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 visit the website: https://secure.healthx.com/ssh.aspx 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.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Uniform-Glossary-01-2020.pdf or call to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $3,000 individual / $6,000 family Out of Network: $6,000 individual / $12,000 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 care and primary care services are covered before you meet your deductible.	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.	There are no other deductibles.
What is the out-of-pocket limit for this plan?	For network providers $7,500 individual / $15,000 family; for out-of-network providers $15,000 individual / $30,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. 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.
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 https://secure.healthx.com/ssh.aspx or call the number listed on your ID card for a list of network 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?	No.	You may see any specialist without a referral.

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	Primary care visit to treat an injury or illness	$30 Copay	30% after deductible	Copay only applies to the office visit.
	Specialist visit	$70 Copay	30% after deductible	Copay only applies to the office visit.
	Preventive care/screening/ immunization	$0 Copay	30% after deductible	
If you have a test	Diagnostic test (x-ray, blood work)	20% after deductible	30% after deductible	Pre-Certification is required on genetic testing, including BRCA tests, and certain diagnostic services. Services may be denied if not obtained.
	Imaging (CT/PET scans, MRIs)	20% after deductible	30% after deductible	Pre-Certification is required on certain imaging services. Services may be denied if not obtained.
If you need drugs to treat your illness or condition	Generic drugs (Tier 1)	Retail: $10 Copay Mail Order: $25 Copay	Not Covered	Covers up to a 30-day supply (retail subscription); 31-90-day supply (mail order prescription).
	Preferred brand drugs (Tier 2)	Retail: $35 Copay Mail Order: $87.50 Copay	Not Covered	
	Non-preferred brand drugs (Tier 3)	Retail: 30% coinsurance after deductible; $125 maximum. Mail Order: 30% coinsurance after deductible; $125 maximum	Not Covered	
	Specialty drugs (Tier 4)	Retail: 50% after deductible, $500 maximum Mail Order: 50% Copay; $500 maximum.	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% after deductible	Not Applicable	Pre-Certification is required on certain surgery services. Services may be denied if not

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)	
	Physician/surgeon fees	20% after deductible	30% after deductible	obtained.
If you need immediate medical attention	Emergency room care	30% after deductible	Not Applicable	Non-emergency services performed in the emergency room or related services, are not covered.
	Emergency medical transportation	30% after deductible	Not Applicable	Pre-Certification is required on air ambulance. Services may be denied if not obtained.
	Urgent care	$50 Copay	30% after deductible	
If you have a hospital stay	Facility fee (e.g., hospital room)	30% after deductible	Not Applicable	Pre-Certification is required. Services may be denied if not obtained.
	Physician/surgeon fees	20% after deductible	30% after deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services (facility)	$30 Copay	Not Applicable	
	Inpatient services	30% after deductible	Not Applicable	Pre-Certification is required. Services may be denied if not obtained.
If you are pregnant	Office visits	$30 Copay	30% after deductible	Post-Certification is required if stay exceeds 48 hours for vaginal delivery or 96 hours for cesarean section. Services may be denied if not obtained.
	Childbirth/delivery professional services	20% after deductible	30% after deductible	
	Childbirth/delivery facility services	30% after deductible	Not Applicable	
If you need help recovering or have other special health needs	Home health care	20% after deductible	30% after deductible	Limited to 30 visits per Plan Year.
	Rehabilitation services	20% after deductible	30% after deductible	Physical, Occupational, and Speech Therapies limited to 30 visits per therapy per Plan Year.
	Habilitation services	20% after deductible	30% after deductible	
	Skilled nursing care	30% after deductible	Not Applicable	Pre-Certification is required. Services may be denied if not obtained. Limited to 60 days per Plan Year.
	Durable medical equipment	20% after deductible	30% after deductible	Pre-Certification is required for certain DME. Services may be denied if not obtained.
	Hospice services	20% after deductible	30% after deductible	Bereavement counseling services are included.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered except services listed under the ACA guidelines (Network)

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)	
	Children's glasses	Not covered	Not covered	None.
	Children's dental check-up	Not covered	Not covered	Not covered except services listed under the ACA guidelines (Network)

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)
- Long-term care
- Infertility treatment
- Long term care
- Routine eye care (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 (30 visits per Plan Year)
- Hearing aids ($1,000 every 36 months)
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Texas Work Force Commission, 101 E. 15th St., Austin TX 78778-0001, https://www.twc.texas.gov/ . Other coverage options may be 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 on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, call the customer service number listed on your ID card.

Does this plan provide Minimum Essential Coverage? Yes.
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa

Chinese (中文): 如果需要中文的帮助，请拨打这个号码

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne'

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$3,000**
- **Specialist copayment** **$70**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$3,000
Copayments	$1,330
Coinsurance	$1,941
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$6,331**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$3,000**
- **Specialist copayment** **$70**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay: $	
Cost Sharing	
Deductibles*	$2,690
Copayments	$1,190
Coinsurance	$484
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,900**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$3,000**
- **Specialist copayment** **$70**
- **Hospital (facility) coinsurance** **30%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay: $	
Cost Sharing	
Deductibles*	$1,610
Copayments	$490
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,100**