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 1-888-472-4352. 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.healthcare.gov/sbc-glossary/ or call 1-888-472-4352 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$1,500/individual $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, preventive services (excluding contraceptives), outpatient behavioral health and substance use disorder services, emergency services, skilled nursing facilities, chiropractic treatment, physician office visits, urgent care, outpatient diagnostic testing, and services paid at no charge. Additionally, no cost sharing will apply to covered charges billed by the Christus Santa Rosa Health System (including facilities, physician groups, and ancillary providers).	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply.
Are there other deductibles for specific services?	Yes. $200 for failure to precertify inpatient stays and organ transplants.	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?	$4,000/individual $12,000/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 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 (unless balance billing is prohibited), health care this plan doesn't cover, prescription drug brand name penalties, and penalties for failure to obtain pre-certification for services.	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?	Not Applicable	This plan does not use a provider network. You can receive covered services from any provider.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

* For more information about limitations and exceptions, see the plan or policy document at www.hchealthbenefits.com.

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
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit, deductible does not apply; 30% coinsurance for other outpatient services	Copay is per provider and only applies to the office visit, x-ray, allergy testing, allergy treatment, and contraceptive injections for birth control. Covered lab work performed in the office is paid at no charge. Coinsurance applies for all other covered in-office services.
	Specialist visit	$45 copay/visit, deductible does not apply; 30% coinsurance for other outpatient services	
	Preventive care/screening/ immunization	No charge	Limited to the following once annually or as listed: routine physical exam, prostatic/testicular exam, routine eye exam (1 every 2 calendar years, includes refraction and glaucoma testing), routine hearing exam (1 every 2 calendar years), as well as services as recommended by the Affordable Care Act (ACA). However, contraceptives are payable under prescription drug coverage. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	**Inpatient** 30% coinsurance **Outpatient Hospital & Standalone Facility** Blood work: No charge X-ray: $45 copay/visit, deductible does not apply	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.hchealthbenefits.com	Generic drugs	**Retail** $10 copay/prescription **Mail order** $15 copay/prescription	Covers up to a 30-day supply (retail and specialty pharmacy); 90-day supply (mail order pharmacy). Preventive medications are covered at no charge as recommended by the ACA; however, covered contraceptives are payable at the applicable Generic and Brand copays. Brand-name drug penalty: If your physician authorizes generic but you choose brand name, you pay the actual cost difference plus the brand name copayment. Purchases at a non-participating pharmacy require you to pay in full then submit a claim form for reimbursement and are subject to an additional 30% coinsurance. Out-of-network mail order prescriptions are not covered. Deductible does not apply to prescription drug expenses. Prescription drugs above $1,250 for a 30-day supply, above $3,750 for a 90-day supply, and all specialty drugs are not covered. However, specialty drugs may be covered at the applicable copay for one 30-day period during a calendar year for each specialty drug when an urgent fill of medication is required, unless otherwise excluded in the plan. Members should contact UIW Human Resources at hrbenefits@uiwtx.edu or (210) 829-6019 for assistance in obtaining alternate funding.
	Preferred brand drugs	**Retail** $25 copay/prescription **Mail order** $37.50 copay/prescription	
	Non-preferred brand drugs	**Retail** $50 copay/prescription **Mail order** $75 copay/prescription	
	Specialty drugs	Not covered	

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	None
	Physician/surgeon fees	30% coinsurance	None
If you need immediate medical attention	Emergency room care	$150 copay/visit, deductible does not apply	Copay is waived if you are admitted to the hospital from the emergency room.
	Emergency medical transportation	30% coinsurance	None
	Urgent care	$50 copay/visit, deductible does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay/day, then 30% coinsurance	Precertification is required or an additional deductible of $200 may apply. Copay applies per confinement and applies each day for the first 5 days.
	Physician/surgeon fees	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/visit, deductible does not apply	Copay is per provider and applies to all covered services incurred during the member's visit.
	Inpatient services	$250 copay/day, then 30% coinsurance	Precertification is required or an additional deductible of $200 may apply. Copay applies per confinement and applies each day for the first 5 days.
If you are pregnant	Office visits	No charge	None
	Childbirth/delivery professional services	30% coinsurance	None
	Childbirth/delivery facility services	$250 copay/day, then 0% coinsurance	Precertification is required for an inpatient stay that is in excess of 48 hours (vaginal delivery) or 96 hours (caesarean delivery) or an additional deductible of $200 may apply. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Copay applies per confinement and applies each day for the first 5 days.

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care	No charge	Limited to 120 visits/calendar year
	Rehabilitation services	30% coinsurance	Limited to 60 visits/calendar year for physical, occupational, and speech therapies combined. Limited to 36 visits/calendar year for pulmonary rehabilitation. No coverage for vision therapy.
	Habilitation services	30% coinsurance	Covered for the treatment of Autism only. Limited to 60 visits/calendar year combined with limits for physical, occupational, and speech therapy.
	Skilled nursing care	$250 copay/day, then no charge	Limited to 100 days/calendar year. Precertification is required or an additional deductible of $200 may apply. Copay applies per confinement and applies each day for the first 5 days.
	Durable medical equipment	30% coinsurance	Replacement allowed after 5 years.
	Hospice services	**Inpatient**: $250 copay/day, then no charge **Outpatient**: 30% coinsurance	Copay applies per confinement and applies each day for the first 5 days.
If your child needs dental or eye care	Children's eye exam	No charge	Limited to 1 exam every 2 calendar years.
	Children's glasses	Not covered	No coverage for children's glasses.
	Children's dental check-up	Not covered	No coverage for dental check-up.

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)
- Hearing aid
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult) / (Child), except as covered under Preventive Care
- Routine foot care
- Specialty drugs and all drugs over $1,250 (30-day supply) and $3,750 (90-day supply)
- Vision therapy
- 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 60 visits/calendar year)
- Habilitation services (limited to the treatment of Autism)
- Private-duty nursing (inpatient only; limited to 70 shifts/calendar year)

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 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, contact: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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 1-888-472-4352.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-472-4352.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-888-472-4352.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-472-4352.

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 the plan or policy document at www.hchealthbenefits.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** **$1,500**
- **Specialist copayment** **$45**
- **Hospital (facility) coinsurance** **30%**
- **Other (Tests) coinsurance** **30%**

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	$1,450
Copayments	$300
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,060**

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** **$45**
- **Hospital (facility) coinsurance** **30%**
- **Other (Brand drug) copayment** **$25**

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	$900
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,320**

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

- **The plan's overall deductible** **$1,500**
- **Specialist copayment** **$45**
- **Hospital (facility) coinsurance** **30%**
- **Other (Physical therapy) coinsurance** **30%**

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	$1,500
Copayments	$300
Coinsurance	$60
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,000**

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