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 by 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 https://www.dol.gov/ebsa/healthreform/ or call 1-866-220-0126 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$500** person / **$1,000** family Tier 1 **$1,000** person / **$2,000** family Tier 2 **$2,500** person/**$5,000** family Tier 3 **$5,000** person / **$10,000** family Tier 4	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. Tier 1, Tier 2 and Tier 3 deductibles cross-feed.
Are there services covered before you meet your deductible?	Yes. Preventive care and some primary 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 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?	**$2,000** person / **$4,000** family Tier 1 **$3,500** person/**$7,000** family, Tier 2 **$5,000** person / **$10,000** 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 3out-of-pocket limits cross-feed.
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 (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** you choose without permission from this plan.

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 (You will pay the least)	Tier 2	Tier 3	Tier 4 (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	$0 Copay per visit; Deductible Waived	$30 Copay per visit; Deductible Waived	$40 Copay per visit; Deductible Waived	50% Coinsurance	None
	Specialist visit	$0 Copay per visit; Deductible Waived	$45 Copay per visit; Deductible Waived	$60 Copay per visit; Deductible Waived	50% Coinsurance	None
	Preventive care/screening/ immunization	No charge; Deductible Waived	No charge; Deductible Waived	No charge; Deductible Waived	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.
If you have a test	Diagnostic test (x-ray, blood work)	Office visit setting no charge; Copay per visit outpatient setting: $25: Deductible Waived	Office visit setting no charge; Copay per visit outpatient setting: $35; Deductible Waived	Office visit setting no charge; Copay per visit outpatient setting: $75: Deductible Waived	50% Coinsurance	Cost sharing does not apply to certain preventive services.
	Imaging (CT/PET scans, MRIs)	10% Coinsurance	20% Coinsurance	30% Coinsurance	50% Coinsurance	All outpatient advanced imaging done within Smith County must be done at UT Health to be considered allowable.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% Coinsurance	20% Coinsurance	30% Coinsurance	50% Coinsurance	None
	Physician/surgeon fees	10% Coinsurance	20% Coinsurance	30% Coinsurance	50% Coinsurance	None
If you need immediate medical attention	Emergency room care	$150 Copay per visit: Deductible waived	$200 Copay per visit: Deductible Waived	$250 Copay per visit: Deductible Waived	$250 Copay per visit; Deductible Waived	Copay may be waived if admitted
	Emergency medical transportation	10% Coinsurance	20% Coinsurance	30% Coinsurance	30% Coinsurance (After Tier 3 deductible)	Tier 3 deductible applies to Tier 4 benefits;$25,000 Maximum benefit per occurrence Ambulance air
	Urgent care	$0 Copay per visit; Deductible Waived	$40 Copay per visit; Deductible Waived	$60 Copay per visit; Deductible Waived	50% Coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network	Out-of-Network	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com.	Generic drugs	Retail: $15 Copay Mail Order: $30 Copay	Not Covered	**$4,000** person/**$8,000** family out-of-pocket per calendar year (combined with medical). If a generic drug is available and you or your doctor chooses a brand-name drug, you will be responsible for the generic coinsurance or copay amount, plus the difference in cost between the brand dispensed and the generic. Prescription drugs covered through **OptumRx.** Covers up to a 30-day supply (retail); 1-90 day supply (mail order & Maintenance Medications); up to a 30-day supply (specialty); preferred diabetic test strips are covered at no cost Once the annual out-of-pocket limit is met, you pay nothing for covered prescription medication
	Preferred brand drugs	Retail: 20% Copay - max cost $70 Mail Order: 20% Copay - max cost $140		
	Non-preferred brand drugs	Retail: 30% Copay - max cost $225 Mail Order: 30% Copay - max cost $450		
	Specialty drugs	Retail: 30% Copay - max cost $250		

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1 (You will pay the least)	Tier 2	Tier 3	Tier 4 (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% Coinsurance	20% Coinsurance	30% Coinsurance	50% Coinsurance	Preauthorization is required. If no preauthorization, benefits could be reduced by $500 of the total cost of the service.
	Physician/surgeon fee	10% Coinsurance	20% Coinsurance	30% Coinsurance	50% Coinsurance	None
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	Office visit: $0 Copay per visit, Deductible waived; Other outpatient services: 10% Coinsurance	Office visit: $30 Copay per visit, Deductible waived; Other outpatient services: 20% Coinsurance	Office visit: $40 Copay per visit, Deductible waived; Other outpatient services: 30% Coinsurance	50% Coinsurance	Preauthorization is required for Partial hospitalization. If no preauthorization, benefits could be reduced by $500 of the total cost of the service for Partial hospitalization.
	Inpatient services	10% Coinsurance	20% Coinsurance	30% 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	No charge; Deductible Waived	No charge; Deductible Waived	No charge; Deductible Waived	50% Coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, deductible, copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% Coinsurance	20% Coinsurance	30% Coinsurance	50% Coinsurance	
	Childbirth/delivery facility services	10% Coinsurance	20% Coinsurance	30% Coinsurance	50% Coinsurance	

Common Medical Event	Services You May Need	What You Will Pay				Limitations, Exceptions, & Other Important Information
		Tier 1 (You will pay the least)	Tier 2	Tier 3	Tier 4 (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	10% Coinsurance	20% Coinsurance	30% Coinsurance	50% Coinsurance	100 Maximum 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	$30 Copay per visit; Deductible Waived	$45 Copay per visit; Deductible Waived	$60 Copay per visit; Deductible Waived	50% Coinsurance	OT/PT/ST- Combined 50 Maximum visits per calendar year
	Habilitation services	Office visit: $30 Copay per visit; Other settings: 10% Coinsurance	Office visit: $45 Copay per visit; Other settings: 20% Coinsurance	Office visit: $60 Copay per visit; Other settings: 30% Coinsurance	50% Coinsurance	None
	Skilled nursing care	10% Coinsurance	20% Coinsurance	30% 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	30% 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	30% 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	Long-term care	Routine foot care
Dental care (adult)	Private-duty nursing	Weight loss programs
Infertility treatment	Routine eye care (adult)	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
Acupuncture	Chiropractic care	Non-emergency care when traveling outside the U.S.
Bariatric surgery (Tier 1 only)	Hearing aids	

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: [insert State, HHS, DOL, and/or other applicable agency contact information]. 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: [insert applicable contact information from instructions].

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 1-800-826-9781.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-826-9781.]

[Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-826-9781.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-826-9781.]

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 (Tier 1) $500
- Specialist copayment (Tier 1) $0
- Hospital (facility) copayment (Tier 1) 10%
- Other coinsurance (Tier 1) 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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,760**

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

- The plan's overall deductible (Tier 2) $1,000
- Primary Care Physician copayment (Tier 2) $30
- Hospital (facility) copayment (Tier 2) 20%
- Other coinsurance (Tier 2) 20%

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$1,000
Copayments	$600
Coinsurance	$900
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,560**

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

- The plan's overall deductible (Tier 2) $1,000
- Specialist copayment (Tier 2) $45
- Hospital (facility) copayment (Tier 2) 20%
- Other coinsurance (Tier 2) 20%

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$1,000
Copayments	$180
Coinsurance	$90
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,270**

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: HealthFirst 1-866-219-1592.
*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 service.