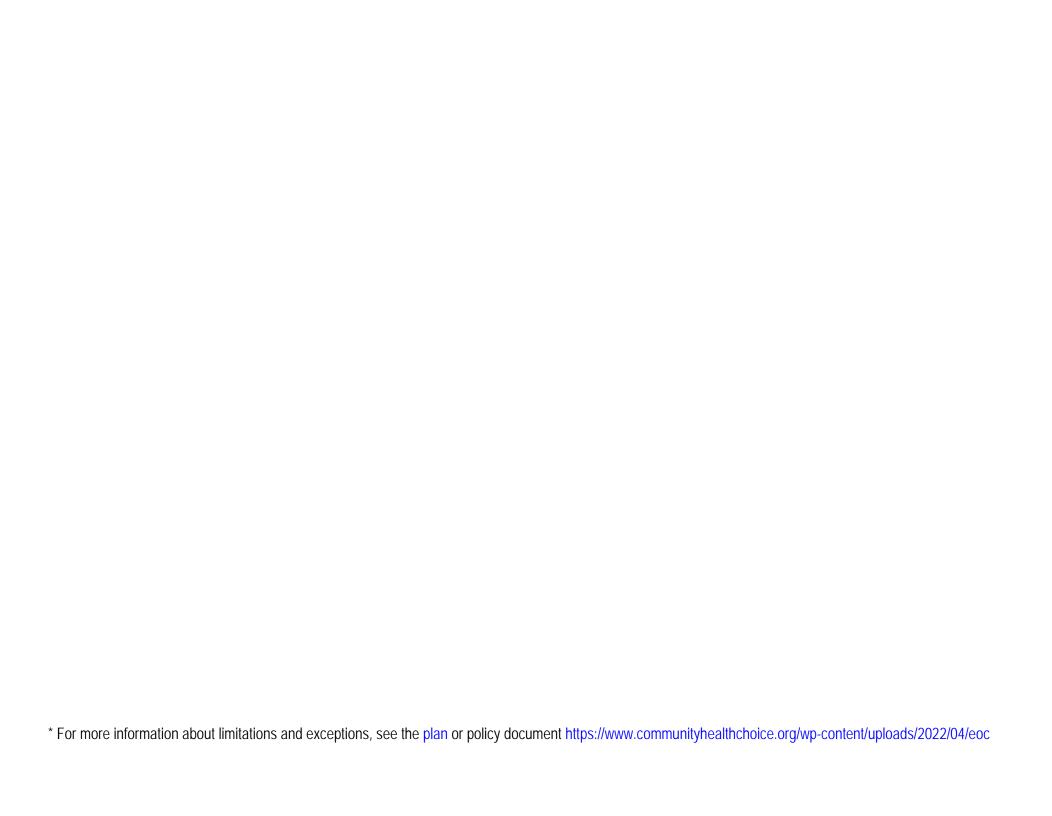
Coverage Period: 01/01/2023-12/31/2023 Coverage for: Individual + Family Plan Type: HMO

The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-855-315-5386 or https://www.communityhealthchoice.org/health-insurance-marketplace/know-the-details-2023/. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-855-315-5386 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---------------------------------|--------------------------------------|-------------------|
| What is the overall deductible? | \$7,700/Individual \$15,400/family | |



^{*} For more information about limitations and exceptions, see the <u>plan</u> or policy document <u>https://www.communityhealthchoice.org/wp-content/uploads/2022/04/eocdeductible-2023.pdf</u>



| | | What You Will Pay | |
|----------------------|-----------------------|-------------------|--|
| Common Medical Event | Services You May Need | | Limitations, Exceptions, & Other Important Information |

^{*} For more information about limitations and exceptions, see the $\underline{\text{plan}}$ or policy document $\underline{\text{https://www.communityhealthchoice.org/wp-content/uploads/2022/04/eocdeductible-2023.pdf}$

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Abortion with exception of limited services
 - *See Section 4(16) of your plan document
- Acupuncture
- Bariatric surgery
- Children's dental check-up

- Cosmetic Surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care

- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractor care (35 visits per year)
- Hearing aids (each ear, every three years)
- Private-duty nursing (Inpatient private duty nursing)
- Routine foot care (diabetes related services)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information f@oT C)1 (ont)2 (i)-3 (nue)

About these Coverage Examples: