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 1-312-906-8080 or go to www.alliedbenefit.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 www.alliedbenefit.com or call 1-312-906-8080 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For HCHD providers $0 person / $0 family; for PPO providers $750 person / $2,250 family; for out-of-network providers $1,000 person / $3,000 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. PPO preventive care, PPO physician's office exams and second surgical opinions 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.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For HCHD medical $2,250 person / $6,750 family; for PPO medical and prescription drug $2,250 person / $6,750 family; $3,500 person / $10,500 family out-of-network.	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?	Penalties for failure to obtain precertification, services in excess of Plan maximums or limits, 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.alliedbenefit.com or call 1-312-906-8080 for a list of network providers.	You pay the least if you use a provider in Tier 1. You pay more if you use a provider in Tier 2. 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 a referral.

All 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
		HCHD Provider	PPO Provider	Out-of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 copay	$20 copay (deductible does not apply)	50% coinsurance	Applies to exam charge only. Chiropractic coverage is limited to 35 visits. *See Plan Document for other services.
	Specialist visit	$10 copay	$20 copay (deductible does not apply)	50% coinsurance	Applies to exam charge only. *See Plan Document for other services.
	Preventive care/screening/ immunization	No charge	No charge (deductible does not apply)	50% 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	30% coinsurance	50% coinsurance	*Does not include emergency room diagnostic services.
	Imaging (CT/PET scans, MRIs)	No charge	30% coinsurance	50% coinsurance	None.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.caremark.com.	Generic drugs	$15 copay/prescription (retail) $45 copay/prescription (extended retail)	$30 copay/prescription (retail)		Covers up to a 30-day supply (retail prescription); 90-day supply (extended retail prescription). Deductible does not apply. Once the prescription drug out-of-pocket maximum has been met, prescription drugs shall be covered at 100% for the remainder of the calendar year. *See Plan Document for non-use of generic drug penalty.
	Preferred brand drugs	$45 copay/prescription (retail) $135 copay/prescription (extended retail)	$90 copay/prescription (retail)		
	Non-preferred brand drugs	$45 copay/prescription (retail) $135 copay/prescription (extended retail)	$90 copay/prescription (retail)		

*For more information about limitations and exceptions, see plan document at www.alliedbenefit.com.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		HCHD Provider	PPO Provider	Out-of-Network Provider	
	Specialty drugs	Not Covered through Caremark; Subject to Calendar Year Deductible and coinsurance Please contact Allied Benefit Systems, LLC at 1-800-288-2078			*Please see Prescription Drug Benefit section within your Plan Document for details.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	30% coinsurance	50% coinsurance	Pre-certification is recommended for certain surgeries.
	Physician/surgeon fees	No charge	30% coinsurance	50% coinsurance	None.
If you need immediate medical attention	Emergency room care	$150 copay	30% coinsurance	30% coinsurance	None.
	Emergency medical transportation	$150 copay	30% coinsurance	30% coinsurance	Pre-certification is recommended for all Air Ambulance services.
	Urgent care	N/A	30% coinsurance	50% coinsurance	None.
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay/per admission	30% coinsurance	50% coinsurance	Pre-certification is recommended for inpatient services.
	Physician/surgeon fees	No charge	30% coinsurance	50% coinsurance	None.

*For more information about limitations and exceptions, see plan document at www.alliedbenefit.com.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		HCHD Provider	PPO Provider	Out-of-Network Provider	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$10 copay/office visit; no charge for other outpatient services.	$20 copay/office visit (deductible does not apply); 30% coinsurance for other outpatient services.	50% coinsurance	None.
	Inpatient services	$250 copay/per admission	30% coinsurance	50% coinsurance	Pre-certification is recommended for inpatient services.
If you are pregnant	Office visits	$10 copay	$20 copay (deductible does not apply)	50% coinsurance	Cost sharing does not apply to certain preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Pre-certification is recommended for vaginal deliveries requiring more than a 48 hour stay and for cesarean section deliveries requiring more than a 96 hour stay.
	Childbirth/delivery professional services	No charge	30% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	$250 copay/per admission	30% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	30% coinsurance	50% coinsurance	Limited to a maximum of 60 visits per plan year. Pre-certification is recommended.
	Rehabilitation services	No charge	30% coinsurance	50% coinsurance	Physical and Occupational Therapy: Limited to a combined maximum of 35 visits of office and outpatient facility services per calendar year. Speech Therapy: Limited to 35 visits per calendar year. Pre-certification is recommended for inpatient services.
	Habilitation services	No charge	30% coinsurance	50% coinsurance	
	Skilled nursing care	No charge	30% coinsurance	50% coinsurance	Limited to 25 days per plan year. Pre-certification is recommended.

*For more information about limitations and exceptions, see plan document at www.alliedbenefit.com.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		HCHD Provider	PPO Provider	Out-of-Network Provider	
	Durable medical equipment	No charge	30% coinsurance	50% coinsurance	None. Pre-certification is recommended for select durable medical equipment.
	Hospice services	No charge	30% coinsurance	50% coinsurance	Patient's life expectancy is 6 months or less. Pre-certification is recommended. Except Medicare.
If your child needs dental or eye care	Children's eye exam	No charge	30% coinsurance	50% coinsurance	Applies from birth through age 5.
	Children's glasses	Not covered		Not covered	Not covered.
	Children's dental check-up	Not covered		Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your plan document for more information and a list of any other excluded services.)

- Bariatric Surgery
- Cosmetic Surgery
- Dental Care (Adult)
- Dental check-ups (Child)
- Glasses (Child)
- Hearing Aids
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- 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.)

- Acupuncture (must be administered by medical doctor)
- Chiropractic Care (limited to 35 visits per plan year)
- Infertility treatment (except assisted reproduction)

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: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, 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: the Plan Administrator at 806-659-2535 or the Texas Department of Insurance at 1-800-252-3439.

*For more information about limitations and exceptions, see plan document at www.alliedbenefit.com.

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 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.

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

*For more information about limitations and exceptions, see plan document at www.alliedbenefit.com.

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	$0
Specialist copayment	$10
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$0
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$560**

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

The plan's overall deductible	$0
Specialist copayment	$10
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$0
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$820**

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

The plan's overall deductible	$0
Specialist copayment	$10
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$300**

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