



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 <a href="#">deductible</a> ?	<a href="#">Network</a> : \$1,500 individual / \$3,000 family <a href="#">Out of Network</a> : \$3,000 individual / \$6,000 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. <a href="#">Preventive care</a> and primary care services are covered before you meet your <a href="#">deductible</a> .	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.	There are no other <a href="#">deductibles</a> .
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	For <a href="#">network providers</a> \$7,500 individual / \$15,000 family; for <a href="#">out-of-network</a> providers \$15,000 individual / \$30,000 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. 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.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, 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="https://secure.healthx.com/ssh.aspx">https://secure.healthx.com/ssh.aspx</a> or call the number listed on your ID card for a list of <a href="#">network 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> ?	No.	You may see any <a href="#">specialist</a> 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.
	<a href="#">Specialist</a> visit	\$70 Copay	30% after deductible	Copay only applies to the office visit.
	<a href="#">Preventive care/screening/immunization</a>	\$0 Copay	30% after deductible	
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	\$70 Copay	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)	\$500 Copay	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	
	<a href="#">Specialty drugs</a> (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	<a href="#">Emergency room care</a>	30% after deductible	Not Applicable	Non-emergency services performed in the emergency room or related services, are not covered.
	<a href="#">Emergency medical transportation</a>	30% after deductible	Not Applicable	Pre-Certification is required on air ambulance. Services may be denied if not obtained.
	<a href="#">Urgent care</a>	\$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	<a href="#">Home health care</a>	20% after deductible	30% after deductible	Limited to 30 visits per Plan Year.
	<a href="#">Rehabilitation services</a>	20% after deductible	30% after deductible	Physical, Occupational, and Speech Therapies limited to 30 visits per therapy per Plan Year.
	<a href="#">Habilitation services</a>	20% after deductible	30% after deductible	
	<a href="#">Skilled nursing care</a>	30% after deductible	Not Applicable	Pre-Certification is required. Services may be denied if not obtained. Limited to 60 days per Plan Year.
	<a href="#">Durable medical equipment</a>	20% after deductible	30% after deductible	Pre-Certification is required for certain DME. Services may be denied if not obtained.
	<a href="#">Hospice services</a>	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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Bariatric surgery</li> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Infertility treatment</li> <li>• Long term care</li> </ul>	<ul style="list-style-type: none"> <li>• Routine eye care (Adult)</li> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>• Chiropractic care (30 visits per Plan Year)</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing aids (\$1,000 every 36 months)</li> </ul>	<ul style="list-style-type: none"> <li>• Non-emergency care when traveling outside the U.S.</li> </ul>

**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](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 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

*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](#) \$1,500
- [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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$1,500
<a href="#">Copayments</a>	\$1,330
<a href="#">Coinsurance</a>	\$2,772
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$5,602</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$1,500
- [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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay: \$

Cost Sharing	
<a href="#">Deductibles*</a>	\$1,500
<a href="#">Copayments</a>	\$1,190
<a href="#">Coinsurance</a>	\$357
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$3,047</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$1,500
- [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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay: \$

Cost Sharing	
<a href="#">Deductibles*</a>	\$1,500
<a href="#">Copayments</a>	\$490
<a href="#">Coinsurance</a>	\$33
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,023</b>