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 www.hfbenefits.com or www.optumrx.com or call 1-866-220-0126 or 1-844-783-1405. 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.hfbenefits.com or call 1-866-220-0126 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$200** person / **$400** family Tier 1 **$400** person / **$800** family Tier 2 **$1,500** person / **$3,000** family Tier 3 **$3,000** person / **$6,000** family Tier 4	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. Tier 1, Tier 2 and Tier 3 deductibles cross-apply.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	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?	**$1,000** person / **$2,000** family Tier 1 **$2,250** person / **$4,500** family Tier 2 **$4,250** person / **$8,500** family Tier 3 **Unlimited** person / **Unlimited** family Tier 4	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. Tier 1, Tier 2 and Tier 3 out-of-pocket maximums and prescription maximums cross-apply.
What is not included in the out-of-pocket limit?	Penalties, 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 www.hfbenefits.com or call 1-866-220-0126 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 (a 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.

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022)
(HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist?	No.	You can see the 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
		Tier 1	Tier 2	Tier 3	Tier 4	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$0 copay	$15 copay	$20 copay	50% coinsurance	Check what your plan covers in the plan document available by calling 1-866-220-0126.
	Specialist visit	$0 copay	$30 copay	$40 copay	50% coinsurance	
	Preventive care/screening/ immunization	No charge	No charge	No charge	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.
If you have a test	Diagnostic test (x-ray, blood work)	Office visit setting no charge; $20 copay outpatient	Office visit setting no charge; $40 copay outpatient	Office visit setting no charge; $60 copay outpatient	50% coinsurance	Cost sharing does not apply to certain preventive services.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	20% coinsurance	20% coinsurance	50% coinsurance	All Outpatient Advance Imaging done within Smith County must be done at UT Health
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available through **OptumRx** at www.OptumRX.com	Generic drugs	Retail: $10 copay per prescription Mail order or 90-day maintenance: $20 copay per prescription				$4,250 person / $8,500 family annual maximum out-of-pocket per calendar year (combined with medical out-of-pocket). Covers up to: a 30-day supply (retail); 1-90 day supply (mail order & maintenance medications); a 30-day supply (specialty). Once the annual out-of-pocket limit is met, you pay nothing for covered prescription medication.
	Preferred brand drugs	Retail: 20% copay, up to maximum of $50 per prescription Mail order or 90-day maintenance: 20% copay, up to maximum of $100 per prescription				
	Non-preferred brand drugs	Retail: 30% copay, up to maximum of $150 per prescription Mail order or 90-day maintenance: 30% copay, up to maximum of $300 per prescription				
	Specialty drugs	Retail: 30% copay, up to maximum of $200 per prescription Mail order: not available.				

[* For more information about limitations and exceptions, see the plan or policy document at www.hfbenefits.com.]

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1	Tier 2	Tier 3	Tier 4	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	20% coinsurance	20% coinsurance	50% coinsurance	None
	Physician/surgeon fees	10% coinsurance	20% coinsurance	20% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	$150 copay	$300 copay	$350 copay	$350 copay	Copay may be waived if admitted.
	Emergency medical transportation	10% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance after Tier 3 deductible	Tier 3 deductible applies to Tier 4 benefits.
	Urgent care	$0 copay	$30 copay	$40 copay	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	20% coinsurance	20% coinsurance	50% coinsurance	Preauthorization is required. If no preauthorization, benefits could be reduced by $500 of the total cost of the service. For additional facility restrictions review your plan document.
	Physician/surgeon fees	10% coinsurance	20% coinsurance	20% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$0 copay Office visits; 10% coinsurance outpatient	$15 copay Office visits; 20% coinsurance outpatient	$20 Copay Office visits; 20% coinsurance outpatient	50% coinsurance	Preauthorization is required for Partial hospitalization. If no preauthorization, benefits could be reduced by $500 of the total cost of the service.
	Inpatient services	10% coinsurance	20% coinsurance	20% coinsurance	50% coinsurance	Preauthorization is required. If no preauthorization, benefits could be reduced by $500 of the total cost of the service.
If you are pregnant	Office visits	$0 copay	$0 copay	$0 copay	$0 copay	Cost sharing does not apply to certain preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% coinsurance	20% coinsurance	20% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	20% coinsurance	20% coinsurance	50% coinsurance	

[* For more information about limitations and exceptions, see the plan or policy document at www.hfbenefits.com.]

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1	Tier 2	Tier 3	Tier 4	
If you need help recovering or have other special health needs	Home health care	10% Coinsurance	20% Coinsurance	20% Coinsurance	50% Coinsurance	100 visits per calendar year. Preauthorization is required. If no preauthorization, benefits could be reduced by $500 of the total cost of the service.
	Rehabilitation services	$20 copay	$30 copay	$40 copay	50% coinsurance	OT/PT/ST – 50 visit combined maximum per calendar year; does not apply to MH/SUD.
	Habilitation services	$20 copay	$30 copay	$40 copay	50% coinsurance	
	Skilled nursing care	10% coinsurance	20% coinsurance	20% coinsurance	50% coinsurance	60 Maximum days per calendar year. Preauthorization is required. If no preauthorization, benefits could be reduced by $500 of the total cost of the service.
	Durable medical equipment	10% coinsurance	20% coinsurance	20% coinsurance	50% coinsurance	Preauthorization is required for DME in excess of $500 for rentals or $1,500 for purchases. If you don't get preauthorization, benefits could be reduced by $500 per occurrence.
	Hospice services	10% coinsurance	20% coinsurance	20% coinsurance	50% coinsurance	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	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.)

- Cosmetic surgery
- Dental care (adult)
- Long-term care
- Private-duty nursing
- Routine eye care (adult)
- Routine foot care

[* For more information about limitations and exceptions, see the plan or policy document at www.hfbenefits.com.]

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery (Tier 1 only) • Chiropractic care (20 visit per calendar year)	• Hearing aids	• Weight loss program

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: BenefitConnect at 1-877-292-6272. 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: www.hfbenefits.com.

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 1-866-220-0126.]

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

Last updated: October 11, 2022

[* For more information about limitations and exceptions, see the plan or policy document at www.hfbenefits.com.]

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 and assumes use of **Tier 1 facilities and providers.**

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$200**
Specialist copayments	**$0**
Hospital (facility) coinsurance	**10%**
Other copayments/coinsurance	**10%**

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	$200
Copayments	$400
Coinsurance	$1,135
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,795**

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

The plan's overall deductible	**$200**
Primary care physician copayments	**$0**
Hospital (facility) coinsurance	**10%**
Other copayments/coinsurance	**10%**

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	$200
Copayments	$630
Coinsurance	$889
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,774**

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

The plan's overall deductible	**$200**
Specialist copayments	**$0**
Hospital (facility) coinsurance	**10%**
Other copayments/coinsurance	**10%**

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	$200
Copayments	$100
Coinsurance	$139
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$439**

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