Decent:Zero 80
Type: POS

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.

You can view a glossary of terms you may not understand at https://www.healthcare.gov/glossary/

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0 for Medical Services	You do not have to meet a deductible to receive coverage for in network care. The Health Plan will pay for your covered medical services less any applicable co-pay. You do have a separate deductible that applies to Specialty Pharmacy only.
Are there services covered before you meet your deductible?	Yes.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. Pharmacy Deductible is $4,500/Individual or $9,000/family	The Pharmacy deductible applies primarily to specialty prescriptions. You do not need to meet this deductible to obtain generic or brand name preferred prescriptions. See Comments in Medical Deductible for more information about deductibles.
What is the out-of-pocket limit for this plan?	$6,000/Individual or $12,000/family for in-network services only	The out-of-pocket limit is the most you could pay in a year for covered in-network services only. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. There is no out-of-pocket limit for out of network services.
What is not included in the out-of-pocket limit?	Premiums and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.decent.com or call 1-866-HeartUs for a list of participating providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Visits with Selected Direct Primary Care Provider to treat an injury or illness	$0 Copay	Not Covered	<ēāĊ i§ ĚĦĊÃ J§Í§sĊ§})G'
	Visit to specialist to treat an injury or illness	$50 Copay	Not Covered	Referral required if seeking in-network benefits from a non-selected primary care provider
	Preventive care/screening/ immunization	No Copay – 100% covered	Not Covered	You may have to pay for services that aren't preventative. **Ask your provider if the services needed are preventive.**
If you have a test	Diagnostic test (x-ray, blood work)	$50 Copay	Not Covered	Pre-Authorization is required for some imaging services. If proper preauthorization is not obtained, services will not be covered.
	Imaging (CT/PET scans, MRIs)	$50 Copay	Not Covered	
If you need prescription drugs	**For covered prescriptions, you will pay the lesser of the cost of the drug or the copay.**			
	Generic drugs	$5 Copay	Not Covered	Applies to formulary generic only.
	Preferred brand drugs	$25 Copay	Not Covered	Applies to formulary preferred brand only.
	Non-preferred brand drugs	$200 Copay	Not Covered	Applies to formulary non-preferred brand.
	Specialty drugs	50% after deductible	Not Covered	Applies to formulary preferred specialty only.
If you have outpatient in office infusion or surgery	Facility fee (e.g., ambulatory surgery center)	$500 Copay	Not Covered	Pre-Authorization may be required for some outpatient surgical procedures. If proper pre-authorization is not obtained, services will not be covered.
	Physician/surgeon fees	$500 Copay	Not Covered	
If you need immediate medical attention	Emergency room care	$250 Copay	$1,000 Copay	If admitted ĊÚ ĦÖé[ĊĦ§ÖĊ ĜÚē ĚĦÍÍ ÚÖÍĜ é[Ĝ 2Úāé ĦĊ[Í 'Úé[Ĝ
	Emergency medical transportation	$750 Copay	$1,000 Copay	None
	Urgent care	$100 Copay	$200 Copay	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	$1,000 Copay	Not covered	Pre-Authorization may be required for some hospital stays. If proper pre-authorization is not obtained, services will not be covered. Copay is per day for a maximum of two days.
	Physician/surgeon fees	$500 Copay	Not covered	Pre-Authorization may be required for some hospital stays. If proper pre-authorization is not obtained, services will not be covered.
Mental health, behavioral health, or substance abuse services	Outpatient services	$50 Copay	Not covered	Pre-Authorization may be required for some hospital stays. If proper pre-authorization is not obtained, services will not be covered. Copay is per day for a maximum of two days.
	Inpatient services	$1,000 Copay	Not covered	
If you are pregnant	Office visits	$25 Copay	Not covered	If the provider bills a global maternity fee there are no copays for prenatal visits and the $1500 co-pay is applied to the global facility bill. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Cost sharing does not apply for preventive services.
	Childbirth/delivery professional/facility services	$1,500 Copay	Not covered	
If you need help recovering or have other special health needs	Private-duty nursing	$50 Copay	Not covered	96 hours per year. Pre-Authorization may be required. If proper pre-authorization is not obtained, services will not be covered.
	Rehabilitation and Chiropractic care	$50 Copay	Not covered	Pre-Authorization may be required. If proper preauthorization is not obtained, services will not be covered.
	Habilitation services	$50 Copay	Not covered	
	Skilled nursing care	$50 Copay	Not covered	Pre-Authorization is required. If proper pre-authorization is not obtained, services will not be covered. Limited to 100 visits per year.
	Durable medical equipment	50% Coinsurance	Not covered	Pre-Authorization may be required. If proper pre- authorization is not obtained, services will not be covered.
	Home health	$50 Copay	Not covered	Pre-Authorization is required. If proper pre-authorization is not obtained, services will not be covered. Limited to 100 visits per year.
	Outpatient Hospice services	$50 Copay		

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 (Adult & Child)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Vision Hardware
- 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.)

- Hearing aids
- Home Health And Hospice Visits limited to 100 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. 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 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.