



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](http://www.hfbenefits.com) or [www.optumrx.com](http://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 <u>deductible</u> ?	<p><b>\$200</b> person / <b>\$400</b> family Tier 1  <b>\$400</b> person / <b>\$800</b> family Tier 2  <b>\$1,500</b> person / <b>\$3,000</b> family Tier 3  <b>\$3,000</b> person / <b>\$6,000</b> family Tier 4</p>	<p>Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u>, each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u>.                      Tier 1, Tier 2 and Tier 3 deductibles cross-feed.</p>
Are there services covered before you meet your <u>deductible</u> ?	<p>Yes. <u>Preventive care</u> and some primary care services are covered before you meet your <u>deductible</u>.</p>	<p>This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u>. See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</p>
Are there <u>deductibles</u> for specific services?	<p>No.</p>	<p>You don't have to meet deductibles for specific services.</p>
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	<p><b>\$1,000</b> person / <b>\$2,000</b> family Tier 1  <b>\$2,000</b> person / <b>\$4,000</b> family Tier 2  <b>\$4,000</b> person / <b>\$8,000</b> family Tier 3  <b>Unlimited</b> person / <b>Unlimited</b> family Tier 4</p>	<p>The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u>, they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.                      Tier 1, Tier 2 and Tier 3 out-of-pocket limits cross-feed.</p>
What is not included in the <u>out-of-pocket limit</u> ?	<p>Penalties, <u>premiums</u>, <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>.</p>
Will you pay less if you use a <u>network provider</u> ?	<p>Yes. See <a href="http://www.hfbenefits.com">www.hfbenefits.com</a> or call 1-866-220-0126 for a list of <u>network providers</u>.</p>	<p>This <u>plan</u> uses a <u>provider network</u>. You will pay less if you use a <u>provider</u> in the <u>plan's network</u>. You will pay the most if you use an <u>out-of-network provider</u>, and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.</p>
Do you need a <u>referral</u> to see a <u>specialist</u> ?	<p>No.</p>	<p>You can see the <u>specialist</u> you choose without permission from this plan.</p>



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	\$15 Copay per visit; Deductible Waived	\$20 Copay per visit; Deductible Waived	50% Coinsurance	None
	<a href="#">Specialist</a> visit	\$0 Copay per visit; Deductible Waived	\$30 Copay per visit; Deductible Waived	\$40 Copay per visit; Deductible Waived	50% Coinsurance	None
	<a href="#">Preventive care/screening/immunization</a>	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	<a href="#">Diagnostic test</a> (x-ray, blood work)	Office visit setting no charge; Copay per visit outpatient setting: \$20; Deductible Waived	Office visit setting no charge; Copay per visit outpatient setting: \$40; Deductible Waived	Office visit setting no charge; Copay per visit outpatient setting: \$60; Deductible Waived	50% Coinsurance	Cost sharing does not apply to certain preventive services.
	Imaging (CT/PET scans, MRIs)	\$125 Copay per visit; Deductible Waived	\$200 Copay per visit; Deductible Waived	\$250 Copay per visit; Deductible Waived	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)	\$125 Copay per visit; Deductible Waived	\$200 Copay per visit; Deductible Waived	20% Coinsurance	50% Coinsurance	None
	Physician/surgeon fees	0% Coinsurance	20% Coinsurance	20% Coinsurance	50% Coinsurance	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$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
	<a href="#">Emergency medical transportation</a>	10% Coinsurance	20% Coinsurance	20% Coinsurance	20% Coinsurance (After Tier 3 deductible)	Tier 3 deductible applies to Tier 4 benefits; \$25,000 Max benefit per occurrence Ambulance air
	<a href="#">Urgent care</a>	\$0 Copay per visit; Deductible Waived	\$30 Copay per visit; Deductible Waived	\$40 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	
<p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.optumrx.com">www.optumrx.com</a>.</p>	Generic drugs	Retail: \$10 Copay Mail Order: \$20 Copay	Not Covered	<p><b>\$4,000</b> person / <b>\$8,000</b> family annual Maximum out-of-pocket per calendar year (Combined with medical out-of-pocket)</p> <p>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. Preferred diabetic test strips are covered at no cost.</p> <p>Prescription drugs covered through <b>OptumRx</b>. Covers up to a 30-day supply (retail); 1-90 day supply (mail order &amp; Maintenance Medications); up to a 30-day supply (specialty); preferred diabetic test strips are covered at no cost</p> <p>Once the annual out-of-pocket limit is met, you pay nothing for covered prescription medication</p>
	Preferred brand drugs	Retail: 20% Copay - max cost \$50 Mail Order: 20% Copay - max cost \$100		
	Non-preferred brand drugs	Retail: 30% Copay - max cost \$150 Mail Order: 30% Copay - max cost \$300		
	<a href="#">Specialty drugs</a>	Retail: 30% Copay - max cost \$200		

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)	\$250 Copay per admission; Deductible Waived	\$300 Copay per admission; Deductible Waived	20% 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	0% Coinsurance	20% Coinsurance	20% Coinsurance	50% Coinsurance	None
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	\$0 Copay per office visit; Deductible Waived Office visits; \$125 Copay per visit; Deductible Waived other outpatient services	\$15 Copay per office visit; Deductible Waived Office visits; \$200 Copay per visit; Deductible Waived other outpatient services	\$20 Copay per office visit; Deductible Waived Office visits; \$250 Copay per visit; Deductible Waived other outpatient services	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	\$250 Copay admission; Deductible Waived	\$300 Copay admission; Deductible Waived	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	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	20% Coinsurance	50% Coinsurance	
	Childbirth/delivery facility services	\$250 Copay per admission; Deductible Waived	\$300 Copay per admission; Deductible Waived	20% 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)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	10% Coinsurance	20% Coinsurance	20% 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.
	<a href="#">Rehabilitation services</a>	\$20 Copay per visit; Deductible Waived	\$30 Copay per visit; Deductible Waived	\$40 Copay per visit; Deductible Waived	50% Coinsurance	OT/PT/ST- Combined 50 Maximum visits per calendar year
	<a href="#">Habilitation services</a>	10% Coinsurance	20% Coinsurance	20% Coinsurance	50% Coinsurance	None
	<a href="#">Skilled nursing care</a>	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.
	<a href="#">Durable medical equipment</a>	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.
	<a href="#">Hospice services</a>	10% Coinsurance	20% Coinsurance	30% Coinsurance	50% Coinsurance	None
<b>If your child needs dental or eye care</b>	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](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: [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, kwijigo holne' 1-800-826-9781.]

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

**PRA Disclosure Statement:** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.



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) \$200
- [Specialist copayment \(Tier 1\)](#) \$0
- Hospital (facility) [copay](#) (Tier 1) \$250
- 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$200
<a href="#">Copayments</a>	\$250
<a href="#">Coinsurance</a>	\$550

*What isn't covered*

Limits or exclusions	\$0
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<b>The total Peg would pay is</b>	<b>\$1,000</b>
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**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) \$400
- Primary Care Physician [copayment \(Tier 2\)](#) \$30
- Hospital (facility) [copay](#) (Tier 2) \$300
- 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*)

<b>Total Example Cost</b>	<b>\$7,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles*</a>	\$400
<a href="#">Copayments</a>	\$1,400
<a href="#">Coinsurance</a>	\$0

*What isn't covered*

Limits or exclusions	\$20
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<b>The total Joe would pay is</b>	<b>\$1,820</b>
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**Mia's Simple Fracture**

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

- The [plan's](#) overall [deductible](#) (Tier 2) \$400
- [Specialist copayment \(Tier 2\)](#) \$30
- Hospital (facility) [copay](#) (Tier 2) \$300
- 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles*</a>	\$400
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$70

*What isn't covered*

Limits or exclusions	\$0
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<b>The total Mia would pay is</b>	<b>\$770</b>
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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.

