Bell County Base Option 7624

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 11/01/2016 – 10/31/2017
Coverage for: Individual + Family | **Plan Type:** CC

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.swhp.org or by calling 1-800-321-7947.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,250** person / **$2,500** family Doesn't apply to preventive care	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 starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific, but see the chart starting on page 2 for other costs for services this plan covers..
Is there an out–of–pocket limit on my expenses?	**$3,750** person / **$7,500** family	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.
What is not included in the out–of–pocket limit?	Premiums, balance-billed 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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.swhp.org or call 1-800-321-7947** for a list of participating providers.	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 starting 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 4. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-800-321-7947 or visit us at www.swhp.org.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.swhp.org/glossary or call 1-800-321-7947 to request a copy.

- **Copayments** 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 participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay/visit	Not covered	——————none——————
	Specialist visit	$30 copay/visit	Not covered	——————none——————
	Other practitioner office visit	$30 copay/visit	Not covered	Physician Assistant or Nurse Practitioner
	Preventive care/screening/immunization	No charge	Not covered	——————none——————
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	——————none——————
	Imaging (CT/PET scans, MRIs)	20% after deductible	Not covered	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.swhp.org.	Generic drugs	$10 copay/retail $20 copay/ maintenance	Not covered	Covers up to a 34-day supply (retail prescription); up to a 90 day supply (mail order prescription)
	Preferred brand drugs	$40 copay/retail $80 copay/ maintenance	Not covered	If a brand name drug is dispensed when a generic is available, 50% coinsurance applies.
	Non-preferred brand drugs	Lesser of $100 or 50% / retail Lesser of $200 or 50% / maintenance	Not covered	Non-formulary: Greater of $100 or 50%/ maintenance not covered
	Specialty drugs	Level 1: 10% Level 2: 20% Level 3: 30% Level 4: 50%	Not covered	Medical deductible does apply. Some Specialty drugs may require prior authorization.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% after deductible	Not covered	——————none——————
	Physician/surgeon fees	20% after deductible	Not covered	——————none——————
If you need immediate medical attention	Emergency room services	$250 copay, plus 20% of charges	$250 copay, plus 20% of charges	——————none——————
	Emergency medical transportation	20% after deductible	20% after deductible	——————none——————
	Urgent care	$75 copay	$75 copay	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% after deductible	Not covered	——————none——————
	Physician/surgeon fee	20% after deductible	Not covered	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30 copay	Not covered	——————none——————
	Mental/Behavioral health inpatient services	20% after deductible	Not covered	Requires referral and approval of Medical Director.
	Substance use disorder outpatient services	$30 copay	Not covered	——————none——————
	Substance use disorder inpatient services	20% after deductible	Not covered	Requires referral and approval of Medical Director.
If you are pregnant	Prenatal and postnatal care	Prenatal: No charge Postnatal: $30 copay	Not covered	——————none——————
	Delivery and all inpatient services	20% after deductible	Not covered	——————none——————
If you need help recovering or have other special health needs	Home health care	$30 copay	Not covered	——————none——————
	Rehabilitation services	$30 copay	Not covered	Benefit maximum of 20 visits per calendar year, based upon medical necessity; additional 10 visits in home only
	Habilitation services	$30 copay	Not covered	Benefit maximum of 20 visits per calendar year, based upon medical necessity; additional 10 visits in home only
	Skilled nursing care	20% after deductible	Not covered	Pre-certification required.
	Durable medical equipment	50% after deductible	Not covered	——————none——————
	Hospice service	No charge	Not covered	——————none——————
If your child needs dental or eye care	Eye exam	$30 copay	Not covered	Limited to one exam per year
	Glasses	Not covered	Not covered	——————none——————
	Dental check-up	Not covered	Not covered	——————none——————

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.)**

- Altered sexual characteristics including sex change operations or any related services
- Blood, blood plasma, and other blood products
- Cosmetic and reconstructive procedures and treatments undertaken to improve or modify a Member's appearance except for mastectomy reconstruction following breast cancer surgery
- Custodial or domiciliary care
- Dental care
- Elective abortions, which are not necessary to preserve the health of the Member
- Elective treatment or elective surgery
- Experimental or investigational treatment
- Genetic testing
- Infertility treatment including any drug whose primary purpose is the treatment of infertility
- Mental health services or disorders are limited to those described in your evidence of coverage
- Non-covered benefits or services
- Cost of services in excess of the usual, customary, and reasonable charges
- Personal comfort items
- Physical and mental exams for employment, licenses, insurance, educational purposes or services for non-medically necessary special education and developmental programs
- Reversal of voluntary surgically-induced sterility; artificial insemination, in-vitro fertilization or family planning therapies
- Rehabilitation services and therapies are limited to those recommended by a Participating or Referral Physician as medically necessary
- Storage of bodily fluids and other body parts
- Experimental organ transplants and associated donor/procurement costs and artificial organs; e.g., heart
- Treatment received in State or Federal facilities or institutions or services or supplies provided by an employer or governmental agency or entity
- Vision corrective surgery including laser application
- War, insurrection, riot, disaster or epidemic
- Weight reduction surgery

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.)**

- Manipulative Therapy

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 1-800-321-7947. 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: [insert applicable contact information from instructions].

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-254-298-3489 durante el horario de 7:00 am a 9:00 pm.

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 meet the minimum value standard for the benefits it provides.**

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** $5,380
- **Patient pays** $2,160

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	$1250
Copays	$20
Coinsurance	$890
Limits or exclusions	$150
Total	**$2,160**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,220
- **Patient pays** $2,180

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	$1040
Copays	$1060
Coinsurance	$0
Limits or exclusions	$80
Total	**$2,180**

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.