This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.hfbenefits.com or by calling 1-866-220-0109.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0** person / **$0** family for **ADP Only**; **$2,000** person / **$4,000** family for Access Direct **PHCS HD** In-Network **$5,000** person / **$10,000** family for Good Shepherd Medical Center **(GSMC)** & Non-Network Providers. Doesn't apply to benefits paid at 100% or penalties.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart on page 2 for how much you pay for covered services after you meet the **deductible**. **In-network deductibles cross apply.**
Are there other deductibles for specific services?	There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out–of–pocket limit on my expenses?	Yes. **$2,500** person / **$5,000** family for **ADP** **$4,500** person / **$9,000** family for **PHCS HD Network** providers **$6,350** person / **$12,700** family for **GSMC** **$8,500** person / **$17,000** family for Non-Network providers.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. **In-Network out-of-pockets cross apply**.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, penalties for failure to comply with the utilization management program, including any portion of a hospital stay that is not certified by utilization management program as being medically necessary, expenses in excess of any maximum benefit, expenses payable at 100%, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. The Non-Network out-of-pockets also exclude the deductibles. The In-Network out-of-pockets include the deductible, coinsurance, and copays for both the Medical and Rx benefits.
Is there an overall annual limit on what the plan pays?	No.	This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. The chart on page 2 describes *specific* coverage limits, such as limits on the number of office visits. **Payment for Renal Dialysis will not exceed 200% of Medicare Allowable.** Services for dialysis must be pre-certified at 1-800-625-6834.

Does this plan use a network of providers?	Yes. For Access Direct Providers visit www.adppo.com or call 1-800-259-3308. For PHCS Healthy Direction Providers visit www.phcs.com.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use Network **providers** by charging you lower **deductibles**, **co-payments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a In-Network Provider	Your Cost If You Use a Non-Network Provider – 200% of Medicare Allowable	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay / visit	50% coinsurance	Co-Payment applies to all services rendered and billed by the physician's office. (same day office visit, lab, x-ray, office surgery and allergy injections)
	Specialist visit	$25 copay / visit	50% coinsurance	

Common Medical Event	Services You May Need	Your Cost If You Use a In-Network Provider	Your Cost If You Use a Non-Network Provider – 200% of Medicare Allowable	Limitations & Exceptions
	Other practitioner office visit	30% coinsurance	50% coinsurance	**Includes Outpatient Therapeutic Treatment** received as a Hospital or other facility, or Physician's office, including but not limited to dialysis, intravenous chemotherapy, other intravenous infusion radiation therapy. Services for dialysis must be pre-certified at 1-800-625-6834.
	Preventive care/screening/immunization	No charge	50% coinsurance	Preventive Care shall include all preventive care services, including Immunizations, recommended by the United States Preventive Services Task Force (USPSTF). *See Plan Document for details.*
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	50% coinsurance	Administered or interpreted on an outpatient basis
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	Includes CT, PET, MRI's and Nuclear Medicine procedures.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.medtrackservices.com	Generic drugs	$20/prescription (retail), $60/prescription (P90 pharmacy) $60/prescription (mail order)		Covers up to a 30-day supply (retail prescription); 90-day supply (select P90 retail pharmacies); 90-day supply (mail order prescription). Out-of-network prescriptions are not covered. The In-Network out-of-pocket includes any any coinsurance, and Rx copays.
	Brand-Name Drugs	$40/prescription (retail), $120/prescription (P90 pharmacy) $120/prescription (mail order)		
	Non-Preferred Brand drugs	$60/prescription (retail) $180/prescription (P90 pharmacy) $180/prescription (mail order)		
	Specialty drugs	30% to a max of $500 for a 30 day supply; 30% to a max of $1,500 for a 90 days supply		

Common Medical Event	Services You May Need	Your Cost If You Use a In-Network Provider	Your Cost If You Use a Non-Network Provider – 200% of Medicare Allowable	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	————————none————————
	Physician/surgeon fees	30% coinsurance	50% coinsurance	————————none————————
If you need immediate medical attention	Emergency room services	**(Emergency)** 30% coinsurance after $300 per visit **(Non-emergency)** 50% coinsurance after $600 copay per visit		Copay waived if admitted
	Emergency medical transportation	30% coinsurance		————————none————————
	Urgent care	$50 copay/visit	50% coinsurance	————————none————————
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance, $0 deductible for ETMC Facility	50% coinsurance	Services must be pre-certified at 1-800-625-6834 in order to avoid a **$250** penalty per occurrence.
	Physician/surgeon fee	30% coinsurance	30% coinsurance	————————none————————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 copay/visit	50% coinsurance	————————none————————
	Mental/Behavioral health inpatient services	30% coinsurance	50% coinsurance	Services must be pre-certified at 1-800-625-6834 in order to avoid a **$250** penalty per occurrence.
	Substance use disorder outpatient services	$25 copay/visit	50% coinsurance	————————none————————
	Substance use disorder inpatient services	30% coinsurance	50% coinsurance	Services must be pre-certified at 1-800-625-6834 in order to avoid a **$250** penalty per occurrence.
If you are pregnant	Prenatal and postnatal care	30% coinsurance	50% coinsurance	Initial in-network visit to determine pregnancy will be paid under the office visit copay.

Common Medical Event	Services You May Need	Your Cost If You Use a In-Network Provider	Your Cost If You Use a Non-Network Provider – 200% of Medicare Allowable	Limitations & Exceptions
	Delivery and all inpatient services	30% coinsurance $0 deductible for ETMC Facility	50% coinsurance	Services must be pre-certified at 1-800-625-6834 for vaginal deliveries requiring more than a 48 hour stay and for cesarean section deliveries requiring more than a 96 hour stay.
If you need help recovering or have other special health needs	Home health care	No Charge	50% coinsurance	Limited to 60 days per calendar year.
	Rehabilitation services	30% coinsurance	50% coinsurance	Outpatient Rehabilitation limited to physical, occupational, speech, and manipulative therapy and **$1,500** each service per Calendar Year. Precertification required for inpatient services, extended care and Home Infusion Therapy. Call HMS at 1-800-625-6834.
	Habilitation services	30% coinsurance	50% coinsurance	Only covered if medically necessary.
	Skilled nursing care	No Charge	50% coinsurance	Limited to **$10,000** per calendar year. Precertification required for inpatient services. Call HMS at 1-800-625-6834.
	Durable medical equipment	30% coinsurance	50% coinsurance	Subject to Medical Necessity
	Hospice service	No Charge	50% coinsurance	Limited to **$20,000** Lifetime maximum.
If your child needs dental or eye care	Eye exam	Not covered except as defined under preventive		Not covered.
	Glasses	Not covered	Not covered	Not covered.
	Dental check-up	Not covered except as defined under preventive		Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- 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 (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care ($1,500 per calendar year)
- Hearing aids (maximum $1,000 each 36 month period)

Your Rights to Continue Coverage: If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-903-297-2500. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights: If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: the HealthFirst at 1-866-220-0109. You can also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage? The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard? The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does not meet the minimum value standard for the benefits it provides.**

Language Access Services: [Spanish (Español): Para obtener asistencia en Español, llame al -1-866-220-0109
[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-220-0109
[Chinese (中文): 如果需要中文的帮助， **请拨打这个号码[** 1-866-220-0109
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-220-0109

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,350
- **Patient pays** $2,190

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$20
Coinsurance	$2,020
Limits or exclusions	$150
Total	**$2,190**

Illustration is based on ETMC Facility Admission

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,000
- **Patient pays** $2,400

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays

Deductibles	$1,270
Copays	$1,050
Coinsurance	$0
Limits or exclusions	$80
Total	**$2,400**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.