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 Decent at 1-866-HeartUs or go to www.decent.com. 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 https://www.healthcare.gov/glossary/ or call 1-866-HeartUs to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0 for Medical Services	See the Common Medical Events chart below for your costs for services this plan covers. You do not have to meet a deductible to receive coverage for network care. The plan will pay for your covered medical services less any applicable copayments. You do have a separate deductible that applies to specialty drugs 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$2,000/Individual or $4,000/family for network services only	The out-of-pocket limit is the most you could pay in a year for covered 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, balance billing charges, 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.

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
		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 (DPC) to treat an injury or illness	No copayment – 100% Covered	Not Covered	You must select a Direct Primary Care Provider (DPC) under this plan.
	Specialist visit	No copayment – 100% Covered	Not Covered	A valid referral to see a network specialist is required to access network benefits excluding OB/Gyns, pediatricians, and urgent and emergency care services.
	Preventive care/screening/ Immunization	No copayment – 100% Covered	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)	No copayment – 100% Covered	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)	No copayment – 100% Covered	Not Covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.decent.com	For covered prescription drugs, you will pay the lesser of the cost of the drug or the copayment.			
	Generic drugs	No copayment – 100% Covered	Not Covered	Applies to formulary-covered generic drugs only.
	Preferred brand drugs	No copayment – 100% Covered	Not Covered	Applies to formulary-covered preferred brand drugs only.
	Non-preferred brand drugs	50% coinsurance	Not Covered	Applies to formulary-covered non-preferred brand drugs only.
	Specialty drugs	50% coinsurance	Not Covered	Applies to formulary-covered preferred specialty drugs only.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No copayment – 100% Covered	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	No copayment – 100% Covered	Not Covered	

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 need immediate medical attention	Emergency room care	No copayment – 100% Covered	$1,000 copayment	Emergency room copayment waived if admitted.
	Emergency medical transportation	No copayment – 100% Covered	$1,000 copayment	None
	Urgent care	No copayment – 100% Covered	$200 copayment	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copayment	Not Covered	Pre-Authorization may be required for some hospital stays. If proper pre-authorization is not obtained, services will not be covered. Copayment is per day for a maximum of two days.
	Physician/surgeon fees	No copayment – 100% Covered	Not Covered	Pre-Authorization may be required for some hospital stays. If proper pre-authorization is not obtained, services will not be covered.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No copayment – 100% Covered	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	$500 copayment	Not Covered	Pre-Authorization may be required for some hospital stays. If proper pre-authorization is not obtained, services will not be covered. Copayment is per day for a maximum of two days.
If you are pregnant	Office visits	No copayment – 100% Covered	Not Covered	If the provider bills a global maternity fee, there are no copayments for prenatal visits and the $1500 copayment 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 services	$1,500 copayment	Not Covered	
	Childbirth/delivery facility services	$1,500 copayment	Not Covered	

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 need help recovering or have other special health needs	Private-duty nursing	$50 copayment	Not Covered	96 hours covered per year. Pre-Authorization may be required. If proper pre-authorization is not obtained, services will not be covered.
	Home health care	$50 copayment per visit	Not Covered	100 days covered per year. Pre-Authorization may be required. If proper pre-authorization is not obtained, services will not be covered.
	Rehabilitation services and Chiropractic Care	No copayment – 100% Covered	Not Covered	Pre-Authorization may be required. If proper preauthorization is not obtained, services will not be covered.
	Habilitation services	No copayment – 100% Covered	Not Covered	
	Skilled nursing care	$50 copayment	Not Covered	100 days covered per year. Pre-Authorization may be required. If proper pre-authorization is not obtained, services will not be covered.
	Durable medical equipment	50% coinsurance	Not Covered	Pre-Authorization may be required. If proper preauthorization is not obtained, services will not be covered
	Hospice services	$50 copayment	Not Covered	100 days covered per year. Pre-Authorization may be required. 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
- Bariatric surgery
- Cosmetic surgery
- Dental care (adult and child)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the US
- Routine foot care
- Vision hardware
- 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

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 contact 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 the 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.