



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 www.pebcinfo.com or call 817-598-6015. 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://healthcare.gov/SBC-Glossary> or call 1-877-370-2849 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	For <u>network providers</u> \$500 individual / \$1,000 family; for <u>out-of-network providers</u> \$1,000 individual / unlimited family.	Generally, you must pay all of the costs from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> is covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	For <u>network providers</u> \$3,000 individual / \$6,000 family; for <u>out-of-network providers</u> there is no out-of-pocket limit.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .

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<p>Will you pay less if you use a network provider?</p>	<p>Yes. Medical: www.myuhc.com or call 1-877-370-2849;</p> <p>Pharmacies: www.cvshealth.com or call 1-855-335-7698.</p>	<p>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.</p>
<p>Do you need a referral to see a specialist?</p>	<p>No.</p>	<p>You can see the specialist you choose without permission from this plan.</p>

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 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	\$25 copay /visit	40% coinsurance	None
	Specialist visit	\$25 copay /visit for UHC Tier 1 providers; \$35 copay/visit for other in-network specialists	40% coinsurance	None
	Preventive care/screening/immunization	No charge	40% coinsurance	You may have to pay for services that aren't preventive . Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	40% coinsurance	You could be charged a copayment , deductible and/or coinsurance if additional services are provided.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Inpatient or outpatient
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.pebcinfo.com or www.cvshealth.com	Generic drugs (Tier 1)	\$15 copay /retail \$30 copay /home delivery	Applicable copayment plus the difference between in-network and out-of-network pharmacy cost	Costs shown are per prescription. Covers up to a 30-day supply (retail prescription);
	Preferred brand drugs (Tier 2)	\$30 copay /retail \$60 copay /home delivery		
	Non-preferred brand drugs (Tier 3)	\$60 copay /retail \$120 copay /home delivery		

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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)	
	Specialty drugs (Tier 4)	Applicable retail or home delivery copayment for each prescription		Covers up to a 90-day supply (home delivery prescription) If you select a brand-name drug that has a generic available, you will pay the applicable copayment plus the difference in cost between the brand-name drug and the generic.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	\$300 copayment/visit + 20% coinsurance (subject to deductible)	\$300 copayment/visit + 20% coinsurance (subject to deductible)	The copayment is waived if you are admitted to the hospital.
	Emergency medical transportation	No charge	40% coinsurance	See your plan document for additional information about non-emergency medical transportation.
	Urgent care	\$35 copay /visit	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Out-of-network: authorization is required; otherwise you will pay an additional \$500 penalty.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None

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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 mental health, behavioral health, or substance abuse services	Outpatient services	\$25 copay /office visit	40% coinsurance	
	Inpatient services	20% coinsurance	40% coinsurance	
If you are pregnant	Office visits	No charge for routine prenatal and postnatal care	40% coinsurance	Cost sharing does not apply to certain preventive services . Depending on the type of services, coinsurance may apply (for example, for high-risk pregnancies). Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	120 visits/plan year (combined home health care/private duty nursing visits).
	Rehabilitation services	\$25 copay /PCP visit; \$25 copay /Tier 1 specialist visit; \$35 copay other specialist visit	40% coinsurance	60 visits/plan year. Includes physical therapy, speech therapy, and occupational therapy.

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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)	
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	20% coinsurance	40% coinsurance	60 days per plan year
	Durable medical equipment	20% coinsurance	40% coinsurance	None
	Hospice services	20% coinsurance	40% coinsurance	None
If your child needs dental or eye care	Children's eye exam	\$25 copay /PCP visit; \$25 copay /Tier 1 specialist visit; \$35 copay other specialist visit	40% coinsurance	Limited to exams to diagnose injury or illness. The plan does not cover refractions to detect vision impairment.
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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](#).)

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|---|--|---|
| <ul style="list-style-type: none"> • Acupuncture • Bariatric surgery • Cosmetic surgery • Dental Care (adult/child) | <ul style="list-style-type: none"> • Long-term care • Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none"> • Routine eye care (adult/child) • Routine Foot Care • Weight loss programs |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

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|---|---|---|
| <ul style="list-style-type: none"> • Chiropractic care (limited to 20 manipulation visits per plan year) | <ul style="list-style-type: none"> • Infertility treatment (artificial insemination limited to 5 rounds per lifetime; infertility drugs are not covered) | <ul style="list-style-type: none"> • Private duty nursing (limited to 120 visits per plan year; combined private duty / home health care visits) |
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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 817-598-6015. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.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 to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: UnitedHealthcare 1-877-370-2849 (medical).

Additionally, a consumer assistance program can help you file your appeal. Contact the Texas Consumer Health Assistance Program, Texas Department of Insurance, Mail Code 111-1A, 333 Guadalupe, P.O. Box 149091, Austin, TX 78714 or 1-855-839-2427 or chap@tdi.state.tx.us or www.texashealthoptions.com.

Does this plan provide Minimum Essential Coverage? Yes – this plan or policy does provide minimum essential coverage.

Does this plan meet Minimum Value Standards? Yes – this health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:

Español: Para obtener asistencia en Español, llame al 1-877-370-2849.

—————*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	\$1,000
Specialist copayment	\$25
Hospital (facility) coinsurance	20%
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	\$12,800
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In this example, Peg would pay:

Cost Sharing	
Deductibles (single person ded.)	\$500
Copayments	\$35
Coinsurance	\$2,200
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$2,795

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

The plan's overall deductible	\$1,000
Specialist copayment	\$25
Hospital (facility) coinsurance	20%
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	\$7,400
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$1,425
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Joe would pay is	\$1,485

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

The plan's overall deductible	\$1,000
Specialist copayment	\$25
Hospital (facility) coinsurance	20%
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	\$1,900
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In this example, Mia would pay:

Cost Sharing	
Deductibles (single person ded.)	\$500
Copayments	\$475
Coinsurance	\$120
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,095

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please call 817-598-6015 or visit us at www.pebcinfo.com.

The plan would be responsible for the other costs of these EXAMPLE covered services.