
 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 1-866-HeartUs. 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 <http://www.dol.gov/ebsa/healthreform>.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$4,500/Individual or \$9,000/family	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$7,150/Individual or \$14,300/family for in-network services only	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered in-network services only. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met. There is no <a href="#">out-of-pocket limit</a> for out of network services.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.decent.com">www.decent.com</a> or call 1-866-HeartUs for a list of <a href="#">participating providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	Yes.	This plan will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> . before you see the <a href="#">specialist</a> .

 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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Selected Direct Primary care to treat an injury or illness	\$0 Copay	Not covered	None
	Non- Selected Primary care visit to treat an injury or illness	\$50 Copay	50% <a href="#">coinsurance</a> after deductible	Referral required if seeking in-network benefits from a non-selected primary care provider
	<a href="#">Specialist</a> visit including Chiropractic Care	\$50 Copay	50% <a href="#">coinsurance</a> after deductible	Referral required if seeking in-network benefits.
	<a href="#">Preventive care/screening/immunization</a>	No Copay – 100% covered	Not covered	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$50 Copay	50% <a href="#">coinsurance</a> after deductible	<a href="#">Pre-Authorization</a> is required for some imaging services. If proper <a href="#">pre-authorization</a> is not obtained, services will not be covered.
	Imaging (CT/PET scans, MRIs)	\$100 Copay after deductible	Not covered	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a>	Preferred generic drugs	\$15 Copay	Not covered	Applies to <a href="#">formulary</a> preferred generic only.
	Preferred brand drugs	\$35 Copay	Not covered	Applies to <a href="#">formulary</a> preferred brand only
	Non-preferred brand drugs	\$100 Copay	Not covered	Applies to <a href="#">formulary</a> non-preferred brand.
	<a href="#">Specialty</a> drugs	\$150 Copay	Not covered	Applies to <a href="#">formulary</a> preferred specialty only.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$500 Copay after deductible	Not covered	<a href="#">Pre-Authorization</a> may be required for some outpatient surgical procedures. If proper <a href="#">pre-authorization</a> is not obtained, services will not be covered.
	Physician/surgeon fees	\$50 Copay after deductible	50% <a href="#">coinsurance</a> after deductible	<a href="#">Pre-Authorization</a> may be required for some outpatient surgical procedures. If proper <a href="#">pre-authorization</a> is not obtained, services will not be covered.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$500 Copay	50% <a href="#">coinsurance</a> after deductible	None
	<a href="#">Emergency medical transportation</a>	\$500 Copay	50% <a href="#">coinsurance</a> after deductible	None
	<a href="#">Urgent care</a>	\$150 Copay	50% <a href="#">coinsurance</a> after deductible	None

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 have a hospital stay	Facility fee (e.g., hospital room)	\$300 Copay/day after deductible	50% <a href="#">coinsurance</a> after deductible	<a href="#">Pre-Authorization</a> may be required for some hospital stays. If proper <a href="#">pre-authorization</a> is not obtained, services will not be covered.
	Physician/surgeon fees	\$50 Copay after deductible	Not covered	<a href="#">Pre-Authorization</a> may be required for some hospital stays. If proper <a href="#">pre-authorization</a> is not obtained, services will not be covered.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$50 Copay	50% <a href="#">coinsurance</a> after deductible	<a href="#">Pre-Authorization</a> may be required for some mental health, behavioral health, or substance abuse services. If proper <a href="#">pre-authorization</a> is not obtained, services will not be covered.
	Inpatient services	50% <a href="#">coinsurance</a> after deductible	50% <a href="#">coinsurance</a> after deductible	
If you are pregnant	Pre and Postnatal Office Visit	\$25 Copay	50% <a href="#">coinsurance</a> after deductible	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, <a href="#">copayment</a> , <a href="#">coinsurance</a> , or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional/facility services	\$1500 Copay	50% <a href="#">coinsurance</a> after deductible	
If you need help recovering or have other special health needs	<a href="#">Private-duty nursing</a>	50% <a href="#">coinsurance</a> after deductible	Not covered	96 hours per year. <a href="#">Pre-Authorization</a> may be required. If proper <a href="#">pre-authorization</a> is not obtained, services will not be covered.
	<a href="#">Rehabilitative Services</a>	50% <a href="#">coinsurance</a> after deductible	Not covered	<a href="#">Pre-Authorization</a> may be required. If proper <a href="#">pre-authorization</a> is not obtained, services will not be covered. Limit does not apply to Autism
	<a href="#">Habilitation services</a>	\$50 Copay	Not covered	
	<a href="#">In-Home Skilled nursing care</a>	50% <a href="#">coinsurance</a> after deductible	Not covered	100 days per year. <a href="#">Pre-Authorization</a> may be required. If proper <a href="#">pre-authorization</a> is not obtained, services will not be covered.
	<a href="#">Durable medical equipment</a>	50% <a href="#">coinsurance</a> after deductible	Not covered	<a href="#">Pre-Authorization</a> may be required. If proper <a href="#">pre-authorization</a> is not obtained, services will not be covered.
	<a href="#">Hospice services</a>	50% <a href="#">coinsurance</a> after deductible	Not covered	<a href="#">Pre-Authorization</a> may be required. If proper <a href="#">pre-authorization</a> is not obtained, services will not be covered.
	<a href="#">Home Health Care</a>	50% <a href="#">coinsurance</a> after deductible	Not covered	<a href="#">Pre-Authorization</a> may be required. If proper <a href="#">pre-authorization</a> is not obtained, services will not be covered.

## 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](#).)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Child and Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Eye Exams & Eye wear (Child and Adult)
- Routine foot care
- Weight loss programs

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

- **Chiropractic care – limited to 35 visits per year**

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the [plan](#) at 1-866-HeartUs. The contact for those agencies is: Texas Department of Insurance at (800) 578-4677 or <http://www.tdi.texas.gov/index.html>, U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/contactEBSA/consumerassistance.html](http://www.dol.gov/ebsa/contactEBSA/consumerassistance.html). Other coverage options to continue coverage are available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://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 to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, you can the Texas Department of Insurance at 1-800-252-3439.

**Does this plan provide Minimum Essential Coverage? Yes.**

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet Minimum Value Standards? Yes.**

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](#).

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*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

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