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 **1-855-579-EVRY**. 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 www.healthcare.gov/sbc-glossary or call **1-855-579-EVRY** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$**4,000 individual / $8,000 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. See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	Yes. Preventive care, routine prenatal and post-natal care, PCP, telemedicine.	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 https://www.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?	$7,000 individual / $14,000 family $1,500 individual / $3,000 family (Pharmacy out-of-pocket limit)	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 and healthcare this **plan** does not 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 **www.evryhealth.com** or call **1-855-579-EVRY** 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 specialist 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 non-urgent clinic	Primary care visit to treat an injury or illness	No charge after **deductible**	Not Covered	Virtual telehealth visits are available at no charge.
	Specialist visit	No charge after **deductible**	Not Covered	There may be a limitation or preauthorization requirement.
	Preventive care/screening/ immunization	No charge, **deductible** does not apply	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
	Retail Clinic (non-urgent)	25% **coinsurance** after **deductible**	Not Covered	None
If you have a test	Diagnostic test (x-ray, blood work)	No charge at physician office after **deductible**	Not Covered	Preauthorization may be required.
	Imaging (CT/PET scans, MRIs)	40% **coinsurance** after **deductible**	Not Covered	Preauthorization may be required. If you don't get preauthorization, payment for care may be denied.

If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.evryhealth.com/formulary	Generic drugs (Tier 1)	0% **coinsurance** for a 30-day supply (retail) 0% **coinsurance** for a 90-day supply (mail order)	Not Covered	Retail is limited to a 30-day supply. Mail order is limited to a 90-day supply. Preauthorization/step therapy may be required. If you don't get preauthorization, payment for care may be denied.
	Preferred brand drugs (Tier 2)	35% **coinsurance** for 30-day supply (retail) after **deductible**, 35% **coinsurance** for the 90-day supply (mail order) after **deductible**	Not Covered	
	Non-preferred brand drugs (Tier 3)	35% **coinsurance** for a 30-day supply (retail) after **deductible**, 35% **coinsurance** for a 90 day supply (mail order) after **deductible**	Not Covered	
	Specialty drugs (Tier 4)	35% **coinsurance** for Preferred Specialty Drug after **deductible**, 35% **coinsurance** for Non-Preferred Specialty Drug after **deductible**	Not Covered	Limited to a 30-day supply. Preauthorization/step therapy may be required. If you don't get preauthorization, payment for care may be denied.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% **coinsurance** after **deductible**	Not Covered	Preauthorization may be required.
	Physician/surgeon fees	25% **coinsurance** after **deductible**	Not Covered	Preauthorization may be required.

If you need immediate medical attention	Emergency room care	$300 **copay**/visit plus 40% **coinsurance** after **deductible**	$300 **copay**/visit plus 40% **coinsurance** after **deductible**	Emergency Room care by an Out-of-Network provider is covered if the services are for an emergency condition.
	Emergency medical transportation	25% **coinsurance** after **deductible**	25% **coinsurance** per transport after **deductible**	Preauthorization is required for non-emergency transportation. If you don't get preauthorization, payment for care may be denied. Emergency Transportation services by an Out-of-Network provider are covered if the services are for an emergency condition.
	Urgent care	40% **coinsurance** after **deductible**	40% **coinsurance** after **deductible**	None
If you have a hospital stay	Facility fee (e.g., hospital room)	40% **coinsurance** after **deductible**	Not Covered	Preauthorization is required. If you don't get preauthorization, payment for care may be denied. However, preauthorization is not required for emergency admissions.
	Physician/surgeon fees	40% **coinsurance** after **deductible**	Not Covered	Preauthorization is required. If you don't get preauthorization, payment for care may be denied. However, preauthorization is not required for emergency admissions.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge; 25% **coinsurance** (after **deductible)** may apply for certain outpatient services	Not Covered	Preauthorization is required for additional visits.
	Inpatient services	40% **coinsurance** after **deductible**	Not Covered	Preauthorization is required. If you don't get preauthorization, payment for care may be denied. However, preauthorization is not required for emergency admissions.

If you are pregnant	Office visits	No charge after **deductible**; **deductible** does not apply if preventive	Not Covered	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC that require preauthorization (e.g. ultrasound).
	Childbirth/delivery professional services	40% **coinsurance** after **deductible**	Not Covered	
	Childbirth/delivery facility services	40% **coinsurance** after **deductible**	Not Covered	
If you need help recovering or have other special health needs	Home health care	25% **coinsurance** after **deductible**	Not Covered	60 visits/calendar year. Preauthorization is required for additional visits.
	Rehabilitation services	No charge after **deductible**	Not Covered	35 visits/calendar year in total for physical therapy, speech therapy and occupational therapy. Preauthorization may be required. If you don't get preauthorization, payment for care may be denied.
	Habilitation services	No charge after **deductible**	Not Covered	
	Skilled nursing care	40% **coinsurance** after **deductible**	Not Covered	25 days/calendar year. Preauthorization may be required.
	Durable medical equipment	20% **coinsurance** for surgically implanted prosthetics after **deductible**, all others 50% **coinsurance** after **deductible**	Not Covered	Preauthorization may be required.
	Hospice services	No charge after **deductible** for home hospice; 40% **coinsurance** after deductible for inpatient hospice	Not Covered	Preauthorization may be required.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	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.)

- Infertility Treatment
- Abortion (except for a pregnancy that, as certified by a physician, places a woman in danger of death or a serious risk of substantial impairment of a major bodily function unless an abortion is performed)
- Cosmetic Surgery (except for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors or diseases when medically necessary)
- Long-Term Care
- Care when traveling outside the U.S.
- Private Nursing Duty
- Dental Care
- Routine Eye Care (Adult)
- Routine Foot Care (except in connection with diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture up to 5 visits per calendar year without preauthorization, after deductible
- Chiropractic Care up to 5 visits per calendar year without preauthorization, after deductible

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

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: for group health coverage contact the **plan**, Evry Health Insurance Company of Texas at 1-855-579-EVRY or visit www.evryhealth.com. For group health coverage subject to ERISA, contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA(3272) or www.dol.gov/ebsa/healthreform. For non-federal governmental group health **plans**, 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. Church **plans** are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law. 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 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: For group health coverage subject to ERISA: Evry Health Insurance Company of Texas at 1-855-579-EVRY or visit www.evryhealth.com, the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA(3272) or www.dol.gov/ebsa/healthreform, and the Texas Department of Insurance, Consumer Protection at 1-800-252-3439 or www.tdi.texas.gov. For non-federal government group health **plans** and church **plans** that are group health **plans**, Evry Health Insurance Company of Texas at 1-855-579-EVRY or www.evryhealth.com or contact the Texas Department of Insurance, Consumer Protection at 1-800-252-3439 or www.tdi.texas.gov. Additionally, a consumer assistance program can help you file your **appeal**. Contact the Texas Department of Insurance's Consumer Health Assistance Program at 1-800-252-3439 or visit www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/tx.html.

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 1-855-579-EVRY.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-579-EVRY.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-855-579-EVRY.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-579-EVRY.

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

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	$4,000
Specialist *copayment*	$0
Hospital (facility) *coinsurance*	40%
Other *coinsurance*	25%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$8,300**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$4,000
Copayments	$0
Coinsurance*	$1,720
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,780**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$4,000
Specialist *copayment*	$0
Hospital (facility) *coinsurance*	40%
Other *coinsurance*	25%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs (*generics including glucose meter*)

Total Example Cost	**$2,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,600
Copayments	$0
Coinsurance*	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,600**

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

The plan's overall deductible	$4,000
Specialist *copayment*	$0
Hospital (facility) *coinsurance*	$300+40%
Other *coinsurance*	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	**$5,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$4,000
Copayments	$300
Coinsurance	$600
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$4,900**

*Coinsurance applies to hospital facility component of total cost.

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