible does not apply) 25% coinsurance for Outpatient Services after Deductible

Benefit	Description	Copayment/ Percentage of Allowed Amount
Inpatient Mental Health Care		
Inpatient Mental Health Care Services	See Section 4(l).	$800 copay, plus 25% coinsurance after Deductible
Inpatient Mental Health Physician Services	Professional fees for Inpatient Mental Health Physician Services. See Section 4(l).	25% coinsurance after Deductible
Inpatient Substance Abuse Disorder Services	See Section 4(l).	$800 copay, plus 25% coinsurance after Deductible
Inpatient Substance Abuse Disorder Physician Services	Professional fees for Inpatient Substance Abuse Disorder Physician Services. See Section 4(l).	25% coinsurance after Deductible
Rehabilitative Therapy		
Outpatient Rehabilitative Therapy	Limited to Medically Necessary Outpatient Rehabilitative Therapy visits to or by a Participating Provider other than a Primary Care Physician.	$40 copay after Deductible
Habilitation Services	See Section 4(s).	$40 copay after Deductible
Speech Therapy	Limited to Medically Necessary.	$40 copay after Deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	Limited to Medically Necessary Rehabilitative Therapy, including occupational, and physical therapy.	$40 copay after Deductible
Chiropractic Care		
Chiropractic Care Visit	Chiropractic Care is limited to 35 visits per year. See Section 4(n).	$40 copay after Deductible
Home Healthcare		
Home Health Visit	Home health visit to or by a Participating Provider other than a Primary Care Physician. Coverage for all Home Health Services is limited to 60 visits per Plan Year. See Section 4(j).	$40 copay after Deductible
Skilled Nursing Facility		
Skilled Nursing Facility	Coverage is limited to 25 days per Plan Year. See Section 4(s).	$800 copay, plus 25% coinsurance after Deductible
Hospice Services		
Hospice Services	Cost sharing and limitations depends on type and site of Service. See Section 4(k).	$40 copay after Deductible
Inpatient Hospice Services	Cost sharing and limitations depends on type and site of Service. See Section 4(k).	$800 copay, plus 25% coinsurance after Deductible
Maternity Services		
Professional Services for Prenatal and Postnatal care	Copayment for Maternity Care by a Participating Provider. See Section 4(m).	$40 copay after Deductible per occurrence
Delivery and all Inpatient Facility Services for Maternity Care	See Section 4(m).	$800 copay, plus 25% coinsurance after Deductible

Benefit	Description	Copayment/ Percentage of Allowed Amount
Pediatric Vision Services		
Routine Eye Exam for Children 18 (until child turns 19) and under	See Section 4(x).	$40 copay after Deductible
Eyeglasses for Children 18 (until child turns 19) and under	See Section 4(x).	$40 copay after Deductible
DME/Orthotics/Prosthetic Medical Appliances and Hearing Aids		
Durable Medical Equipment	See Section 4(f).	30% coinsurance after Deductible
Hearing Aids	See Section 4(f).	30% coinsurance after Deductible
Diabetic Services and Education		
Diabetes Education	See Section 4(e).	$15 copay after Deductible
Diabetes Care Management	See Section 4(e).	$15 copay after Deductible
Transplant Services		
Inpatient Transplant Services	For other covered Transplant Services, Copayments for other benefits will apply, as appropriate. See Section 4(t).	$800 copay, plus 25% coinsurance after Deductible
Prescription Drugs		
Preventive Drugs	Certain Preventive Drugs are covered by the Plan at 100%, with no Deductible. Refer to https://www.healthcare.gov/what-are-my-preventive-care-benefits/ for current covered preventive drugs. See Section 4(o).	$0
Generic Drugs	See Section 4(o).	$5 copay (Deductible does not apply)
Preferred Brand Drugs	See Section 4(o).	$50 copay after Deductible
Non-Preferred Brand Drugs	See Section 4(o).	$75 copay after Deductible
Specialty Drugs	See Section 4(o).	35% coinsurance after Deductible
Mail Order Prescription Drugs		
Generic drugs	Formulary Generic Drugs obtained through Mail Order Service. See Section 4(o).	$5 copay (30-day supply) $12.50 copay (90-day supply) (Deductible does not apply)

Benefit	Description	Copayment/ Percentage of Allowed Amount
Preferred Brand Drugs	Formulary Preferred Brand Drugs obtained through Mail Order Service. See Section 4(o).	$50 copay (30-day supply) $125 copay (90-day supply) Deductible applies
Non-Preferred Brand Drugs	Formulary Non-Preferred Brand Drugs obtained through Mail Order Service. See Section 4(o).	$75 copay (30-day supply) $187.50 copay (90-day supply) Deductible applies
Not Covered Services		
Services Your Plan Does NOT Cover	- Acupuncture - Bariatric Surgery - Dental Care (Adult and Child) - Vision (Adult) - Long-Term Care - Non-Emergency Care when traveling outside the U.S. - Routine Eye Care (Adult) - Weight Loss Programs - Infertility Treatment - Cosmetic Surgery	Review Evidence of Coverage for complete list under “General Exclusions and Limitations.” See Section 5.

Schedule of Benefits – Community Premier Gold 021

This Schedule of Benefits summarizes benefit information for Covered Services that are fully described in the "Contract Benefit Management" section of this Contract. Please read Your entire Contract carefully to fully understand all terms, conditions, exclusions, and limitations that apply.

Medical and Pharmacy (Combined) Deductible	
Deductible, per individual, per Plan Year	$2,500
Deductible, per family, per Plan Year	$5,000
Out-of-Pocket Maximum	
Out-of-Pocket Maximum, per individual, per Plan Year	$8,600
Out-of-Pocket Maximum, per family, per Plan Year	$17,200

Benefit	Description	Copayment/ Percentage of Allowed Amount
Ambulatory Patient Services		
Primary Care Office Visit	Physician Office Visit not for Preventive Care Services. See Section 4(p).	$30 copay (Deductible does not apply)
Specialist Visit	See Section 4(i).	$60 copay (Deductible does not apply)
Outpatient Services	Outpatient Services and Habilitation Services are subject to different cost-sharing depending on whether the Service is an Office Visit or other Outpatient Service. Office visits are subject to Copays, while facility-based Services are subject to coinsurance.	
Outpatient Surgery Facility Fee	Outpatient Hospital Services performed in an Outpatient Facility or in a Hospital without admission. See Section 4(h).	25% coinsurance after Deductible
Outpatient Surgery Physician/ Surgical Services	Professional fees for outpatient or Ambulatory Surgical Procedures. See Section 4(h).	25% coinsurance after Deductible
Outpatient Laboratory	See Section 4(g) and 4(h).	25% coinsurance after Deductible
Outpatient X-rays and Diagnostic Imaging	See Section 4(g) and 4(h).	25% coinsurance after Deductible
Outpatient CT/PET/MRI and other Outpatient Diagnostic Procedures	See Section 4(g) and 4(h).	25% coinsurance after Deductible
Dialysis	Per Visit for Dialysis. See Section 4(h).	$60 copay after Deductible
Allergy Testing and Treatments	Per Visit for Allergy Treatments. See Section 4(h).	$60 copay after Deductible
Chemotherapy, Radiation, and Infusion Therapy	See Section 4(h).	$60 copay after Deductible

Benefit	Description	Copayment/ Percentage of Allowed Amount
Preventive Care Services		
Preventive Care Services	Preventive Care Services are covered by the Plan at 100%, with no Deductible. Refer to https://www.healthcare.gov/what-are-my-preventive-care-benefits/ for current list of covered Preventive Care Services. See Section 4(p).	$0
Immunizations	Age appropriate immunizations are covered by the Plan at 100%, with no Deductible. Refer to https://www.healthcare.gov/what-are-my-preventive-care-benefits/ for current list of covered Preventive Care. See Section 4(p).	$0
Hospital Services		
Inpatient Hospital Services	See Section 4(h).	25% coinsurance after Deductible
Inpatient Physician and Surgical Services	Professional fees for inpatient surge and other inpatient Physician Services. See Section 4(h).	25% coinsurance after Deductible
Emergency Services		
Emergency Room Services	Per episode of Emergency Room Services. See Section 4(g).	25% coinsurance after Deductible
Emergency Transportation Services	See Section 4(v).	$60 copay after Deductible
Urgent Care Services		
Urgent Care Facility	See Section 4(w).	$45 copay (Deductible does not apply)
Outpatient Mental Health Care and Substance Abuse Disorder Treatment	Mental/Behavioral Health Outpatient Services, Substance Abuse Disorder Outpatient Services, and Habilitation Services are subject to different cost-sharing depending on whether the Service is an Office Visit or other Outpatient Service. Office visits are subject to Copays, while facility-based Services are subject to coinsurance	
Outpatient Mental Health Services	Outpatient mental health care visit to or by a Health Professional. See Section 4(l).	$30 copay for Office Visits (Deductible does not apply) 25% coinsurance for Outpatient Services after Deductible
Outpatient Substance Abuse Disorder Services	Outpatient Substance Abuse Disorder visit to or by a Health Professional. See Section 4(l).	$30 copay for Office Visits (Deductible does not apply) 25% coinsurance for Outpatient Services after Deductible

Benefit	Description	Copayment/ Percentage of Allowed Amount
Inpatient Mental Health Care		
Inpatient Mental Health Care Services	See Section 4(l).	25% coinsurance after Deductible
Inpatient Mental Health Physician Services	Professional fees for Inpatient Mental Health Physician Services. See Section 4(l).	25% coinsurance after Deductible
Inpatient Substance Abuse Disorder Services	See Section 4(l).	25% coinsurance after Deductible
Inpatient Substance Abuse Disorder Physician Services	Professional fees for Inpatient Substance Abuse Disorder Physician Services. See Section 4(l).	25% coinsurance after Deductible
Rehabilitative Therapy		
Outpatient Rehabilitative Therapy	Limited to Medically Necessary Outpatient Rehabilitative Therapy visits to or by a Participating Provider other than a Primary Care Physician.	$30 copay (Deductible does not apply)
Habilitation Services	See Section 4(s).	$30 copay (Deductible does not apply)
Speech Therapy	Limited to Medically Necessary.	$30 copay (Deductible does not apply)
Rehabilitative Occupational and Rehabilitative Physical Therapy	Limited to Medically Necessary Rehabilitative Therapy, including occupational, and physical therapy.	$30 copay (Deductible does not apply)
Chiropractic Care		
Chiropractic Care Visit	Chiropractic Care is limited to 35 visits per year. See Section 4(n).	$60 copay after Deductible
Home Healthcare		
Home Health Visit	Home health visit to or by a Participating Provider other than a Primary Care Physician. Coverage for all Home Health Services is limited to 60 visits per Plan Year. See Section 4(j).	$60 copay after Deductible
Skilled Nursing Facility		
Skilled Nursing Facility	Coverage is limited to 25 days per Plan Year. See Section 4(s).	25% coinsurance after Deductible
Hospice Services		
Hospice Services	Cost sharing and limitations depends on type and site of Service. See Section 4(k).	$60 copay after Deductible
Inpatient Hospice Services	Cost sharing and limitations depends on type and site of Service. See Section 4(k).	25% coinsurance after Deductible
Maternity Services		
Professional Services for Prenatal and Postnatal care	Copayment for Maternity Care by a Participating Provider. See Section 4(m).	$60 copay after Deductible per occurrence
Delivery and all Inpatient Facility Services for Maternity Care	See Section 4(m).	25% coinsurance after Deductible

Benefit	Description	Copayment/ Percentage of Allowed Amount
Pediatric Vision Services		
Routine Eye Exam for Children 18 (until child turns 19) and under	See Section 4(x).	$60 copay after Deductible
Eyeglasses for Children 18 (until child turns 19) and under	See Section 4(x).	$60 copay after Deductible
DME/Orthotics/Prosthetic Medical Appliances and Hearing Aids		
Durable Medical Equipment	See Section 4(f).	30% coinsurance after Deductible
Hearing Aids	See Section 4(f).	30% coinsurance after Deductible
Diabetic Services and Education		
Diabetes Education	See Section 4(e).	$30 copay after Deductible
Diabetes Care Management	See Section 4(e).	$30 copay after Deductible
Transplant Services		
Inpatient Transplant Services	For other covered Transplant Services, Copayments for other benefits will apply, as appropriate. See Section 4(t).	25% coinsurance after Deductible
Prescription Drugs		
Preventive Drugs	Certain Preventive Drugs are covered by the Plan at 100%, with no Deductible. Refer to https://www.healthcare.gov/what-are-my-preventive- care-benefits/ for current covered preventive drugs. See Section 4(o).	$0
Generic Drugs	See Section 4(o).	$15 copay (Deductible does not apply)
Preferred Brand Drugs	See Section 4(o).	$30 copay (Deductible does not apply)
Non-Preferred Brand Drugs	See Section 4(o).	$60 copay (Deductible does not apply)
Specialty Drugs	See Section 4(o).	$250 copay (Deductible does not apply)
Mail Order Prescription Drugs		
Generic drugs	Formulary Generic Drugs obtained through Mail Order Service. See Section 4(o).	$15 copay (30-day supply) $37.50 copay (90-day supply) (Deductible does not apply)

Benefit	Description	Copayment/ Percentage of Allowed Amount
Preferred Brand Drugs	Formulary Preferred Brand Drugs obtained through Mail Order Service. See Section 4(o).	$30 copay (30-day supply) $75 copay (90-day supply) (Deductible does not apply)
Non-Preferred Brand Drugs	Formulary Non-Preferred Brand Drugs obtained through Mail Order Service. See Section 4(o).	$60 copay (30-day supply) $150 copay (90-day supply) (Deductible does not apply)
Not Covered Services		
Services Your Plan Does NOT Cover	- Acupuncture - Bariatric Surgery - Dental Care (Adult and Child) - Vision (Adult) - Long-Term Care - Non-Emergency Care when traveling outside the U.S. - Routine Eye Care (Adult) - Weight Loss Programs - Infertility Treatment - Cosmetic Surgery	Review Evidence of Coverage for complete list under "General Exclusions and Limitations." See Section 5.

Schedule of Benefits – Community Select Gold 022

This Schedule of Benefits summarizes benefit information for Covered Services that are fully described in the "Contract Benefit Management" section of this Contract. Please read Your entire Contract carefully to fully understand all terms, conditions, exclusions, and limitations that apply.

Medical and Pharmacy (Combined) Deductible	
Deductible, per individual, per Plan Year	$1,800
Deductible, per family, per Plan Year	$3,600
Out-of-Pocket Maximum	
Out-of-Pocket Maximum, per individual, per Plan Year	$9,200
Out-of-Pocket Maximum, per family, per Plan Year	$18,400

Benefit	Description	Copayment/ Percentage of Allowed Amount
Ambulatory Patient Services		
Primary Care Office Visit	Physician Office Visit not for Preventive Care Services. See Section 4(p).	$5 copay (Deductible does not apply)
Specialist Visit	See Section 4(i).	$30 copay (Deductible does not apply)
Outpatient Services	Outpatient Services and Habilitation Services are subject to different cost-sharing depending on whether the Service is an Office Visit or other Outpatient Service. Office visits are subject to Copays, while facility-based Services are subject to coinsurance.	
Outpatient Surgery Facility Fee	Outpatient Hospital Services performed in an Outpatient Facility or in a Hospital without admission. See Section 4(h).	30% coinsurance after Deductible
Outpatient Surgery Physician/ Surgical Services	Professional fees for outpatient or Ambulatory Surgical Procedures. See Section 4(h).	30% coinsurance after Deductible
Outpatient Laboratory	See Section 4(g) and 4(h).	$15 copay after Deductible
Outpatient X-rays and Diagnostic Imaging	See Section 4(g) and 4(h).	$15 copay after Deductible
Outpatient CT/PET/MRI and other Outpatient Diagnostic Procedures	See Section 4(g) and 4(h).	30% coinsurance after Deductible
Dialysis	Per Visit for Dialysis. See Section 4(h).	$30 copay after Deductible
Allergy Testing and Treatments	Per Visit for Allergy Treatments. See Section 4(h).	$5 copay after Deductible

Benefit	Description	Copayment/ Percentage of Allowed Amount
Chemotherapy, Radiation, and Infusion Therapy	See Section 4(h).	$30 copay after Deductible
Preventive Care Services		
Preventive Care Services	Preventive Care Services are covered by the Plan at 100%, with no Deductible. Refer to https://www.healthcare.gov/what-are-my-preventive-care-benefits/ for current list of covered Preventive Care Services. See Section 4(p).	$0
Immunizations	Age appropriate immunizations are covered by the Plan at 100%, with no Deductible. Refer to https://www.healthcare.gov/what- are-my-preventive- care-benefits/ for current list of covered Preventive Care. See Section 4(p).	$0
Hospital Services		
Inpatient Hospital Services	See Section 4(h).	$800 copay, plus 30% coinsurance after Deductible
Inpatient Physician and Surgical Services	Professional fees for inpatient surge and other inpatient Physician Services. See Section 4(h).	30% coinsurance after Deductible
Emergency Services		
Emergency Room Services	Per episode of Emergency Room Services. See Section 4(g).	$500 copay, plus 30% coinsurance after Deductible
Emergency Transportation Services	See Section 4(v).	$30 copay after Deductible
Urgent Care Services		
Urgent Care Facility	See Section 4(w).	$30 copay (Deductible does not apply)
Outpatient Mental Health Care and Substance Abuse Disorder Treatment	Mental/Behavioral Health Outpatient Services, Substance Abuse Disorder Outpatient Services, and Habilitation Services are subject to different cost-sharing depending on whether the Service is an Office Visit or other Outpatient Service. Office visits are subject to Copays, while facility-based Services are subject to coinsurance.	
Outpatient Mental Health Services	Outpatient mental health care visit to or by a Health Professional. See Section 4(l).	$5 copay for Office Visits (Deductible does not apply) 30% coinsurance for Outpatient Services after Deductible
Outpatient Substance Abuse Disorder Services	Outpatient Substance Abuse Disorder visit to or by a Health Professional. See Section 4(l).	$5 copay for Office Visits (Deductible does not apply) 30% coinsurance for Outpatient Services after Deductible

Benefit	Description	Copayment/ Percentage of Allowed Amount
Inpatient Mental Health Care		
Inpatient Mental Health Care Services	See Section 4(l).	$800 copay, plus 30% coinsurance after Deductible
Inpatient Mental Health Physician Services	Professional fees for Inpatient Mental Health Physician Services. See Section 4(l).	30% coinsurance after Deductible
Inpatient Substance Abuse Disorder Services	See Section 4(l).	$800 copay, plus 30% coinsurance after Deductible
Inpatient Substance Abuse Disorder Physician Services	Professional fees for Inpatient Substance Abuse Disorder Physician Services. See Section 4(l).	30% coinsurance after Deductible
Rehabilitative Therapy		
Outpatient Rehabilitative Therapy	Limited to Medically Necessary Outpatient Rehabilitative Therapy visits to or by a Participating Provider other than a Primary Care Physician.	$30 copay after Deductible
Habilitation Services	See Section 4(s).	$30 copay after Deductible
Speech Therapy	Limited to Medically Necessary.	$30 copay after Deductible
Rehabilitative Occupational and Rehabilitative Physical Therapy	Limited to Medically Necessary Rehabilitative Therapy, including occupational, and physical therapy.	$30 copay after Deductible
Chiropractic Care		
Chiropractic Care Visit	Chiropractic Care is limited to 35 visits per year. See Section 4(n).	$30 copay after Deductible
Home Healthcare		
Home Health Visit	Home health visit to or by a Participating Provider other than a Primary Care Physician. Coverage for all Home Health Services is limited to 60 visits per Plan Year. See Section 4(j).	$30 copay after Deductible
Skilled Nursing Facility		
Skilled Nursing Facility	Coverage is limited to 25 days per Plan Year. See Section 4(s).	$800 copay, plus 30% coinsurance after Deductible
Hospice Services		
Hospice Services	Cost sharing and limitations depends on type and site of Service. See Section 4(k).	$30 copay after Deductible
Inpatient Hospice Services	Cost sharing and limitations depends on type and site of Service. See Section 4(k).	$800 copay, plus 30% coinsurance after Deductible
Maternity Services		
Professional Services for Prenatal and Postnatal care	Copayment for Maternity Care by a Participating Provider. See Section 4(m).	$30 copay after Deductible per occurrence
Delivery and all Inpatient Facility Services for Maternity Care	See Section 4(m).	$800 copay, plus 30% coinsurance after Deductible

Benefit	Description	Copayment/ Percentage of Allowed Amount
Pediatric Vision Services		
Routine Eye Exam for Children 18 (until child turns 19) and under	See Section 4(x).	$30 copay after Deductible
Eyeglasses for Children 18 (until child turns 19) and under	See Section 4(x).	$30 copay after Deductible
DME/Orthotics/Prosthetic Medical Appliances and Hearing Aids		
Durable Medical Equipment	See Section 4(f).	30% coinsurance after Deductible
Hearing Aids	See Section 4(f).	30% coinsurance after Deductible
Diabetic Services and Education		
Diabetes Education	See Section 4(e).	$5 copay after Deductible
Diabetes Care Management	See Section 4(e).	$5 copay after Deductible
Transplant Services		
Inpatient Transplant Services	For other covered Transplant Services, Copayments for other benefits will apply, as appropriate. See Section 4(t).	$800 copay, plus 30% coinsurance after Deductible
Prescription Drugs		
Preventive Drugs	Certain Preventive Drugs are covered by the Plan at 100%, with no Deductible. Refer to https://www.healthcare.gov/what-are-my-preventive-care-benefits/ for current covered preventive drugs. See Section 4(o).	$0
Generic Drugs	See Section 4(o).	$5 copay (Deductible does not apply)
Preferred Brand Drugs	See Section 4(o).	$50 copay (Deductible does not apply)
Non-Preferred Brand Drugs	See Section 4(o).	$100 copay after Deductible
Specialty Drugs	See Section 4(o).	40% coinsurance after Deductible
Mail Order Prescription Drugs		
Generic drugs	rmulary Generic Drugs obtained through Mail Order Service. See Section 4(o).	$5 copay (30-day supply) $12.50 copay (90-day supply) (Deductible does not apply)
Preferred Brand Drugs	Formulary Preferred Brand Drugs obtained through Mail Order Service. See Section 4(o).	$50 copay (30-day supply) $125 copay (90-day supply) (Deductible does not apply)

Benefit	Description	Copayment/ Percentage of Allowed Amount
Non-Preferred Brand Drugs	Formulary Non-Preferred Brand Drugs obtained through Mail Order Service. See Section 4(o).	$100 copay (30-day supply) $250 copay (90-day supply) (Deductible applies)
Not Covered Services		
Services Your Plan Does NOT Cover	- Acupuncture - Bariatric Surgery - Dental Care (Adult and Child) - Vision (Adult) - Long-Term Care - Non-Emergency Care when traveling outside the U.S. - Routine Eye Care (Adult) - Weight Loss Programs - Infertility Treatment - Cosmetic Surgery	Review Evidence of Coverage for complete list under “General Exclusions and Limitations.” See Section 5.

Schedule of Benefits (All Plans- Zero-Cost Variation)

This Schedule of Benefits summarizes benefit information for Covered Services that are fully described in the "Contract Benefit Management" section of this Contract. Please read Your entire Contract carefully to fully understand all terms, conditions, exclusions, and limitations that apply.

Medical and Pharmacy (Combined) Deductible	
Deductible, per individual, per Plan Year	$0
Deductible, per family, per Plan Year	$0
Out-of-Pocket Maximum	
Out-of-Pocket Maximum, per individual, per Plan Year	$0
Out-of-Pocket Maximum, per family, per Plan Year	$0

Benefit	Description	Copayment/ Percentage of Allowed Amount
Ambulatory Patient Services		
Primary Care Office Visit	Physician Office Visit not for Preventive Care Services. See Section 4(p).	$0
Specialist Visit	See Section 4(i).	$0
Outpatient Services	Outpatient Services and Habilitation Services are subject to different cost-sharing depending on whether the Service is an Office Visit or other Outpatient Service. Office visits are subject to Copays, while facility-based Services are subject to coinsurance.	
Outpatient Surgery Facility Fee	Outpatient Hospital Services performed in an Outpatient Facility or in a Hospital without admission. See Section 4(h).	$0
Outpatient Surgery Physician/ Surgical Services	Professional fees for outpatient or Ambulatory Surgical Procedures. See Section 4(h).	$0
Outpatient Laboratory	See Section 4(g) and 4(h).	$0
Outpatient X-rays and Diagnostic Imaging	See Section 4(g) and 4(h).	$0
Outpatient CT/PET/MRI and other Outpatient Diagnostic Procedures	See Section 4(g) and 4(h).	$0
Dialysis	Per Visit for Dialysis. See Section 4(h).	$0
Allergy Testing and Treatments	Per Visit for Allergy Treatments. See Section 4(h).	$0
Chemotherapy, Radiation, and Infusion Therapy	See Section 4(h).	$0

Benefit	Description	Copayment/ Percentage of Allowed Amount
Preventive Care Services		
Preventive Care Services	Preventive Care Services are covered by the Plan at 100%, with no Deductible. Refer to https://www.healthcare.gov/what-are-my-preventive- care-benefits/ for current list of covered Preventive Care Services. See Section 4(p).	$0
Immunizations	Age appropriate immunizations are covered by the Plan at 100%, with no Deductible. Refer to https://www.healthcare.gov/what-are-my-preventive-care-benefits/ for current list of covered Preventive Care. Section 4(p).	$0
Hospital Services		
Inpatient Hospital Services	Copayment for each day of inpatient Services. See Section 4(h).	$0
Inpatient Physician and Surgical Services	Professional fees for inpatient surgery and other inpatient Physician Services. See Section 4(h).	$0
Emergency Services		
Emergency Room Services	Per episode of Emergency Room Services. See Section 4(g). Copay waived if admitted to the Hospital (Inpatient Hospital expenses apply).	$0
Emergency Transportation Services	See Section 4(v).	$0
Urgent Care Services		
Urgent Care Facility	See Section 4(w).	$0
Outpatient Mental Health Care and Substance Abuse Disorder Treatment	Mental/Behavioral Health Outpatient Services, Substance Abuse Disorder Outpatient Services, and Habilitation Services are subject to different cost-sharing depending on whether the Service is an Office Visit or other Outpatient Service. Office visits are subject to Copays, while facility-based Services are subject to coinsurance.	
Outpatient Mental Health Services	Outpatient mental health care visit to or by a Health Professional. See Section 4(l).	$0
Outpatient Substance Abuse Disorder Services	Outpatient Substance Abuse Disorder visit to or by a Health Professional. See Section 4(l).	$0
Inpatient Mental Health Care		
Inpatient Mental Health Care Services	Copayment for each day of inpatient Services. See Section 4(l).	$0
Inpatient Mental Health Physician Services	Professional fees for Inpatient Mental Health Physician Services. See Section 4(l).	$0
Inpatient Substance Abuse Disorder Services	Copayment for each day of Inpatient Substance Abuse Disorder Services. See Section 4(l)	$0
Inpatient Substance Abuse Disorder Physician Services	Professional fees for Inpatient Substance Abuse Disorder Physician Services. See Section 4(l).	$0

Benefit	Description	Copayment/ Percentage of Allowed Amount
Rehabilitative Therapy		
Outpatient Rehabilitative Therapy	Limited to Medically Necessary Outpatient Rehabilitative Therapy visits to or by a Participating Provider other than a Primary Care Physician.	$0
Habilitation Services Mental/Behavioral Health Outpatient Services, Substance Abuse Disorder Outpatient Services, and Habilitation Services are subject to different cost-sharing depending on whether the Service is an Office Visit or other Outpatient Service. Office visits are subject to Copays, while Facility-Based Services are subject to coinsurance	See Section 4(s).	$0
Speech Therapy	Limited to Medically Necessary.	$0
Rehabilitative Occupational and Rehabilitative Physical Therapy	Limited to Medically Necessary Rehabilitative Therapy, including Occupational and Physical Therapy.	$0
Chiropractic Care		
Chiropractic Care Visit	Chiropractic Care is limited to 35 visits per year. See Section 4(n).	$0
Home Healthcare		
Home Health Visit	Home health visit to or by a Participating Provider other than a Primary Care Physician. Coverage for all Home Health Services is limited to 60 visits per Plan Year. See Section 4(j).	$0
Skilled Nursing Facility		
Skilled Nursing Facility	Copayment for each day of skilled nursing facility Services. Coverage is limited to 25 days per Plan Year. See Section 4(s).	$0
Hospice Services		
Hospice Services	Cost sharing and limitations depends on type and site of Service. See Section 4(k).	$0
Inpatient Hospice Services	Cost sharing and limitations depends on type and site of Service. See Section 4(k).	$0
Maternity Services		
Professional Services for Prenatal and Postnatal care	Copayment for Maternity Care by a Participating Provider. See Section 4(m).	$0
Delivery and all Inpatient Facility Services for Maternity Care	Copayment for each day of inpatient Services. See Section 4(m).	$0

Benefit	Description	Copayment/ Percentage of Allowed Amount
Pediatric Vision Services		
Routine Eye Exam for Children 18 (until child turns 19) and under	See Section 4(x).	$0
Eyeglasses for Children 18 (until child turns 19) and under	See Section 4(x).	$0
DME/Orthotics/Prosthetic Medical Appliances and Hearing Aids		
Durable Medical Equipment	See Section 4(f).	$0
Hearing Aids	See Section 4(f).	$0
Diabetic Services and Education		
Diabetes Education	See Section 4(e).	$0
Diabetes Care Management	See Section 4(e).	$0
Transplant Services		
Inpatient Transplant Services	Copayment for each day of inpatient Services for transplant. For other covered Transplant Services, Copayments for other benefits will apply, as appropriate. See Section 4(t).	$0
Prescription Drugs		
Preventive Drugs	Certain Preventive Drugs are covered by the Plan at 100%, with no Deductible. Refer to https://www.healthcare.gov/what-are-my-preventive-care-benefits/ for current covered preventive drugs. See Section 4(o).	$0
Generic Drugs	See Section 4(o).	$0
Preferred Brand Drugs	See Section 4(o).	$0
Non-Preferred Brand Drugs	See Section 4(o).	$0
Specialty Drugs	See Section 4(o).	$0
Mail Order Prescription Drugs		
Generic drugs	Formulary Generic Drugs obtained through Mail Order Service. See Section 4(o).	$0
Preferred Brand Drugs	Formulary Preferred Brand Drugs obtained through Mail Order Service. See Section 4(o).	$0
Non-Preferred Brand Drugs	Formulary Non-Preferred Brand Drugs obtained through Mail Order Service. See Section 4(o).	$0

Benefit	Description	Copayment/ Percentage of Allowed Amount
Not Covered Services		
Services Your Plan Does NOT Cover	- Acupuncture - Bariatric Surgery - Dental Care (Adult and Child) - Vision (Adult) - Long-Term Care - Non-Emergency Care when traveling outside the U.S. - Routine Eye Care (Adult) - Weight Loss Programs - Infertility Treatment - Cosmetic Surgery	Review Evidence of Coverage for complete list under “General Exclusions and Limitations.” See Section 5.

LANGUAGE ASSISTANCE

Community Health Choice is required by federal law to provide the following information.

COMMUNITY HEALTH CHOICE

NON-DISCRIMINATION STATEMENT (MARKETPLACE)

Discrimination is Against the Law

Community Health Choice complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Community Health Choice does not exclude or treat people differently because of race, color, national origin, age, disability or sex.

Community Health Choice:

- Provides free aids and services to people with disabilities so that they can communicate effectively with us, such as:
  - Qualified sign-language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

Community Health Choice also trains staff to be mindful of cultural differences in communication styles, body language, and decision-making processes.

If you need these services, contact our Member Services Department

DSNP: Local: 713.295.5007 | Toll-Free 1.833.276.8306

STAR+PLUS: Local: 713.295.2300 | Toll-Free: 1.888.435.2850

STAR/CHIP: Local: 713.295.2294 | Toll-Free: 1.888.760.2600

Marketplace: Local: 713.295.6704 | Toll-Free 1.855.315.5386

If you believe that Community Health Choice has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Community Health Choice
Attn: Service Improvement Department
4888 Loop Central Drive, Suite 600
Houston, Texas 77081

Phone: 1.855.315.5386 TDD/TTY 711
Fax: 713.295.7036
Email: ServiceImprovement@CommunityHealthChoice.org

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, call 713.295.6704 or email MemberServices@CommunityHealthChoice.org.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Phone: 1.800.368.1019, 800.537.7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Arabic العربية

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1.855.315.5386.

Chinese

注意：如果　使用繁體中文，　可以免費獲得語言援助服務。請致電 1.855.315.5386

English

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1.855.315.5386.

French

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez 1.855.315.5386.

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1.855.315.5386.

Gujarati

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1.855.315.5386.

Hindi

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1.855.315.5386 **पर कॉल करें।**

Japanese

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1.855.315.5386まで、お電話にてご連絡ください。

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.855.315.5386번으로 전화해 주십시오

Lao

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1.855.315.5386.

Persian

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1.855.315.5386 تماس بگیرید.

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1.855.315.5386.

Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.855.315.5386.

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1.855.315.5386.

Urdu

توجہ: اگر آپ اردو بولتے ہیں تو آپ کے لئے مفت زبان کی مدد کی خدمات دستیاب ہیں۔ فون کریں 1.855.315.5386۔

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1.855.315.5386.

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