This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.healthselectoftexas.com** or by calling **(866) 336-9371 (TTY 711)**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: **$0** person **/ $0** family Non-Network: **$500** person **/ $1,500** family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over. See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$50** for prescription drug expenses per person, **$5,000** for bariatric surgery for active employees, and **$200** per service for certain non-prior authorized services.	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.
Is there an out–of–pocket limit on my expenses?	Yes. Network: **$6,550** person **/ $13,100** family. Non-Network: **$7,000** coinsurance maximum per person.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Contributions, balance-billed charges, health care this plan doesn't cover, and bariatric surgery benefits.	Even though you pay these expenses, they don't count toward the **out–of–pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of network providers, see www.healthselectoftexas.com or call **(866) 336-9371**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their network. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes. A valid written referral from your primary care physician is required to see a specialist.	This plan will pay some or all of the costs to see a **specialist** for covered services, but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about **excluded services**.

Questions: Call **(866) 336-9371** for Customer Service or visit us at www.healthselectoftexas.com. If you aren't clear about any of the underlined terms used in this document, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or www.cciio.cms.gov or call **(866) 336-9371** to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay	40% coinsurance	----------None----------
	Specialist visit	$40 copay	40% coinsurance	A valid referral to see a network specialist is required to access network benefits excluding OB/Gyns, chiropractors and eye exams by ophthalmologists and optometrists.
	Other practitioner office visit	Not Covered	Not Covered	----------None----------
	Preventive care/screening/immunization	No Charge	40% coinsurance	----------None----------
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	----------None----------
	Imaging (CT/PET scans, MRIs)	$100 copay plus 20% coinsurance	$100 copay plus 40% coinsurance	Prior authorization may be required. Failure to obtain prior authorization may increase your cost.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at: www.caremark.com/ers	Generic drugs	$10 copay (non-maintenance), $10 copay (maintenance); $30 copay (mail order or extended day supply)	$10 copay plus 40% coinsurance (non-maintenance) $10 copay plus 40% coinsurance (maintenance); $30 copay plus 40% coinsurance (mail order or extended day supply)	Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
	Preferred brand drugs	$35 copay (non-maintenance), $45 copay (maintenance); $105 copay (mail order or extended day supply)	$35 copay plus 40% coinsurance (non-maintenance) $45 copay plus 40% coinsurance (maintenance); $105 copay plus 40% coinsurance (mail order or extended day supply)	Prior authorization may be required. Failure to obtain prior authorization may increase your cost. Note: If a generic drug is available and you choose to buy the preferred brand drug, you will pay the generic copay plus the cost difference between the preferred brand drug and the generic drug.
	Non-preferred brand drugs	$60 copay (non-maintenance), $75 copay (maintenance); $180 copay (mail order or extended day supply)	$60 copay plus 40% coinsurance (non-maintenance) $75 copay plus 40% coinsurance (maintenance); $180 copay plus 40% coinsurance (mail order or extended day supply)	Prior authorization may be required. Failure to obtain prior authorization may increase your cost. Note: If a generic drug is available and you choose to buy the non-preferred brand drug, you will pay the generic copay plus the cost difference between the non-preferred brand drug and the generic drug.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
	Specialty drugs	If purchased through a pharmacy, specialty drugs are covered as preferred brand drugs or non-preferred brand drugs as listed above. Otherwise, covered as a medical benefit.	If purchased through a pharmacy, specialty drugs are covered as preferred brand drugs or non-preferred brand drugs as listed above. Otherwise, covered as a medical benefit.	Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copay plus 20% coinsurance	$100 copay plus 40% coinsurance	Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	----------None----------
If you need immediate medical attention	Emergency room services	$150 copay plus 20% coinsurance	$150 copay plus 20% coinsurance	If admitted, copay is applied to inpatient hospital copay.
	Emergency medical transportation	20% coinsurance	20% coinsurance Non-network deductible does not apply	----------None----------
	Urgent care	$50 copay plus 20% coinsurance	$50 copay plus 40% coinsurance	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	$150/day copay per admission plus 20% coinsurance	$150/day copay per admission plus 40% coinsurance	$750 copay max per admission. $2,250 copay max per calendar year per person. Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	----------None----------

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 copay	40% coinsurance	----------None----------
	Mental/Behavioral health inpatient services	$150/day copay per admission plus 20% coinsurance	$150/day copay per admission plus 40% coinsurance	$750 copay max per admission. $2,250 copay max per calendar year per person. Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
	Substance use disorder outpatient services	$25 copay	40% coinsurance	----------None----------
	Substance use disorder inpatient services	$150/day copay per admission plus 20% coinsurance	$150/day copay per admission plus 40% coinsurance	$750 copay max per admission. $2,250 copay max per calendar year per person. Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
If you are pregnant	Prenatal and postnatal care	No Charge	40% coinsurance	No charge for network pre-natal office visits or obstetrician delivery.
	Delivery and all inpatient services	$150/day copay per admission plus 20% coinsurance	$150/day copay per admission plus 40% coinsurance	$750 copay max per admission. $2,250 copay max per calendar year per person. Prior authorization may be required. Failure to obtain prior authorization may increase your cost.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance Max of 100 visits per calendar year per person.	Prior authorization may be required. Failure to obtain prior authorization may increase your cost. Non-network home infusion therapy is not covered.
	Rehabilitation services	20% coinsurance	40% coinsurance	----------None----------
	Habilitation services	20% coinsurance	40% coinsurance	----------None----------
	Skilled nursing care	20% coinsurance	40% coinsurance	Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
	Durable medical equipment	20% coinsurance	40% coinsurance	Replacement limit of one every 3 years per person unless change in condition or physical status. Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
	Hospice service	20% coinsurance	40% coinsurance	Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
If your child needs dental or eye care	Eye exam	$40 copay	40% coinsurance	Limit of one routine exam per calendar year per person. No referral is required for eye exams.
	Glasses	Not Covered	Not Covered	----------None----------
	Dental check-up	Not Covered	Not Covered	----------None----------

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Artificial insemination
- Cosmetic surgery
- Dental check-up
- Educational services, excluding Diabetes Self-Management Training Programs
- Glasses
- Long-term care
- Non-network home infusion therapy
- Personal comfort items
- Routine foot care
- Weight-loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery
- Chiropractic care
- Hearing aids
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine eye exams
- Virtual Visits

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**[1], which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at (866) 336-9371. 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.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact (866) 336-9371 or visit www.healthselectoftexas.com.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Para obtener asistencia en Español, llame al (866) 336-9371 durante el horario de 8:00am a 7:00pm CST Lunes-Viernes, y 7:00am a 3:00pm CST Sábado.

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

[1] Under the HealthSelect plan, the payment you make for health plan coverage is called a contribution rather than a premium.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,060
- **Patient pays** $1,480

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles (Prescription)	$50
Copays (3 day hospital inpatient stay)	$450
Coinsurance	$980
Limits or exclusions	$0
Total	**$1,480**

Note: These numbers assume the patient has given notice of her pregnancy to the plan. If you are pregnant and have not given notice of your pregnancy, your cost may be higher. For more information, please contact (866)336-9371.

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,640
- **Patient pays** $760

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles (Prescription)	$50
Copays (6 months of preferred brand name insulin and 4 specialist office visits)	$430
Coinsurance	$280
Limits or exclusions	$0
Total	**$760**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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