This is only a summary. Please read the FEHB Plan brochure RI-73-881 that contains the complete terms of this plan. **All benefits are subject to the definitions, limitations, and exclusions set forth in the FEHB Plan brochure.** Benefits may vary if you have other coverage, such as Medicare. You can get the FEHB Plan brochure at https://fehb.swhp.org or by calling 1-800-321-7947.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$ _0_/Self Only $ _0_/Self Plus One $ _0__/Self and Family	You must pay all the costs up to the **deductible** amount before this plan begins to pay for certain 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** and for which services are subject to the **deductible**.
Are there other deductibles for specific services?	No.	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?	$ 4,500/Self Only $ 9,000/Self Plus One (embedded) $9,000/Self and Family (embedded)	The **out-of-pocket limit,** or catastrophic maximum, is the most you could pay during the year for your share of the cost of covered services. This limit helps you plan for health care expenses. The "per covered individual" amount is the most that any one member would have to pay, regardless of whether the individual is enrolled in Self Plus One, or Self and Family.
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 https://fehb.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. [We use the terms **preferred** or participating for **providers** in our **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.	
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See this plan's FEHB brochure for additional information about **excluded services**.

- **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	$20 copay per visit	Not covered	——————none——————
	Specialist visit	$45 copay per visit	Not covered	——————none——————
	Other practitioner office visit	$45 copay per visit	Not covered	——————none——————
	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)	$100 per procedure	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.fehb.swhp.org	Generic drugs	$6 copay/retail, non-maintenance $12 copay/mail order, maintenance	Not covered	Covers up to a 30-day supply or 100 units (retail); and the lesser of 90-day or 360 units (mail order).
	Preferred brand drugs	$50 copay/retail, non-maintenance $100 copay/mail order, maintenance	Not covered	Covers up to a 30-day supply or 100 units (retail); and the lesser of 90-day or 360 units (mail order).
	Non-preferred brand drugs	$100 or 50% copayment, whichever is greater	Not covered	Covers up to a 30-day supply or 100 units (retail, not available for maintenance). $250 cap on Non-preferred & Non-formulary.
	Specialty drugs	$250 copay/non-maintenance	Not covered	Failure to obtain pre-authorization may result in the denial of coverage for this service. Please consult www.swhp.org or call 1-800-321-7947 to verify pre-authorization requirements.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center) Physician/surgeon fees	$250 copay per procedure	Not covered	——————none——————
If you need immediate medical attention	Emergency room services	$250 copay per visit	$250 copay per visit	——————none——————
	Emergency medical transportation	$125 copay	$125 copay	——————none——————
	Urgent care	$50 copay per visit	$50 copay per visit	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room) Physician/surgeon fee	$250 per day	Not covered	$750 maximum

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	$20 copay	Not covered	
	Mental/Behavioral health inpatient services	$250 per day	Not covered	
	Substance use disorder outpatient services	$20 copay	Not covered	
	Substance use disorder inpatient services	$250 per day	Not covered	
If you are pregnant	Prenatal and postnatal care	Prenatal: No charge Postnatal: $45 copay	Not covered	——————none——————
	Delivery and all inpatient services	$250 per day	Not covered	$750 maximum
If you need help recovering or have other special health needs	Home health care	$45 copay	Not covered	——————none——————
	Rehabilitation services	$45 copay	Not covered	60 visits per calendar year
	Habilitation services	$45 copay	Not covered	60 visits per calendar year
	Skilled nursing care	$250 per day	Not covered	Requires pre-authorization. Limited to 60 days per calendar year. $750 maximum
	Durable medical equipment	30% of charges	Not covered	——————none——————
	Hospice service	No charge	Not covered	——————none——————
If your child needs dental or eye care	Eye exam	$45 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 this plan's FEHB brochure for other excluded services.)

- Acupuncture
- Chiropractic care
- Routine dental care
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Personal comfort items
- Routine Foot Care

Other Covered Services **(This isn't a complete list. Check this plan's FEHB brochure for other covered services and your costs for these services.)**

- Routine eye care (adult)
- Private duty nursing

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending on the circumstances, you may be eligible for a 31-day free extension of coverage, to convert to an individual policy, and to receive temporary continuation of coverage (TCC). Your TCC rights will 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. An individual policy may also provide different benefits than you had 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, see the FEHB Plan brochure, contact your HR office/retirement system, contact your plan at 1-800-321-7947 or visit www.opm.gov.insure/health.

Your Appeal Rights:

If you are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal**. For information about your **appeal** rights please see Section 3, "How you get care," and Section 8 "The disputed claims process," in your plan's FEHB brochure. If you need assistance, you can contact:

1-800-321-7947

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." **Coverage under this plan qualifies as 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). **The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.**

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.

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** $6,890
- **Patient pays** $650

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	$0
Coinsurance	$500
Limits or exclusions	$150
Total	**$650**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,885
- **Patient pays** $515

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	$0
Copays	$45
Coinsurance	$390
Limits or exclusions	$80
Total	**$515**

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.

Questions: Call 1-800-321-7947 or visit us at https://fehb.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 or call 1-800-321-7947 to request a copy.