



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, visit <https://exchange.imperialhealthplan.com/texas/> or contact us at 1-800-595-0619 or <https://exchange.imperialhealthplan.com/texas/contact-information/>. 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 <https://exchange.imperialhealthplan.com/texas/members> or call 1-800-595-0619 to request a copy.

| Important Questions                                                             | Answers                                                                                                                                                                                                                                                                                                                                                                                                | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|---------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | \$2500 per person   \$5000 per group                                                                                                                                                                                                                                                                                                                                                                   | Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .                                                                                                                                             |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. Primary care, <a href="#">specialist</a> visits, <a href="#">preventive care</a> , generic drugs, preferred drugs, non-preferred drugs, <a href="#">specialty drugs</a> , <a href="#">urgent care</a> , outpatient mental, behavioral, or substance abuse services, office visits while pregnant, child eye care, child dental care, are covered before meeting your <a href="#">deductible</a> . | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">percentage copayment</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-carebenefits/">https://www.healthcare.gov/coverage/preventive-carebenefits/</a> . |
| Are there other <a href="#">deductibles</a> for specific services?              | No.                                                                                                                                                                                                                                                                                                                                                                                                    | You don't have to meet deductibles for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | \$8600 per person   \$17200 per group                                                                                                                                                                                                                                                                                                                                                                  | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.                                                                                                                                                                                                                                                                                              |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> doesn't cover.                                                                                                                                                                                                                                                                           | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="https://www.imperialhealthplan.com/texas/hmo-exchange/provider-">https://www.imperialhealthplan.com/texas/hmo-exchange/provider-</a>                                                                                                                                                                                                                                                 | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan</a> 's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider</a> 's charge and what your <a href="#">plan</a> pays ( <a href="#">balance</a>                                                                                                                                        |

| Important Questions                                                          | Answers                                                                            | Why This Matters:                                                                                                                                                                                                                       |
|------------------------------------------------------------------------------|------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                              | directory or call 1-800-838-5914 for a list of <a href="#">network providers</a> . | <a href="#">billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ? | Yes.                                                                               | This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .                    |

 All [copayment](#) and [percentage copayment](#) 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<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                           |
| If you visit a health care <a href="#">provider's office</a> or clinic                                                                                                                                                                                                                              | Primary care visit to treat an injury or illness        | \$30 <a href="#">copay</a> /visit            | Not covered                                        | None                                                                                                                                                                                      |
|                                                                                                                                                                                                                                                                                                     | <a href="#">Specialist</a> visit                        | \$60 <a href="#">copay</a> /visit            | Not covered                                        |                                                                                                                                                                                           |
|                                                                                                                                                                                                                                                                                                     | <a href="#">Preventive care/screening</a> /immunization | No Charge                                    | Not covered                                        |                                                                                                                                                                                           |
| If you have a test                                                                                                                                                                                                                                                                                  | <a href="#">Diagnostic test</a> (x-ray, blood work)     | 25% <a href="#">percentage copayment</a>     | Not covered                                        | You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for. |
|                                                                                                                                                                                                                                                                                                     | Imaging (CT/PET scans, MRIs)                            | 25% <a href="#">percentage copayment</a>     | Not covered                                        |                                                                                                                                                                                           |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="https://client.formularynavigator.com/Search.aspx?siteCode=5261847175">https://client.formularynavigator.com/Search.aspx?siteCode=5261847175</a> | Preventive drugs (Tier 1)                               | No Charge                                    | Not Covered                                        | Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription). <a href="#">Preauthorization</a> is required for certain drugs.                           |
|                                                                                                                                                                                                                                                                                                     | Generic drugs (Tier 2)                                  | \$15 <a href="#">copay</a> /prescription     | Not covered                                        |                                                                                                                                                                                           |
|                                                                                                                                                                                                                                                                                                     | Preferred brand drugs (Tier 3)                          | \$30 <a href="#">copay</a> /prescription     | Not covered                                        |                                                                                                                                                                                           |
|                                                                                                                                                                                                                                                                                                     | Non-preferred brand drugs (Tier 4)                      | \$60 <a href="#">copay</a> /prescription     | Not covered                                        |                                                                                                                                                                                           |
|                                                                                                                                                                                                                                                                                                     | <a href="#">Specialty drugs</a> (Tier 5)                | \$250 <a href="#">copay</a> /prescription    | Not covered                                        |                                                                                                                                                                                           |
| If you have outpatient surgery                                                                                                                                                                                                                                                                      | Facility fee (e.g., ambulatory surgery center)          | 25% <a href="#">percentage copayment</a>     | Not covered                                        | <a href="#">Preauthorization</a> is required.                                                                                                                                             |
|                                                                                                                                                                                                                                                                                                     | Physician/surgeon fees                                  | 25% <a href="#">percentage copayment</a>     | Not covered                                        |                                                                                                                                                                                           |

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://exchange.imperialhealthplan.com/texas/individual-eoc/>

| Common Medical Event                                                      | Services You May Need                            | What You Will Pay                            |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                         |
|---------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------|----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                                  | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>              | 25% <a href="#">percentage copayment</a>     | 25% <a href="#">percentage copayment</a>           | None                                                                                                                                                                                                                                                                                                                                                                                           |
|                                                                           | <a href="#">Emergency medical transportation</a> | 25% <a href="#">percentage copayment</a>     | 25% <a href="#">percentage copayment</a>           |                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                                           | <a href="#">Urgent care</a>                      | \$45 <a href="#">copay</a> /visit            | \$45 <a href="#">copay</a> /visit                  |                                                                                                                                                                                                                                                                                                                                                                                                |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)               | 25% <a href="#">percentage copayment</a>     | Not covered                                        | All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units; <a href="#">Preauthorization</a> is required.                                                                                                                                                                                                                                   |
|                                                                           | Physician/surgeon fees                           | 25% <a href="#">percentage copayment</a>     | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                              | \$30 <a href="#">copay</a> /visit            | Not covered                                        | None                                                                                                                                                                                                                                                                                                                                                                                           |
|                                                                           | Inpatient services                               | 25% <a href="#">percentage copayment</a>     | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                |
| If you are pregnant                                                       | Office visits                                    | \$30 <a href="#">copay</a> /visit            | Not covered                                        | Cost sharing does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">percentage copayment</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Will cover 48-hour hospital stay for uncomplicated vaginal delivery and 96-hour hospital stay for uncomplicated caesarean section. |
|                                                                           | Childbirth/delivery professional services        | 25% <a href="#">percentage copayment</a>     | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                                           | Childbirth/delivery facility services            | 25% <a href="#">percentage copayment</a>     | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                |
| If you need help recovering or have other special health needs            | <a href="#">Home health care</a>                 | 25% <a href="#">percentage copayment</a>     | Not covered                                        | 60 visits per year                                                                                                                                                                                                                                                                                                                                                                             |
|                                                                           | <a href="#">Rehabilitation services</a>          | 25% <a href="#">percentage copayment</a>     | Not covered                                        | 35 visits per year. Includes chiropractic, physical therapy, speech therapy, and occupational therapy                                                                                                                                                                                                                                                                                          |
|                                                                           | <a href="#">Habilitation services</a>            | \$30 <a href="#">copay</a> /visit            | Not covered                                        | 25 visits per year                                                                                                                                                                                                                                                                                                                                                                             |
|                                                                           | <a href="#">Skilled nursing care</a>             | 25% <a href="#">percentage copayment</a>     | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                                           | <a href="#">Durable medical equipment</a>        | 25% <a href="#">percentage copayment</a>     | Not covered                                        | Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.                                                                                                                                                                                                                                                                                                          |
|                                                                           | <a href="#">Hospice services</a>                 | 25% <a href="#">percentage copayment</a>     | Not covered                                        | <a href="#">Preauthorization</a> is required.                                                                                                                                                                                                                                                                                                                                                  |

\* For more information about limitations and exceptions, see the [plan](#) or policy document at <https://exchange.imperialhealthplan.com/texas/individual-eoc/>

| Common Medical Event                          | Services You May Need      | What You Will Pay                            |                                                    | Limitations, Exceptions, & Other Important Information            |
|-----------------------------------------------|----------------------------|----------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------|
|                                               |                            | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                   |
| <b>If your child needs dental or eye care</b> | Children's eye exam        | No Charge                                    | Not covered                                        | Coverage limited to 1 exam/year.                                  |
|                                               | Children's glasses         | No Charge                                    | Not covered                                        | Coverage limited to 1 pair of glasses/year.                       |
|                                               | Children's dental check-up | No Charge                                    | Not covered                                        | Coverage limited to 2 dental check-ups & cleanings/calendar year. |

## 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 in cases of rape, incest, or when the life of the mother is endangered)
- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery
- Dental care (Adult)
- Infertility treatment (except diagnosis of the medical cause and surgery to treat medical cause)
- 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.)

- Chiropractic care (limited to 35 visits per year)
- Hearing aids (once every 3 years)

**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 are: Imperial Insurance Companies at 1-800-595-0619. You may also contact the Texas Department of Insurance at 1-800-578-4677 at 333 Guadalupe Street, Austin, TX 78707 or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://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](http://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: Texas Department of Insurance at 1-800-578-4677 or visit <https://www.tdi.texas.gov>. Additionally, a consumer assistance program can help you file your [appeal](#). Contact Texas Department of Insurance at 1-800-252-3439.

**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 1-800-595-0619.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-595-0619.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-595-0619.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijijigo holne' 1-800-595-0619.

*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 [percentage copayments](#)) 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](#) \$2,500
- [Specialist percentage copayment](#) \$60
- Hospital (facility) [percentage copayment](#)
- Other [percentage copayment](#)

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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing                         |                |
|--------------------------------------|----------------|
| <a href="#">Deductibles</a>          | \$2,000        |
| <a href="#">Copayments</a>           | \$40           |
| <a href="#">Percentage Copayment</a> | \$2,000        |
| What isn't covered                   |                |
| Limits or exclusions                 | \$60           |
| <b>The total Peg would pay is</b>    | <b>\$4,100</b> |

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$2,500
- [Specialist percentage copayment](#) \$60
- Hospital (facility) [percentage copayment](#)
- Other [percentage copayment](#)

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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing                         |                |
|--------------------------------------|----------------|
| <a href="#">Deductibles</a>          | \$900          |
| <a href="#">Copayments</a>           | \$700          |
| <a href="#">Percentage Copayment</a> | \$0            |
| What isn't covered                   |                |
| Limits or exclusions                 | \$20           |
| <b>The total Joe would pay is</b>    | <b>\$1,620</b> |

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$2,500
- [Specialist percentage copayment](#) \$60
- Hospital (facility) [percentage copayment](#)
- Other [percentage copayment](#)

This EXAMPLE event includes services like:  
[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing                         |                |
|--------------------------------------|----------------|
| <a href="#">Deductibles</a>          | \$2,000        |
| <a href="#">Copayments</a>           | \$300          |
| <a href="#">Percentage Copayment</a> | \$20           |
| What isn't covered                   |                |
| Limits or exclusions                 | \$0            |
| <b>The total Mia would pay is</b>    | <b>\$2,320</b> |

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-595-0619

\*Note: This [plan](#) has other [deductibles](#) for specific services included in this coverage example. See "Are there other [deductibles](#) for specific services?" row above.

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.