



This chart only summarizes covered benefits. Please refer to the Certificate of Insurance for coverage details including exclusions and limitations.

POLICY YEAR: CALENDAR	In-Network	Out-of-Network
DEDUCTIBLE	\$750 per Insured Person \$1,500 per Family	\$1,000 per Insured Person \$2,000 per Family
Per admission deductible	\$250	\$500
OUT-OF-POCKET MAXIMUM (Includes deductible)	\$2,000 per Insured Person \$4,000 per Family	\$4,000 per Insured Person \$8,000 per Family
COINSURANCE PERCENTAGE	80% after Deductible	60% after Deductible
PRE-AUTHORIZATION PENALTY	Failure to Pre-authorize outpatient surgery and inpatient services, requiring preauthorization, reduces benefits by \$500. Failure to Pre-authorize all other services requiring preauthorization reduces benefits by 50%. This penalty does not apply to services obtained from an In-Network Provider.	

COVERED MEDICAL SERVICES for PREFERRED PROVIDERS (In-Network Benefits)

GENERAL SERVICES (Including Medical & Behavioral Health Services)

• Non-Specialist Office Visit ¹	\$25 Copay, per visit	• Emergency Room ³	\$500 copay/visit plus 20% Coinsurance
• Specialist Office Visit ²	\$35 Copay, per visit	• Minor Emergency/Urgent Care	\$75 Copay

PREVENTIVE CARE SERVICES (For a complete list of preventive care services please refer to your Certificate of Insurance.)

• Preventive Care	No Copay
-------------------	----------

- OTHER HEALTH CARE SERVICES**
- All other services, including but not limited to those listed below: 80% after Deductible*
- **Inpatient Services** (Facility Charges; Physician Services; Surgical Procedures; Pre-Admission Testing; Operating/Recovery Room; Labor & Delivery; Neonatal Intensive Care Unit (NICU); Intensive Care Unit (ICU); Coronary Care Units; Laboratory Tests/X-rays; Rehabilitation Facility; Behavioral Health Facilities; Skilled Nursing Facility*)
 - **Outpatient Services** (Facility Charges; Physician Services; Surgical Procedures; Observation Unit; Behavioral Health Facilities)
 - **Ambulance** (Air/Ground)
 - **Diagnostic Tests** (Facility/Physician) – MRI; CT Scan; Sleep Study; Stress Test; EKG; PET Scan; Ultrasound; Cardiac Imaging; Genetic Testing; Colonoscopy (non-preventive)
 - **Other Services** (Allergy Testing/Serum/Injections; Surgical Procedures in Physician Office; Family Planning Services; Medical Supplies; Therapy Services; Hospice Care; Pain Management; Dialysis Services; Organ Transplant Services; Home Health Care*; Home Infusion Medications; Internal Implantable Devices; Amino Acid-Based Elemental Formulas; Diabetic Services*; Durable Medical Equipment*; Limited Accidental Dental Care*; Prosthetics*; Orthotics*; Spinal Manipulation*)
 - **All Other Covered Services** (not specified herein)
- * Covered Service Limitations (Combined In/Out-of-Network Maximum)**
- | | |
|---|---|
| • Durable Medical Equipment – Limited to \$3,000 per Policy Year | • Prosthetics – Limited to \$10,000 per Lifetime |
| • Skilled Nursing Facility – Limited to 60 days per Policy Year | • Orthotics – Limited to \$10,000 per Lifetime |
| • Limited Accidental Dental Care – Limited to \$10,000 per Policy Year | • Spinal Manipulation – Limited to 20 visits per Policy Year |
| • Home Health Care – Limited to 30 visits per Policy Year | |

NON-PREFERRED PROVIDERS (Out-of-Network Benefits)	60% after Deductible
--	----------------------

¹ **Non-Specialist Office Visits** – include Lab/X-ray services, injectables & supplies. Other services provided in a physician's office are subject to additional deductible & copays/coinsurance.

² **Specialist Office Visits** – include Lab/X-ray services. Other services provided in a physician's office are subject to additional deductible & copays/coinsurance.

³ **Out-of-Network Emergency Room Services** apply towards the Plan's In-Network benefits (i.e. - coinsurance, deductible, out-of-pocket maximum, etc.)

⁴ **Diabetic Services** – If there is a Prescription Drug Rider, see the Rider for details regarding benefits for Diabetic Services.



You have the option to choose this Consumer Choice of Benefits Health Maintenance Organization that, either in whole or in part, does not provide state mandated health benefits normally required in accident & sickness insurance policies/evidences of coverage in Texas. This standard health benefit plan may provide a more affordable health plan for you although, at the same time, it may provide you with fewer health plan benefits than those normally included as state-mandated health benefits in policies in Texas. If you choose this standard health benefit plan, please consult with your insurance agent to discover which state-mandated health benefits are excluded in this evidence of coverage. The following is a summary of the Copay amounts You & any Dependents must pay when receiving the services listed below. These services must be performed, prescribed, or directed by Your Primary Care Physician or designated OB/GYN Physician. Please refer to Your Evidence of Coverage for a detailed explanation of covered & non-covered services.

PLAN YEAR	Calendar Year
PLAN YEAR DEDUCTIBLE	\$1,000 per Member / \$2,000 per Family
PER ADMISSION DEDUCTIBLE	\$250 admission deductible
OUT-OF-POCKET MAXIMUM (Includes Deductible)	\$2,000 per Member / \$5,000 per Family

COVERED MEDICAL SERVICES			
GENERAL SERVICES (Including Medical & Behavioral Health Services)			
• PCP Office Visit ¹	\$15 Copay, per visit	• Emergency Room	\$500 copay/visit plus 20% Coins. \$45 Copay
• Specialist Office Visit ²	\$25 Copay, per visit	• Minor Emergency/Urgent Care	

PREVENTIVE CARE SERVICES (For a complete list of preventive care services please refer to your Evidence of Coverage.)	
• Preventive Care	No Copay

OTHER HEALTH CARE SERVICES	
<i>All other services, including but not limited to those listed below:</i>	20% Copay after Deductible
<ul style="list-style-type: none"> • Inpatient Services (Facility Charges; Physician Services; Surgical Procedures; Pre-Admission Testing; Operating/Recovery Room; Labor & Delivery; Neonatal Intensive Care Unit (NICU); Intensive Care Unit (ICU); Coronary Care Units; Laboratory Tests/X-rays; Rehabilitation Facility; Behavioral Health Facilities; Skilled Nursing Facility*) • Outpatient Services (Facility Charges; Physician Services; Surgical Procedures; Observation Unit; Behavioral Health Facilities) • Ambulance (Air/Ground) • Diagnostic Tests (Facility/Physician) – MRI; CT Scan; Sleep Study; Stress Test; EKG; PET Scan; Ultrasound; Cardiac Imaging; Genetic Testing; Colonoscopy (non-preventive) • Other Services (Allergy Testing/Serum/Injections; Surgical Procedures in Physician Office; Family Planning Services; Medical Supplies; Therapy Services; Hospice Care; Pain Management; Dialysis Services; Organ Transplant Services; Home Health Care*; Home Infusion Medications; Internal Implantable Devices; Amino Acid-Based Elemental Formulas; Diabetic Services³; Durable Medical Equipment*; Limited Accidental Dental Care*; Prosthetics*; Orthotics*; Spinal Manipulation*) • All Other Covered Services (not specified herein) 	
Covered Service Limitations	
<ul style="list-style-type: none"> • Durable Medical Equipment – Limited to \$3,000 per Plan Year • Skilled Nursing Facility – Limited to 60 days per Plan Year • Limited Accidental Dental Care – Limited to \$10,000 per Plan Year • Home Health Care – Limited to 30 visits per Plan Year 	<ul style="list-style-type: none"> • Prosthetics – Limited to \$10,000 per Lifetime • Orthotics – Limited to \$10,000 per Lifetime • Spinal Manipulation – Limited to 20 visits per Plan Year

¹ **PCP Office Visits** – include Lab/X-ray services, injectables & supplies. Other services provided in a physician’s office are subject to additional deductible & copays/coinsurance.

² **Specialist Office Visits** – include Lab/X-ray services. Other services provided in a physician’s office are subject to additional deductible & copays/coinsurance.

³ **Diabetic Services** – If there is a Prescription Drug Rider for Your Plan, see the Rider for details regarding copayments for Diabetic Services.



This chart only summarizes covered benefits. Please refer to the Certificate of Insurance for coverage details including exclusions and limitations.

POLICY YEAR: CALENDAR	In-Network	Out-of-Network
DEDUCTIBLE	\$500 per Insured Person \$1,000 per Family	\$1,000 per Insured Person \$2,000 per Family
Per admission deductible	\$250	\$500
OUT-OF-POCKET MAXIMUM (Includes deductible)	\$2,000 per Insured Person \$4,000 per Family	\$4,000 per Insured Person \$8,000 per Family
COINSURANCE PERCENTAGE	80% after Deductible	60% after Deductible
PRE-AUTHORIZATION PENALTY	Failure to Pre-authorize outpatient surgery and inpatient services, requiring preauthorization, reduces benefits by \$500. Failure to Pre-authorize all other services requiring preauthorization reduces benefits by 50%. This penalty does not apply to services obtained from an In-Network Provider.	

COVERED MEDICAL SERVICES for PREFERRED PROVIDERS (In-Network Benefits)	
GENERAL SERVICES (Including Medical & Behavioral Health Services)	
<ul style="list-style-type: none"> Non-Specialist Office Visit¹ \$15 Copay, per visit Specialist Office Visit² \$25 Copay, per visit 	<ul style="list-style-type: none"> Emergency Room³ \$500 copay/visit plus 20% Coinsurance Minor Emergency/Urgent Care \$45 Copay
PREVENTIVE CARE SERVICES (For a complete list of preventive care services please refer to your Certificate of Insurance.)	
<ul style="list-style-type: none"> Preventive Care No Copay 	
OTHER HEALTH CARE SERVICES	
<i>All other services, including but not limited to those listed below: 80% after Deductible</i>	
<ul style="list-style-type: none"> Inpatient Services (Facility Charges; Physician Services; Surgical Procedures; Pre-Admission Testing; Operating/Recovery Room; Labor & Delivery; Neonatal Intensive Care Unit (NICU); Intensive Care Unit (ICU); Coronary Care Units; Laboratory Tests/X-rays; Rehabilitation Facility; Behavioral Health Facilities; Skilled Nursing Facility*) Outpatient Services (Facility Charges; Physician Services; Surgical Procedures; Observation Unit; Behavioral Health Facilities) Ambulance (Air/Ground) Diagnostic Tests (Facility/Physician) – MRI; CT Scan; Sleep Study; Stress Test; EKG; PET Scan; Ultrasound; Cardiac Imaging; Genetic Testing; Colonoscopy (non-preventive) Other Services (Allergy Testing/Serum/Injections; Surgical Procedures in Physician Office; Family Planning Services; Medical Supplies; Therapy Services; Hospice Care; Pain Management; Dialysis Services; Organ Transplant Services; Home Health Care*; Home Infusion Medications; Internal Implantable Devices; Amino Acid-Based Elemental Formulas; Diabetic Services⁴; Durable Medical Equipment*; Limited Accidental Dental Care*; Prosthetics*; Orthotics*; Spinal Manipulation*) All Other Covered Services (not specified herein) 	
* Covered Service Limitations (Combined In/Out-of-Network Maximum)	
<ul style="list-style-type: none"> Durable Medical Equipment – Limited to \$3,000 per Policy Year Skilled Nursing Facility – Limited to 60 days per Policy Year Limited Accidental Dental Care – Limited to \$10,000 per Policy Year Home Health Care – Limited to 30 visits per Policy Year 	<ul style="list-style-type: none"> Prosthetics – Limited to \$10,000 per Lifetime Orthotics – Limited to \$10,000 per Lifetime Spinal Manipulation – Limited to 20 visits per Policy Year
NON-PREFERRED PROVIDERS (Out-of-Network Benefits)	60% after Deductible

¹ **Non-Specialist Office Visits** – include Lab/X-ray services, injectables & supplies. Other services provided in a physician's office are subject to additional deductible & copays/coinsurance.

² **Specialist Office Visits** – include Lab/X-ray services. Other services provided in a physician's office are subject to additional deductible & copays/coinsurance.

³ **Out-of-Network Emergency Room Services** apply towards the Plan's In-Network benefits (i.e. - coinsurance, deductible, out-of-pocket maximum, etc.)

⁴ **Diabetic Services** – If there is a Prescription Drug Rider, see the Rider for details regarding benefits for Diabetic Services.