Decent: Remote Saver 60
Plan 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?	$6,900/Individual or $13,800/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.
Are there services covered before you meet your deductible?	Yes. Preventive Services and Services with your selected Primary Care Provider	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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$6,900/Individual or $13,800/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.

Last updated: 09/23/2020

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	Selected Direct Primary care visit to treat an injury or illness	$0 Copay	Not Covered	None
	Visit to specialist to treat an injury or illness	0% coinsurance after deductible	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)	0% coinsurance after deductible	Not Covered	Pre-Authorization is required for some imaging services. If proper pre-authorization is not obtained, services will not be covered.
	Imaging (CT/PET scans, MRIs)	0% coinsurance after deductible	Not Covered	
If you need prescription drugs	Preventive drugs	$15 Copay	Not Covered	Applies to formulary preventive only.
	Generic drugs	Fully Covered after deductible	Not Covered	Applies to formulary generic only.
	Preferred brand drugs	Fully Covered after deductible	Not Covered	Applies to formulary preferred brand only.
	Non-preferred brand drugs	Fully Covered after deductible	Not Covered	Applies to formulary non-preferred brand.
	Specialty drugs	Fully Covered after deductible	Not Covered	Applies to formulary preferred specialty only.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance after deductible	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	0% coinsurance after deductible	Not Covered	
If you need immediate medical attention	Emergency room care	0% coinsurance after deductible	50% coinsurance after deductible	None
	Emergency medical transportation	0% coinsurance after deductible	50% coinsurance after deductible	None
	Urgent care	0% coinsurance after deductible	50% coinsurance after deductible	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)	0% coinsurance after deductible	Not covered	Pre-Authorization may be required for some hospital stays. If proper pre-authorization is not obtained, services will not be covered.
	Physician/surgeon fees	0% coinsurance after deductible	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	0% coinsurance after deductible	Not covered	Pre-Authorization may be required for some mental health, behavioral health, or substance abuse services. If proper pre-authorization is not obtained, services will not be covered.
	Inpatient services	0% coinsurance after deductible	Not covered	
If you are pregnant	Office visits	0% coinsurance after deductible	Not covered	Cost sharing does not apply for preventive services. Depending on the type of services, copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional/facility services	0% coinsurance after deductible	Not covered	
If you need help recovering or have other special health needs	Private-duty nursing	0% coinsurance after deductible	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	0% coinsurance after deductible	Not covered	Pre-Authorization may be required. If proper preauthorization is not obtained, services will not be covered. Habilitation services Limit does not apply to Autism.
	Habilitation services	0% coinsurance after deductible	Not covered	
	Skilled nursing care	0% coinsurance after deductible	Not covered	100 days per year. Pre-Authorization may be required. If proper pre-authorization is not obtained, services will not be covered.
	Durable medical equipment	0% coinsurance after deductible	Not covered	Pre-Authorization may be required for some hospital stays. If proper pre-authorization is not obtained, services will not be covered.
	Home health and hospice services	0% coinsurance after deductible	Not covered	Pre-Authorization may be required for some hospital stays. If proper pre-authorization 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	Infertility treatment	Vision Hardware
Bariatric surgery	Long-term care	Routine foot care
Cosmetic surgery	Non-emergency care when traveling outside the U.S.	Weight loss programs
Dental care (Adult & Child)		

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
Chiropractic care	Hearing aids

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.