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 harborhealthresources or call Member Services at 1-855-481-0225. 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 1-855-481-0225 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: Individual $2,000 / Family $4,000	Generally, you must pay all 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. Certain office visits, Preventive care/screening, Urgent care and prescription drugs in-network	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 hhttps://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 network providers $8,200 individual / $16,400 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 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.
Will you pay less if you use a network provider?	Yes. See HarborHealthNetwork or call 1-855-481-0225 for a list of network providers.	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 network provider / specialist you choose without a referral.

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 Harbor Health Express	$30 copay / visit, deductible does not apply $30 copay / visit, deductible does not apply	Not Covered	Member are encouraged to select a Primary Care provider. Cost share applies to in-person visit and telehealth visit. Certain procedures performed in the office may have a coinsurance.
	Specialist visit	$60 copay / visit, deductible does not apply	Not Covered	None
	Preventive care/screening immunization	No Charge	Not Covered	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)	25% coinsurance	Not Covered	None
	Imaging (CT/PET scans, MRIs)	25% coinsurance	Not Covered	Prior authorization is required for certain imaging or there may be no coverage.

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.harborhealth.com/medications	Tier 1	Deductible does not apply **30-Day Supply** $15 copay Retail **90-Day Supply** $37 copay Mail Order	Not Covered	Tier 1 drugs are available with $0 copay including prescribed generic contraceptives and tobacco cessation medications. Certain preventive medications (including certain contraceptives) are covered at No Charge. To learn more about drug tiers and about copays / coinsurance for specific drugs, visit www.harborhealth.com/medications Prior authorization is required for certain drugs or there may be no coverage.
	Tier 2	Deductible does not apply **30-Day Supply** $30 copay Retail **90-Day Supply** $75 copay Mail Order	Not Covered	
	Tier 3	Deductible does not apply **30-Day Supply** $60 copay Retail **90-Day Supply** $150 copay Mail Order	Not Covered	
	Tier 4 Specialty drugs	Deductible does not apply **30-Day Supply** $250 copay	Not Covered	Prior authorization is required for certain Specialty drugs or there may be no coverage.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	Not Covered	Prior authorization is required for certain services or there may be no coverage.
	Physician/surgeon fees	25% coinsurance	Not Covered	

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 immediate medical attention	Emergency room care	25% coinsurance	Out of Network Emergency room care covered as in-network benefit	None
	Emergency medical transportation	25% coinsurance	Out of Network Emergency medical transportation covered as in-network	None
	Urgent care	$45 copay / visit, deductible does not apply	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	Not Covered	Prior authorization is required for certain services or there may be no coverage.
	Physician/surgeon fees	25% coinsurance	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	25% coinsurance	Not Covered	Mental Health Office Visit is $30 copay / visit, deductible does not apply Prior authorization is required for certain services or there may be no coverage.
	Inpatient services	25% coinsurance	Not Covered	Prior authorization is required for certain services or there may be no coverage.

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 are pregnant	Office visits	$30 copay / visit, deductible does not apply	Not Covered	Cost share applies to in-person visit and telehealth visit. Cost sharing does not apply for preventive services in the office. Certain procedures performed in the office may have a coinsurance. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound)
	Childbirth/delivery professional services	25% coinsurance	Not Covered	
	Childbirth/delivery facility services	25% coinsurance	Not Covered	
If you need help recovering or have other special health needs	Home health care	25% coinsurance	Not Covered	60 visits / per plan year
	Rehabilitation services	$30 copay / visit, deductible does not apply	Not Covered	Limits per plan year: Physical, Occupational, Speech, Chiropractic: combined limit 35 visits per plan year. No limits apply for treatment of covered mental health or substance use disorders. No limits apply for Acquired Brain Injury services.
	Habilitation services	$30 copay / visit, deductible does not apply	Not Covered	Limits per plan year: Physical, Occupational, Speech, Chiropractic: combined limit 35 visits per plan year. No limits apply for treatment of covered mental health or substance use disorders.
	Skilled nursing care	25% coinsurance	Not Covered	25 days / per plan year

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)	
	Durable medical equipment	25% coinsurance	Not Covered	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment. Prior authorization is required for certain Durable medical equipment rented or purchased over $2,000.
	Hospice services	Home Hospice services 25% coinsurance Inpatient Hospice services 25% coinsurance	Not Covered	Prior authorization is required for certain services or there may be no coverage.
If your child needs dental or eye care	Children's eye exam	$0 copay / visit	Not Covered	Coverage limited to one exam/per plan year
	Children's glasses	25% coinsurance	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.)

- Abortion (except when life of mother at risk)
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care (except as covered for certain diseases)
- 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 (see plan for limits)
- Hearing aids (see plan for limits)
- Private-duty nursing (see plan for limits)

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: Harbor Health at 1-855-481-0225. You may also contact your state insurance department at 1-800-252-3439 or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform 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: Member service number listed on the back of your ID card or Texas Department of Insurance at 1-800-578-4677 or visit https://tdi.texas.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? **Not Applicable.**
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 1-855-481-0225

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-481-0225

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-855-481-0225

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-481-0225

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	$2,000
Specialist *[cost sharing]*	$60
Hospital (facility) *[cost sharing]*	25%
Other *[cost sharing]*	25%

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	$2,000
Copayments	$10
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,870**

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$2,000
Specialist *[cost sharing]*	$60
Hospital (facility) *[cost sharing]*	25%
Other *[cost sharing]*	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	$80
Copayments	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,280**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	$2,000
Specialist *[cost sharing]*	$60
Hospital (facility) *[cost sharing]*	25%
Other *[cost sharing]*	25%

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	$2,000
Copayments	$200
Coinsurance	$10
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,210**

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