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. 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. 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 get the FEHB Plan brochure at fehb.swhp.org and view the Glossary at healthcare.gov/sbc-glossary. You can call 1-844-633-5325 to request a copy of either document.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$300 / Self Only $600 / Self Plus One $600 / Self and Family	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. **[For family coverage, see instructions for additional applicable language.]**
Are there services covered before you meet your deductible?	Yes. Preventive care and ACA preventive drugs 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 other 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?	$5,500 / Self Only $11,000 / Self Plus One $11,000 / Self and Family	The out-of-pocket limit, or catastrophic maximum, is the most you could pay in a year for covered services. **[For family coverage, see instructions for additional applicable language.]**
What is not included in the out-of-pocket limit?	Premiums 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 swhp.org or call 844-633-5325 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 a referral.

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
		Participating Provider (You will pay the least)	Non-Participating Provider (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	Adult: $25 copayment per visit, deductible does not apply Pediatric: $25 copayment per visit, deductible does not apply	Not covered	None
	Specialist visit	$50 copayment per visit, deductible does not apply	Not covered	
	Preventive care/screening/ immunization	No charge, deductible does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (X-ray, blood work)	No charge, deductible does not apply	Not covered	None
	Imaging (CT/PET scans, MRIs)	10% after deductible	Not covered	Services requiring preauthorization that are not preauthorized will be denied. Refer to fehb.swhp.org or call 844-633-5325.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at fehb.swhp.org.	ACA preventive drugs	No charge, deductible does not apply	Not covered	Copayments are per 30-day supply. Maintenance drugs are allowed up to a 90-day supply for copayments if obtained through a Baylor Scott & White Pharmacy or participating pharmacy. Mail Order: Available for a 1- to 90-day supply. Non-maintenance drugs obtained through mail order are limited to a 30-day supply maximum. Some specialty drugs may require preauthorization. 30-day supply only. Formulary insulin prescriptions have a maximum copayment of $25 per prescription per 30-day supply.
	Tier 1: Preferred generic drugs	$10 copayment per prescription, deductible does not apply	Not covered	
	Tier 2: Preferred brand name drugs	30% of charges up to a maximum $75 copayment per prescription, deductible does not apply	Not covered	
	Tier 3: Non-preferred generic drugs and non-preferred brand name drugs	50% of charges up to a $200 copayment per prescription, deductible does not apply	Not covered	
	Tier 4: Specialty drugs	Tier 1: $400 copayment per prescription, deductible does not apply. Tier 2: $400 copayment per prescription, deductible does not apply. Tier 3: $600 copayment per prescription, deductible does not apply.	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% after deductible	Not covered	Services requiring preauthorization that are not preauthorized will be denied. Refer to fehb.swhp.org or call 844-633-5325.
	Physician/surgeon fees	No charge	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	10% after deductible	10% after deductible	Emergency room copayment waived if episode results in hospitalization for the same condition within 24 hours.
	Emergency medical transportation	$125 copayment per service after deductible	$125 copayment per service after deductible	None
	Urgent care	$50 copayment per visit	$50 copayment per visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% after deductible	Not covered	Services requiring preauthorization that are not preauthorized will be denied. Refer to fehb.swhp.org or call 844-633-5325.
	Physician/surgeon fees	No charge	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Adult: $25 copayment per visit, deductible does not apply Pediatric: $25 copayment per visit, deductible does not apply	Not covered	Services requiring preauthorization that are not preauthorized will be denied. Refer to fehb.swhp.org or call 844-633-5325.
	Inpatient services	10% after deductible	Not covered	
If you are pregnant	Office visits	$50 copayment per visit, deductible does not apply	Not covered	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	10% after deductible	Not covered	Inpatient care for the mother and newborn child in a health care facility is covered for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarean section.
	Childbirth/delivery facility services	10% after deductible	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	$50 copayment per visit, deductible does not apply	Not covered	Services requiring preauthorization that are not preauthorized will be denied. Refer to fehb.swhp.org or call 844-633-5325.
	Rehabilitation services	$50 copayment per visit, deductible does not apply	Not covered	Limited to 35 visits for rehabilitation services and 35 visits for habilitation services per plan year. Limit is combined for physical therapy, occupational therapy, and speech therapy. Limits do not apply for therapies for children with developmental delays, autism spectrum disorder and mental health services. Services requiring preauthorization that are not preauthorized will be denied. Refer to fehb.swhp.org or call 844-633-5325.
	Habilitation services	$50 copayment per visit, deductible does not apply	Not covered	
	Skilled nursing care	10% after deductible	Not covered	Limited to 60 days per plan year. Services requiring preauthorization that are not preauthorized will be denied. Refer to fehb.swhp.org or call 844-633-5325.
	Durable medical equipment	30% of charges	Not covered	Services requiring preauthorization that are not preauthorized will be denied. Refer to fehb.swhp.org or call 844-633-5325.
	Hospice services	No charge	Not covered	
If your child needs dental or eye care	Children's eye exam	$50 copayment per visit	Not covered	Limited to one eye exam per plan year.
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your FEHB Plan brochure for more information and a list of any other excluded services.)

- Acupuncture
- Dental care (Adult and Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Personal comfort items

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your FEHB Plan Brochure.)

- Chiropractic care (Limited to 35 visits per plan year)
- Hearing aids (Limited to one device per ear every 3 years)
- Private duty nursing when medically necessary and preauthorized (Limitations apply when used under Home Health Care)

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 Baylor Scott & White Care Plan at 844-633-5325 or swhp.org; Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 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: Baylor Scott & White Care Plan at 844-633-5325 or swhp.org; Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform; Texas Department of Insurance at 1-800-578-4677 or tdi.texas.gov.

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 844-633-5325.

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

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	**$300**
Specialist copayment	**$50**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**N/A**

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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$300
Copayments	$40
Coinsurance	$900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,300**

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

The plan's overall deductible	**$300**
Specialist copayment	**$50**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**N/A**

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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$0
Copayments	$400
Coinsurance	$900
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,320**

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

The plan's overall deductible	**$300**
Specialist copayment	**$50**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**N/A**

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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$300
Copayments	$600
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,100**

The plan would be responsible for the other costs of these EXAMPLE covered services.