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 1-855-315-5386 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.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible? | $2,200/ Individual \| $4,400/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. |

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

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | $15 copay/visit Deductible does not apply. | Not Covered | None |
| | Specialist visit | $30 copay/visit Deductible does not apply. | Not Covered | None |
| | Preventive care/screening/ immunization | No Charge Deductible does not apply | Not Covered | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| If you have a test | Diagnostic test (x-ray, blood work) | $15 copay/visit after deductible | Not Covered | None |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance after deductible/test | Not Covered | Requires preauthorization for certain services. Failure to obtain an authorization may result in denial of benefits. *See Section 3(g) |
| If you need drugs to treat your illness or condition<br>More information about prescription drug coverage is available at https://www.communityhealthchoice.org/wp-content/uploads/2022/04/formulary-2023.pdf | Generic drugs | $15 copay/prescription (retail)<br>$37.5 copay/prescription (mail order) Deductible does not apply | Not Covered | Covers up to 30 day supply (retail). Covers up to 90 day supply (mail order). Please refer to formulary for cost share tiers. Tier 1 includes preferred generics and some lower cost brand products. *See Section 3(n). |
| | Preferred brand drugs | $30 copay/prescription after deductible/prescription (retail)<br>$75 copay after | Not Covered | Covers up to 30 day supply (retail). Covers up to 90 day supply (mail order). Preauthorization may be required for a branded medication when the generic |

* 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

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

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| | Urgent care | $30 copay/visit. Deductible does not apply | Not Covered | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% 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 |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | $15 copay/office visit Deductible does not apply and 20% coinsurance after deductible for other outpatient services | Not Covered | Requires preauthorization for certain services, failure to obtain preauthorization may result in denial of benefits. Depending on type of service, a copayment or coinsurance may apply. |

* 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 Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Participating Provider (You will pay the least) | Non-Participating Provider (You will pay the most) | |
| other special health needs | | | | may result in denial of benefits. Limited to 60 visits per year. |
| | Rehabilitation services | $30 copay after deductible/visit | Not Covered | Requires preauthorization for certain services, failure to obtain preauthorization may result in denial of benefits. |
| | Habilitation services | $30 copay after deductible/visit | Not Covered | Requires preauthorization for certain services, failure to obtain preauthorization may result in denial of benefits. |
| | Skilled nursing care | 20% coinsurance after deductible | Not Covered | Requires preauthorization for certain services, failure to obtain preauthorization may result in denial of benefits. Limited to 25 days per year. |
| | Durable medical equipment | 30% coinsurance after deductible | Not Covered | Requires preauthorization for certain services, failure to obtain preauthorization may result in denial of benefits. Limited to plan requirements. *See Section 3(e). |
| | Hospice services | $30 copay after deductible/day<br>20% coinsurance after deductible in an inpatient setting. | Not Covered | Depending on the type of services, a copayment or coinsurance may apply. Limited to plan requirements. *See section 3(j) |
| If your child needs dental or eye care | Children's eye exam | deductible/visit | 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

## 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 | |

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