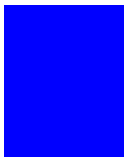
The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-855-315-



All copayments and coinsurance a -		

* For more information about limitations and exceptions, see the plan or policy document https://www.communityhealthchoice.org/wp-content/uploads/2022/04/eoc-deductible-2023.pdf

Common Medical Even	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the leas	Non-Participating Provider (You will pay the mos	

* For more information about limitations and exceptions, see the plan or policy document https://www.communityhealthchoice.org/wp-content/uploads/2022/04/eoc-deductible-2023.pdf

Common Medical Even	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the leas	Non-Participating Provider (You will pay the mos	
other special health needs				
	Rehabilitation services	$40 copay after deductible/visit		

* For more information about limitations and exceptions, see the plan or policy document https://www.communityhealthchoice.org/wp-content/uploads/2022/04/eoc-deductible-2023.pdf

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services)		
x Abortion with exception of limited services *See Section 4(16) of your plan document	x Cosmetic Surgery	x Non-emergency care when traveling outside the U.S.
x Acupuncture	x Dental care (Adult)	x Routine eye care (Adult)
x Bariatric surgery	x Infertility treatment	x Weight loss programs
x Children's dental check-up	x Long-term care	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
x Chiropractor care (35 visits per year)	x Private-duty nursing (Inpatient private duty nursing)	x Routine foot care (diabetes related services)
x Hearing aids (each ear, every three years)		

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Texas Department of Insurance, 333 Guadalupe, Austin TX 78701 at 1-800-578-4677 or the issuer at 1-855-315-5386. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Texas Department of Insurance, 333 Guadalupe Austin, TX 78701 or 1-800-578-4677.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Not Applicable

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-315-5386

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-315-5386

Chinese (p e): ô Ý7Â0[p e$× Ž “, 1- 855-315-5386

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-315-5386

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

The plan's overall deductible	$1,600
Specialist copayment	$40
Hospital (facility) coinsurance	25%
Other cost sharing	25%

This EXAMPLE event includes services like:
Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (after visit)