North Texas Tollway Authority

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage Period: 01/01/2022 – 12/31/2022
Coverage for: Family | Plan Type: HDP

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 214-224-2264. 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 deductible?	For network providers $1,500 individual / $3,000 family; for out-of-network providers $3,000 individual / $6,000 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, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care is 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://healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For network providers $3,000 individual / $6,000 family; for out-of-network providers there is no out-of-pocket limit.	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.

Questions: Call 214-224-2264 or visit us at www.pebcinfo.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at https://healthcare.gov/SBC-Glossary or call 1-877-370-2849 to request a copy.

Will you pay less if you use a network provider?	Yes. Medical: www.myuhc.com or call 1-877-370-2849; Pharmacies: www.cvshealth.com or call 1-855-335-7698	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 can see the specialist you choose without permission from this plan.

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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	20% coinsurance	40% coinsurance	None
	Specialist visit	20% coinsurance	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)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	
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)	20% coinsurance	Applicable in-network coinsurance plus the difference between in-network and out-of-network pharmacy cost.	Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription). If you select a brand-name drug that has a generic available, you will pay the applicable coinsurance plus the full difference in cost between the brand-name drug and the generic. You will pay the entire cost of the prescription until the deductible is met.
	Preferred brand drugs (Tier 2)	20% coinsurance		
	Non-preferred brand drugs (Tier 3)	20% coinsurance		
	Specialty drugs (Tier 4)	20% coinsurance		
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	20% coinsurance	20% coinsurance	None
	Emergency medical	20% coinsurance	40% coinsurance	See your plan document for additional

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)	
	transportation			information about non-emergency medical transportation.
	Urgent care	20% coinsurance	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	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	20% coinsurance	40% coinsurance	60 visits/plan year. Includes physical therapy, speech therapy, and occupational therapy.

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	20% coinsurance	40% coinsurance	Limited to exams to diagnose injury or illness. Refractions to detect vision impairment are not covered by the plan.
	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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental Care (adult/child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (adult/child)
- 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 (limited to 20 manipulation visits per plan year)
- Infertility treatment (artificial insemination limited to 5 rounds per lifetime; infertility drugs are not covered)
- Private duty nursing (limited to 120 visits per plan year; combined private duty / home health care visits)

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 214-224-2264. 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	**$3,000**
Specialist coinsurance	**20%**
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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	N/A
Coinsurance	$1,930
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,990**

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 coinsurance	**20%**
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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	N/A
Coinsurance	$870
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$3,930**

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

The plan's overall deductible	**$3,000**
Specialist coinsurance	**20%**
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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,900
Copayments	N/A
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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 214-224-2264 or visit us at www.pebcinfo.com.

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