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 allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-855-315-5386 to request a copy.

	$800/ Individual | $1,600/family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
	Yes. Preventive Services, Primary Care, Specialist, Urgent Care and Generic drugs.	This plan covers some items and services 10.32 4249 (es)4 (10.32 4249 (.88 0.9 (er)7.1 (v)4 (i4

All _____ and _____ costs shown in this chart are after your _____ has been met, if a _____ applies.

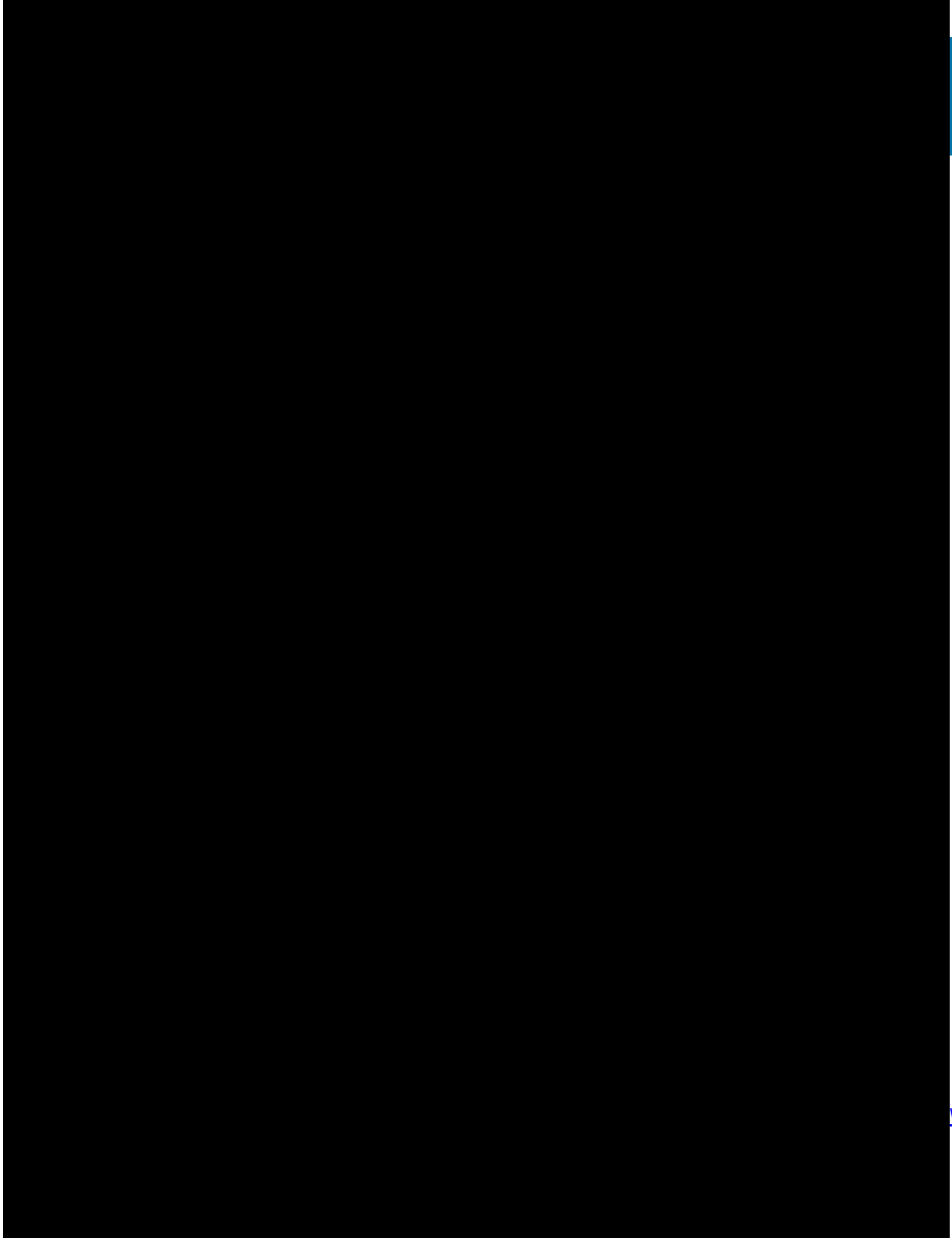
* For more information about limitations and exceptions, see the plan or policy document https://www.communityhealthchoice.org/wp-content/uploads/2022/04/eoc-deductible-2023.pdf

				equivalent is preferred on the formulary. Failure to obtain preauthorization to show medical necessity may increase your costs. Note: If a generic drug is available and you choose to buy the preferred brand drug, you will pay the generic copay plus the cost difference between the preferred and generic. Tier 2 includes high cost generics and preferred brand.
	Non-preferred brand drugs	$60 copay/prescription after deductible (retail) $150 copay/prescription after deductible (mail order).	Not Covered	Covers up to 30 day supply (retail). Covers up to 90 day supply (mail order). Tier 3 includes non-preferred formulary products (can include non-preferred generic products).
	Specialty drugs	$250 copay/prescription after deductible (retail)	Not Covered	

* 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

	Facility fee (e.g., hospital room)	30% coinsurance after deductible	Not Covered	Requires preauthorization for certain services, failure to obtain preauthorization may result in denial of benefits.
	Physician/surgeon fees	$0 copay after deductible/visit	Not Covered	None
	Outpatient services	$20 copay/office visit Deductible does not apply and 30% coinsurance after deductible for other outpatient services		

* 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



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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	

x Chiropractor care (35 visits per year)	x Private-duty nursing (Inpatient private duty nursing)
x Hearing aids (each ear, every three years)	

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.

- [illegible]
- [illegible]
- [illegible]
- [illegible] sharing

Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Ser(illegible) rg 095>BDC202>9201 TT1 1 Tf33>-4 <30>-4 <25>B-4 <49