Scott and White Health Plan

https://fehb.swhp.org

Customer Service 800-321-7947

Scott&White HEALTH PLAN
PART OF BAYLOR SCOTT & WHITE HEALTH

2017

A Health Maintenance Organization (standard option)

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides.

IMPORTANT
- Rates: Back Cover
- Changes for 2017: Page 13
- Summary of benefits: Page 69

Region 1 Serving the Central and West Texas Areas

Region 2 Serving the North Texas Area

Enrollment in these plans is limited.

You must live or work in the Scott and White Health Plan geographic service area to enroll. Please see Section 1 under Service Area for a list of counties for our two service areas.

ACCREDITED NCQA HEALTH PLAN COMMENDABLE

Enrollment Codes for Central and West Texas participants:

A84 Standard Option - Self only

A86 Standard Option - Self + One

A85 Standard Option - Self and Family

Enrollment Codes for North Texas participants:

P84 Standard Option - Self only

P86 Standard Option - Self + One

P85 Standard Option - Self and Family

FEHB
Federal Employees Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

RI 73-881

Important Notice from Scott and White Health Plan (SWHP) About Our Prescription Drug Coverage and Medicare

The Office of Personnel Management (OPM) has determined that the SWHP's prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 through December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 800-772-1213, (TTY:) 800-325-0778.

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help.
- Call 800-MEDICARE 800-633-4227, (TTY:) 877-486-2048.

Table of Contents

Introduction

This brochure describes the benefits of Scott and White Health Plan (SWHP) under our contract (CS 2942) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. This plan is underwritten by SWHP. Customer service may be reached at 800-321-7947 or through our website: https://fehb.swhp.org. The address for SWHP administrative offices is:

Scott and White Health Plan
1206 West Campus Drive
Temple, TX 76502

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One coverage, you and one eligible family member that you designate when you enroll are entitled to these benefits. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2017, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2017, and changes are summarized on page 13. Rates are shown at the end of this brochure.

Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

The ACA establishes a minimum value for the 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.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples,

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member, "we" means SWHP.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care providers, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.

- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Periodically review your claim history for accuracy to ensure we have not been billed for services that you did not receive.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.

If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 800-321-7947 and explain the situation.
- If we do not resolve the issue

CALL - THE HEALTH CARE FRAUD HOTLINE
877-499-7295
OR go to www.opm.gov/oig

You can also write to:

United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise)
  - Your child age 26 or over (unless he/she is disabled and incapable of self-support prior to age 26)
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage, (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Discrimination is Against the Law

Discrimination is Against the Law

The FEHB plan complies with applicable Federal civil rights laws, to include both Title VII and Section 1557 of the ACA. Pursuant to Section 1557 the FEHB plan does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, or sex (including pregnancy and gender identity).

Preventing medical mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own health care and that of your family members by learning more about and understanding your risks. Take these simple steps:

1. **Ask questions if you have doubts or concerns.**

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you take notes, ask questions, and understand answers.

2. **Keep and bring a list of all the medicines you take.**

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines and dosage that you take, including non-prescription (over-the-counter) medicines and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as to latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask your pharmacist about the medication if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.
- Understand both the generic and brand names of your medication. This helps ensure you don't receive double dosing from taking both a generic and a brand. It also helps prevent you from taking a medication to which you are allergic.

3. **Get the results of any test or procedure.**

- Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, through the Plan or Provider's portal?
- Don’t assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.
- Ask what the results mean for your care.

4. **Talk to your doctor about which hospital or clinic is best for your health needs.**

- Ask your doctor about which hospital or clinic has the best care and results for your condition if you have more than one hospital or clinic to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital or clinic.

5. **Make sure you understand what will happen if you need surgery.**

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
  - Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
  - "Exactly what will you be doing?"
  - "About how long will it take?"

- "What will happen after surgery?"
- "How can I expect to feel during recovery?"

- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

For more information on patient safety, please visit:

- http://www.jointcommission.org/speakup.aspx. The Joint Commission's Speak Up™ patient safety program.
- http://www.jointcommission.org/topics/patient_safety.aspx. The Joint Commission helps health care organizations to improve the quality and safety of the care they deliver.
- www.ahrq.gov/patients-consumers/. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org/. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions ("Never Events")

When you enter the hospital for treatment of one medical problem, you don't expect to leave with additional injuries, infections or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, cn indicate a significant problem in the safety and credibility of a health care facility. these conditions and errors are sometimes called "Never Events" or "Serious Reportable Events."

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores, and fractures, and to reduce medical errors that should never happen. When such an event occurs, neither you nor your FEHB plan will incur costs to correct the medical error.

You will not be billed for inpatient services related to treatment of specific hospital-acquired conditions or for inpatient services needed to correct Never Events, if you use SWHP contracted providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

FEHB Facts

Coverage information

- **No pre-existing condition limitation** — We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

- **Minimum essential coverage (MEC)** — Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard**

  Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.

- **Where you can get information about enrolling in the FEHB Program**

  See www.opm.gov/healthcare-insurance for enrollment information as well as:

  - Information on the FEHB Program and plans available to you
  - A health plan comparison tool
  - A list of agencies that participate in Employee Express
  - A link to Employee Express
  - Information on and links to other electronic enrollment systems

  Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans,* brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

  - When you may change your enrollment;
  - How you can cover your family members;
  - What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
  - When your enrollment ends; and
  - When the next Open Season for enrollment begins.

  We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact your employing or retirement office.

- **Types of coverage available for you and your family**

  Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

  If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event.

  The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

  Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26.

  If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

If you have a qualifying life event (QLE) - such as marriage, divorce, or the birth of a child -outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/ payroll office, or retirement office.

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below. A Self Plus One enrollment covers you and your spouse, or one other eligible family ember as described in the chart below.

Children	Coverage
Natural children, adopted children, and stepchildren	Natural, adopted children and stepchildren (including children of same-sex domestic partners in certain states) are covered until their 26th birthday.
Foster children	Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.
Children Incapable of self-support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Married children	Married children (but **NOT** their spouse or their own children) are covered until their 26th birthday.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay. You can find additional information at www.opm.gov/healthcare-insurance.

- **Children's Equity Act**

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll in Self Plus One or Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;

- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children.

If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2017 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2016 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

If your enrollment continues after you are no longer eligible for coverage, (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

- **When you retire**

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

- **When FEHB coverage ends**

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment, or
- You are a family member no longer eligible for coverage.

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC).

- **Upon divorce**

  If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* or other information about your coverage choices. You can also download the guide from OPM's website, www.opm.gov/healthcare-insurance/healthcare/plan-information/guides.

- **Temporary Continuation of Coverage (TCC)**

  If you leave Federal service, Tribal employment, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). The Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal or Tribal job, if you are a covered dependent child and you turn 26, etc.

  You may not elect TCC if you are fired from your Federal or Tribal job due to gross misconduct.

  Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* from your employing or retirement office or from www.opm.gov/healthcare-insurance/healthcare/plan-information/guides. It explains what you have to do to enroll.

  Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a new kind of tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHB Program coverage.

- **Finding replacement coverage**

  In lieu of offering a non-FEHB plan for conversion purposes, we will assist you, as we would assist you in obtaining a plan conversion policy, in obtaining health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace. For assistance in finding coverage, please contact us at 800-321-7947 or visit our website at: **https://fehb.swhp.org** .

- **Health Insurance Marketplace**

  If you would like to purchase health insurance through the Affordable Care Act's Health Insurance Marketplace, please visit **www.HealthCare.gov**. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

Section 1. How this plan works

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. We are solely responsible for the selection of these providers in your area. Contact us for a copy of our most recent provider directory.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

General features of our Standard Option

We have Open Access benefits

Our HMO offers Open Access benefits. This means you can receive covered services from a participating provider without a required referral from you primary care physician or by another participating provider in the network.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance.

Health education resources and account management tools

Health education resources and account management tools are available on our website at https://fehb.swhp.org.

- Wellness programs are available online or by calling Customer Service at 800-321-7947.
- You can access your claims and explanations of benefits (EOBs) by visiting https://fehb.swhp.org and logging in to the SWHP member portal**.**
- You can view, display and order ID cards.

Your rights and responsibilities

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, and our providers. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Scott and White Health Plan began operation in January of 1982 as a not-for profit Health Maintenance Organization (HMO).
- Scott and White Health Plan is a privately owned, not-for-profit community-based health maintenance organization and does not include any partners.

Your are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities by visiting our website, fehb.swhp.org.

If you want more information about us, call 800- 321-7947, or write to Scott and White Health Plan, 1206 West Campus Drive, Temple, TX 76502. You may also visit our website at: fehb.swhp.org.

By law, you have the right to access your personal health information (PHI). For more information regarding access to PHI, visit our website at: fehb.swhp.org. You can also contact us to request that we mail a copy regarding access to PHI.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Service Area

To enroll in this Plan, you must live in or work in our service areas. This is where our providers practice. Scott and White Health Plan has two service areas for the FEHB program. Our service area include Central and West Texas, and North Texas.

The following counties comprise our **Central and West Texas** service area:

Austin, Bastrop, Bell, Blanco, Bosque, Brazos, Burleson, Burnet, Caidwell, Coke, Coleman, Concho, Coryell, Crockett, Falls, Fayette, Freestone, Grimes, Hamilton, Hays, Hill, Irion, Kimble, Lampasas, Lee, Leon, Limestone, Liano, Madison, Mason, McCulloch, McLennan, Menard, Milam, Mills, Reagan, Robertson, Runnels, San Saba, Schleicher, Sterling, Sutton, Tom Green, Travis, Walker, Waller, Washington and Williamson.

The following counties comprise our **North Texas** service area:

Collin, Dallas, Denton, Ellis, Erath, Hood, Johnson, Rockwall, Somervell, and Tarrant.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other health care services out of our service area unless the services have prior plan approval.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. Changes for 2017

Do not rely only on these change descriptions; this Section is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

PROGRAM-WIDE CHANGES

- There are no program-wide changes for 2017.

BENEFIT CHANGES

- Catastrophic protection out-of-pocket maximum — The Plan will decrease the self only total out of pocket maximum from $5,500 to $4,500, increase the self plus one total out of pocket maximum from $7,000 to $9,000, and increase the self and family total out of pocket maximum from $7,000 to $9,000.
- Emergency Room — The Plan will increase the emergency room copayment from $150 per visit to $250 per visit.

BENEFIT CLARIFICATIONS

- We have removed the exclusion for services, drugs, or supplies related to sex transformations.

SERVICE AREA

- Scott and White Health Plan expanded the service area to include ten counties in North Texas (see previous page). The expanded service includes separate rate information (see back cover).

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation letter (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 800-321-7947 or write to us at:

Scott and White Health Plan
1206 West Campus Drive
Temple, TX 76502

You may also request replacement cards through our website: https://fehb.swhp.org.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments and/or coinsurance. We are an Open Access health plan, so you can receive covered services from a participating provider without a referral from a primary care physician or by another participating provider in the network.

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.

We list Plan providers in the provider directory, which we update monthly on our website, https://fehb.swhp.org.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update monthly on our website, https://fehb.swhp.org.

What you must do to get covered care

Now that you have chosen SWHP, your next choice will be deciding who will provide most of your health care services. SWHP is an Open Access Health Plan. A member can go to any network provider without a referral.

- **Primary care**

Members may choose a network primary care physician (PCP) if they would like, but PCP designation is not required by SWHP. If you choose a PCP, you may choose from the following:

- Family Medicine doctors treat all age groups from newborn to the elderly
- Internal Medicine doctors treat patients 18 age or older
- Pediatric doctors treat children up to age 18

In selecting a PCP, consider which clinic or doctor would be most convenient to meet your own medical needs. You and your dependents may select his or her own PCP. You can change your PCP at any time by simply contacting Customer Service or by going to our website, https://fehb.swhp.org.

- **Specialty care**

All non-emergent medical care must be provided by SWHP network providers. SWHP does not require a referral from a primary care physician before you can access a specialist. Simply call the specialist's office and make an appointment.

Please note: Due to the nature of some specialties, some physician offices may require a referral prior to making your appointment. This is the choice of that physician's office and not a requirement of SWHP.

Behavioral Health Services as well as certain other services may require prior authorization through SWHP Health Services. Examples of services, procedures, or tests that may require prior notification and/or authorization by SWHP are listed on page 16.

Here are some other things you should know about specialty care:

- If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call Health Services and they will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic and disabling condition and lose access to your specialist because we:
  - terminate our contract with your specialist for other than cause;
  - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program plan; or
  - reduce our service area and you enroll in another FEHB plan;

You may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

- **Hospital care**

For elective hospital admissions and certain types of procedures, you need a prior authorization from the SWHP Health Services before the day of the procedure, if you want to be sure SWHP will pay for the hospital and procedure. Each day you are in the hospital, SWHP nurses and Medical Directors review with your physician the level of care you require and work with him/her to determine the amount of time you need to stay in the hospital.

If you are hospitalized as a result of the emergency, you should contact the SWHP Health Services within 24 – 48 hours of any admission at 888-316-7947. Coverage for continued treatment is assured when approval is obtained from the SWHP Medical Director through the Health Services. SWHP will approve or deny the requested post-stabilization treatment within one hour if contacted by the provider or facility. Emergency care in a hospital emergency room requires a copayment**,** which will be waived if hospital admission occurs within 24 hours.

- **If you are hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 800-321-7947. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- you are discharged, not merely moved to an alternative care center;
- the day your benefits from your former plan run out; or
- the 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

You need prior Plan approval for certain services

For elective hospital admissions and certain types of procedures listed under "Other Services," you need a prior authorization from the SWHP Health Services before the day of the procedure, if you want to be sure SWHP will pay for the hospital and procedure. You must get prior approval for certain services. Failure to do so could result in denial of benefits.

- **Inpatient Hospital Admission**

Precertification is the process by which – prior to your inpatient hospital admission – we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition.

- **Other services**

For certain services, your physician must obtain prior approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.

Notification requested:

1. Acute (contracted) hospital admissions (medical, surgical, behavioral health)
2. Admissions to inpatient or outpatient (contracted) hospice programs

Prior Authorization required:

All services requested to be provided by non-contracted providers must have prior authorization.

1. Admissions to LTAC, Rehabilitation, and SNF facilities
2. Admissions to behavioral health/substance abuse residential, partial hospitalization, and day programs (not office visits to contracted providers)
3. Neuropsychological and psychological testing
4. Applied behavioral analysis therapy
5. Outpatient electroconvulsive therapy (ECT)
6. Solid organ and stem cell transplants (Pre-Transplant Eval; Transplant; Post-Transplant Care)
7. Weight loss (bariatric) surgeries (if a covered benefit, not covered by many plans)
8. Procedures which may be considered cosmetic and thus not covered (e.g. face lift, brow lift, blepharoplasty, liposuction, abdominoplasty, breast reconstruction (not associated with medically indicated mastectomy), surgery for gynecomastia, rhinoplasty, genioplasty, treatment of varicose veins, etc.)
9. Orthognathic surgery
10. Treatments for sleep apnea (other than CPAP/CPAP-related supplies)
11. Home health services, including all requests for hourly or private duty nursing
12. Durable medical equipment (DME) – See Addendum A for specific items
13. Orthotics and prosthetics – See Addendum B for specific items
14. Spinal fusion and vertebroplasty
15. X-Stop Spacer for Spinal Stenosis
16. Artificial Disc Implantation/Replacement
17. Ventricular assist devices (VAD)

18. Genetic testing (Except chromosome testing)
19. Intrathecal Pain Pump Implantation/Therapy
20. Spinal Stimulators
21. Vagal Nerve Stimulators
22. Fixed Wing or Jet Medical Transports
23. IVIG Therapy
24. Lung Volume Reduction Surgery
25. Transaortic or Transapical Valve Insertion or Replacement (TAVI/TAVR)
26. Insulin Pumps and/or Continuous Glucose Monitors
27. Bone-Anchored Hearing Aids (BAHA)
28. Cochlear Implants
29. Dental Services and Anesthesia for Dental Services
30. Epidural Adhesiolysis

Addendum A - Durable Medical Equipment (purchase or rental):

- Oral appliances
- Electric, semi-electric, air fluidized, and advanced technology beds and related equipment
- Oxygen and related equipment
- Ventilators and related equipment
- High frequency chest wall oscillation air-pulse generator system; including vest, hose, and related equipment
- Bone stimulators
- Spinal Cord Stimulators
- Functional neuromuscular stimulation, transcutaneous stimulation of sequential muscle groups of ambulation with computer control, entire system
- Functional electrical stimulation, transcutaneous stimulation of nerve and/or muscle groups, complete system
- Power wheelchairs and related equipment
- Power operated vehicles and related equipment
- Custom made and specially sized wheelchairs and related equipment
- Dialysis equipment
- Defibrillators and related equipment (includes chest/vest defibrillators)
- Non-specific, miscellaneous, and unlisted DME codes

Addendum B – Orthotics and Prosthetics

- Breast implants (unless status post medically indicated mastectomy)
- Lower and upper limb prosthetics (including myoelectric and microprocessor controlled) and related equipment/supplies
- Facial, nasal, and auricular prostheses
- Non-specific, miscellaneous, and unlisted orthotic and prosthetic codes

How to request precertification for an admission or get prior authorization for Other services

First, your physician, your hospital, you, or your representative, must call us at 888-316-7947 before admission or services requiring prior authorization are rendered.

Next, provide the following information:

- enrollee's name and Plan identification number;
- patient's name, birth date, identification number and phone number;
- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting physician;
- name of hospital or facility; and
- number of days requested for hospital stay.

- **Non-urgent care claims**

For non-urgent care claims, we will tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15 day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent care claims**

If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether it is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to provide notice of the specific information we need to complete our review of the claim. We will allow you up to 48 hours from the receipt of this notice to provide the necessary information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) to end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 888-316-7947. You may also call OPM's Health Insurance 3 at 202-606-0737 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 888-316-7947. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

- **Emergency inpatient admission**

If you are hospitalized as a result of an emergency, you should contact the SWHP Health Services within 24 – 48 hours of any admission at 888-316-7947. Coverage for continued treatment is assured when approval is obtained from the SWHP Medical Director through SWHP Health Services. SWHP will approve or deny the requested post-stabilization treatment within one hour if contacted by the provider or facility. Emergency care in a hospital emergency room requires a copayment**,** which will be waived if hospital admission occurs within 24 hours.

- **Maternity care**

For each person covered for maternity/childbirth benefits, we will provide inpatient care for the mother and her newborn child in a healthcare facility for a minimum of:

- 48 hours following an uncomplicated vaginal delivery, and
- 96 hours following an uncomplicated delivery by cesarean section.

This benefit does not require a covered female who is eligible for maternity/childbirth benefits to (a) give birth in a hospital or other healthcare facility; or (b) remain in a hospital or other healthcare facility for the minimum number of hours following birth of the child.

If a covered mother or her newborn child is discharged before the 48 or 96 hours has expired, we will provide coverage for post delivery care. Post delivery care includes parent education, assistance and training in breast-feeding and bottle-feeding, and the performance of any necessary and appropriate clinical tests. Care will be provided by a physician, registered nurse, or other appropriate licensed healthcare provider, and the mother will have the option of receiving the care at her home, the healthcare provider's office, or a healthcare facility.

- **If your treatment needs to be extended**

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

What happens when you do not follow the precertification rules when using non-network facilities

Without preauthorization, SWHP does not pay for out-of-network elective procedures, or treatment for minor illness. SWHP will not assume financial responsibility for out-of-network treatment if you are well enough to return to a SWHP provider or facility.

SWHP out-of-network benefits are limited to accidental injuries and sudden illnesses.

When seeking treatment in an out-of-network emergency room, provide your member identification card. This will speed up the processing and payment of your bill by SWHP. This will also allow the treating physician to discuss your emergency care with your provider if necessary.

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

If you disagree with our pre-service claim decision

If you have a pre-service claim and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below.

If you have already received the service, supply, or treatment, then you have a post-service claim and must follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent care claim**

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to:

1. Precertify your hospital stay or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or
2. Ask you or your provider for more information.

   You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

   If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your costs for covered services

This is what you will pay out-of-pocket for covered care:

Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., coinsurance and copayments) for the covered care you receive.
Copayments	A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services. Example: When you see your primary care physician, you pay a copayment of $20 per office visit, and when you go in to an Urgent Care center, you pay $45 per visit.
Deductible	We do not have a deductible.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. Example: In our Plan, you pay 30% of our allowance for durable medical equipment.
Differences between our Plan allowance and the bill	After your (copayments and coinsurance) total $4,500 for self only, $9,000 for self plus one, or $9,000 per family enrollment in any calendar year, you do not have to pay any more for covered services. Be sure to keep accurate records of your copayments since you are responsible for informing us when you reach the maximum.
Your catastrophic protection out-of-pocket maximum	After your (copayments and coinsurance) total **$4,500 for self only**, **$9,000 for self plus one**, or **$9,000 for self and family** enrollment in any calendar year, you do not have to pay any more for covered services. Be sure to keep accurate records of your copayments since you are responsible for informing us when you reach the maximum.
Carryover	If you changed to this Plan during open season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your old plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your old plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.
When Government Facilities Bill Us	Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Section 5. Standard Option Benefits

See page 13 for how our benefits changed this year. Page 69 is a benefits summary of the Standard Option. Make sure that you review the benefits that are available.

Section 5. Standard Option Benefits Overview

This Plan offers a Standard Option. The benefit package is described in Section 5. Make sure that you review the benefits that are available.

The Standard Option Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the *general exclusions* in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about Standard Option benefits, contact us at 800-321-7947 or on our website at https://fehb.swhp.org.

Unique features of our Standard Option:

- No deductible
- Low copays or coinsurance for most services
- No charge for preventive care, lab, x-ray, and non-routine mammograms
- Only $6 for preferred generic drugs
- All wellness programs are no charge to members. Programs include:
  - Online Lifestyle Management Programs - Balance, Nourish, Relax, Breathe, Care for Depression, Dream, Care for Your Health, and Care for Pain
  - Health coaches - direct access to a coach for help on over 65 different diseases and conditions
  - Shared decision-making - gives the member reliable tools and information to better make decisions with their physicians on treatment options they may have been given related to “preference sensitive” conditions.
- 24 hour nurse line included at no charge
- Customer service available from 7 am to 8 pm Central Time, 7 days a week

Section 5(a). Medical services and supplies provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You Pay
Diagnostic and treatment services	**Standard**
Professional services of physicians • In physician's office	$20 per visit to a primary care physician $45 per visit to specialist
Professional services of physicians • In an urgent care center • During a hospital stay • In a skilled nursing facility • Office medical consultations • Second surgical opinion	$50 per visit to urgent care center $250 per day/$750 copay max per admit for inpatient hospital stay
Not covered: Chiropractic services.	*All charges*
Lab, X-ray and other diagnostic tests	**Standard**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • Ultrasound • Electrocardiogram and EEG • BRCA testing - Per the PPACA, the Plan will cover BRCA testing for women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2.	Nothing
CT Scans MRI Angiograms Myelography PET Scans	$100 per procedure

Lab, X-ray and other diagnostic tests - continued on next page

Benefit Description	You Pay
Lab, X-ray and other diagnostic tests (cont.)	**Standard**
Stress Tests	$100 per procedure
Preventive care, adult	**Standard**
Routine physical annually which includes: • Total Blood Cholesterol • Colorectal Cancer Screening, including - Fecal occult blood test - Sigmoidoscopy screening – every five years starting at age 50 - Double contrast barium enema – every five years starting at age 50 - Colonoscopy screening – every ten years starting at age 50 • Tobacco cessation counseling • Obesity screening and counseling • Lung cancer screening • Depression screening • Diabetes screening • Blood Pressure screening	Nothing
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	Nothing
Well woman care - including, but not limited to: • Routine Pap test • Human papillomavirus testing for women age 30 and up once every three years • Annual counseling for sexually transmitted infections. • Annual counseling and screening for human immune-deficiency virus. • Contraceptive methods and counseling • Screening and counseling for interpersonal and domestic violence. • BRCA risk assessment and genetic counseling	Nothing
Routine mammogram – covered for women age 40 and older, as follows: • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years	Nothing
Routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC): • Tetanus-diphtheria (Td) booster – once every 10 years, ages19 and over (except as provided for under Childhood immunizations) • Influenza vaccine, annually • Pneumococcal vaccine, age 65 and older Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm and HHS at www.healthcare.gov/prevention. CDC: http://www.cdc.gov/vaccines/schedules/index.html	Nothing

Preventive care, adult - continued on next page

Benefit Description	You Pay
Preventive care, adult (cont.)	**Standard**
Please refer to the specific link to women's preventive services. https://www.healthcare.gov/preventive-care-women/	
Not covered: Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges*
Preventive care, children	**Standard**
• Childhood immunizations as recommended by the Centers for Disease Control and Prevention (CDC). •	Nothing
• Well-child care charges for routine examinations, immunizations and care (up to age 22) • Examinations, such as: - Eye exams through age 17 to determine the need for vision correction, which include: • one refraction annually • examinations for amblyopia and strabismus – limited to one screening examination (ages 3 through 5) - Hearing exams through age 17 to determine the need for hearing correction, which include: • one hearing test annually - Examinations done on the day of immunizations (ages 3 up to age 22) - Obesity screening age 6 and older - Depression screening adolescents aged 12 to 18 years Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm and HHS at www.healthcare.gov/prevention. CDC: http://www.cdc.gov/vaccines/schedules/index.html	Nothing
Maternity care	**Standard**
Complete maternity (obstetrical) care, such as: • Prenatal care • Screening for gestational diabetes for pregnant women between 24-28 weeks gestation or first prenatal visit for women at a high risk. • Breast feeding support, supplies and counseling for each birth	Nothing
• Delivery • Postnatal care	Delivery - $250 per day/$750 copay max per admit Postnatal - $20 per visit to PCP, $45 per visit to specialist
Note: Here are some things to keep in mind:	

Maternity care - continued on next page

Benefit Description	You Pay
Maternity care (cont.)	**Standard**
• You do not need to precertify your vaginal delivery; see page 19 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will cover an extended stay (you do not need to precertify the normal length of stay). We will extend your inpatient stay for you or your baby if medically necessary , but you, your representative, your doctor, or your hospital must precertify the extended stay. See page 19 for other circumstances. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b). • Hospital services are covered under Section 5(c) and Surgical benefits Section 5(b).	
Family Planning	**Standard**
Contraceptive counseling on an annual basis	Nothing
A range of voluntary family planning services, limited to: • counseling • sex education instruction in accordance with medically acceptable standards • diagnostic procedures to determine the cause of infertility • intrauterine devices and diaphragms • contraceptive devices • placement of contraceptive devices Note: We cover oral contraceptives under the prescription drug benefit.	$20 per visit to PCP $45 per visit to specialist
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling*	*All Charges*
Infertility services	**Standard**
Diagnosis and treatment of infertility, except as shown in *Not covered.* Infertility services are covered for Artificial Insemination up to 6 cycles. Donor sperm is not a covered benefit. In Vitro Fertilization with up to 3 cycles is covered. There is no coverage for infertility for any other unlisted service including reversal of previous sterilization procedures.	30% of charges / $9000 maximum
Not covered: • *Infertility services after voluntary sterilization* • *Fertility drugs* • *Assisted reproductive technology (ART) procedures, such as:* • *artificial insemination (except as noted above) (AI)*	*All Charges*

Infertility services - continued on next page

Benefit Description	You Pay
Infertility services (cont.)	**Standard**
• *in vitro fertilization (except as noted above) (IVF)* • *embryo transfer and gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* • *intravaginal insemination (IVI)* • *intracervical insemination (ICI)* • *intrauterine insemination (IUI)* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg*	*All Charges*
Allergy care	**Standard**
• Testing and treatment • Allergy injections • Allergy serum	Nothing
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*
Treatment therapies	**Standard**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/ Tissue Transplants on page xxx. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Applied Behavior Analysis (ABA) - Children with autism spectrum disorder • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. Note: We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See *Other services under You need prior Plan approval for certain services* on page 14.	$45 per visit

Benefit Description	You Pay
Physical and occupational therapies	**Standard**
60 visits for the services of each of the following: • Qualified physical therapists • Occupational therapists Note: We only cover therapy when a provider: • orders the care Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 60 sessions.	$45 per visit Nothing per visit during covered inpatient admission
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All Charges*
Speech therapy	**Standard**
• 60 visits per calendar year	$45 per visit
Habilitative Therapy	**Standard**
Habilitative services for children under age 19 with congenital or genetic birth defects including, but not limited to, autism or an autism spectrum disorder, and cerebral palsy. Services included physical, occupational and speech therapy for 60 visits per year, per service.	$45 per visit
Hearing services (testing, treatment, and supplies)	**Standard**
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care, children.*	$20 per visit to PCP $45 per visit to specialist
Not covered: • *Hearing services that are not shown as covered*	*All Charges*
Vision services (testing, treatment, and supplies)	**Standard**
• Annual eye refraction Note: See *Preventive care, children* for eye exams for children	$45 per visit
Not covered: • *Eyeglasses or contact lenses and examinations for them, except as shown above* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All Charges*

Benefit Description	You Pay
Foot care	**Standard**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. Note: See Orthopedic and prosthetic devices for information on podiatric shoe inserts.	$20 per visit to PCP $45 per visit to specialist
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All Charges*
Orthopedic and prosthetic devices	**Standard**
Note: All orthotics and prosthetics must be pre-authorized. • Breast implants (unless status post medically indicated mastectomy) • Lower and upper limb prosthetics (including myoelectric and microprocessor controlled) and related equipment/supplies • Facial, nasal, and auricular prostheses • Non-specific, miscellaneous, and unlisted orthotic and prosthetic codes For information on the professional charges for the surgery to insert an implant, see Section 5(b) Surgical procedures. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) Services provided by a hospital or other facility, and ambulance services.	30% of charges
Not covered: • *Orthopedic and corrective shoes* • *Arch supports* • *Foot orthotics* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices*	*All Charges*
Durable medical equipment (DME)	**Standard**
Note: All DME must be pre-authorized for coverage. When pre-authorized, we cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oral appliances • Electric, semi-electric, air fluidized, and advanced technology beds and related equipment • Oxygen and related equipment • Ventilators and related equipment	30% of charges

Durable medical equipment (DME) - continued on next page

Benefit Description	You Pay
Durable medical equipment (DME) (cont.)	**Standard**
• High frequency chest wall oscillation air-pulse generator system; including vest, hose, and related equipment • Bone stimulators • Spinal Cord Stimulators • Functional neuromuscular stimulation, transcutaneous stimulation of sequential muscle groups of ambulation with computer control, entire system • Functional electrical stimulation, transcutaneous stimulation of nerve and/or muscle groups, complete system • Power wheelchairs and related equipment • Power operated vehicles and related equipment • Custom made and specially sized wheelchairs and related equipment • Dialysis equipment • Defibrillators and related equipment (includes chest/vest defibrillators) • Breast Pump Rentals • Non-specific, miscellaneous, and unlisted DME codes Call us at 800-321-7947 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.	30% of charges
Not covered: Shoe inserts and other removable devices (see 'not covered' list under Orthopedic and prosthetic devices).	*All charges*
Home health services	**Standard**
• Home healthcare ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications.	$45 per visit
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family;* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative*	*All Charges*
Chiropractic	**Standard**
Not Covered Available through our Affinity Program (25% discount on charges)	*All charges*

Benefit Description	You Pay
Alternative treatments	**Standard**
Not covered: • *Naturopathic services* • *Hypnotherapy* • *Biofeedback* • *Acupuncture* - Available through our Affinity Program (25% discount on charges)	*All Charges*
Educational classes and programs	**Standard**
Coverage is provided for: • Diabetes self management • Childhood obesity education	$20 per visit to PCP $45 per visit to specialist
Wellness Programs • Online Lifestyle Management Programs (Balance, Nourish, Relax, Breathe, Care for Depression, Dream, Care for Your Health, Care for Pain)	Nothing for participating in wellness programs.
Tobacco Cessation programs, including individual/group/telephone counseling, over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence (if prescribed by a physician and purchased at a network pharmacy).	Nothing for tobacco cessation programs.

Section 5(b). Surgical and anesthesia services provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The services listed below are for the charges billed by a physician or other health care professional for your surgical care. See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES**. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You Pay
Surgical procedures	**Standard**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre-and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Surgical treatment of morbid obesity (bariatric surgery) • Insertion of internal prosthetic devices. See 5(a) –*Orthopedic and prosthetic devices* for device coverage information • Treatment of burns Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	Nothing
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot - (see Foot care)*	*All Charges*

Benefit Description	You Pay
Reconstructive surgery	**Standard**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birthmarks; and webbed fingers and toes. • Surgical treatment for gender reassignment is limited to the following: - Mastectomy - Urethroplasty (reconstruction of female urethra) - Amputation of penis - Penile prosthesis - Orchiectomy - Insertion of testicular prosthesis - Scrotoplasty - Intersex surgery male to female [a series of staged procedures] - Intersex surgery female to male [a series of staged procedures] - Vulvectomy - Plastic repair of introitus - Clitoroplasty for intersex state - Perineoplasty - Vaginectomy - Construction of artificial vagina - Vaginoplasty for intersex state - Hysterectomy - Salpingo-oophorectomy • All stages of breast reconstruction surgery following a mastectomy, such as: - Surgery to produce a symmetrical appearance of breasts; - Treatment of any physical complications, such as lymphedemas; - Breast prostheses and surgical bras and replacements (see *Prosthetic devices*) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	Nothing
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury.*	*All Charges*

Benefit Description	You Pay
Oral and maxillofacial surgery	**Standard**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures.	Nothing
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All Charges*
Organ/tissue transplants	**Standard**
Solid Organ Transplants: These solid organ transplants are subject to medical necessity and experimental/investigational review by the Plan. See Other services under You need prior Plan approval for certain services on page 14. • Cornea • Heart • Heart-lung • Kidney • Kidney-Pancreas • Liver • Pancreas • Isolated Small intestine • Intestinal transplants (small intestine with the liver) or small intestine with multiple organs such as the liver, stomach, and pancreas • Lung: Single/bilateral/lobar • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis	Nothing
Blood or Marrow Stem Cell Transplants The Plan extends coverage for the diagnoses as indicated below: • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma – recurrence (relapsed) - Advanced non-Hodgkin's lymphoma - recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs)	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You Pay
Organ/tissue transplants (cont.)	**Standard**
- Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic leukemia (CLL/SLL) - Hemoglobinopathy - Marrow Failure and Related Disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic Syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for: - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma – recurrence (relapsed) - Advanced non-Hodgkin's lymphoma - recurrence (relapsed) - Amyloidosis - Neuroblastoma	Nothing
Blood or Marrow Stem Cell Transplants: Not Subject to Medical Necessity • Allogeneic transplants for: - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) • Autologous transplants for: - Multiple myeloma - Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors	Nothing
Blood or Marrow Stem Cell Transplants: Not Subject to Medical Necessity. May Be Limited to Clinical Trials. • Autologous transplants for: - Autologous transplants for: - Epithelial ovarian cancer - Childhood rhabdomyosarcoma - Advanced Ewing sarcoma - Aggressive non-Hodgkin's lymphomas (Mantle Cell lymphoma, adult T-cell leukemia/lymphoma, peripheral T-cell lymphomas and aggressive Dendritic Cell neoplasms) - Advanced Childhood kidney cancers - Mantle Cell (Non-Hodgkin lymphoma)	Nothing
Mini-transplants performed in a Clinical Trial Setting (non-myeloablative, reduced intensity conditioning for member over 60 years of age with a diagnosis listed below): Subject to Medical Necessity	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You Pay
Organ/tissue transplants (cont.)	**Standard**
Tandem transplants: Subject to medical necessity • Autologous tandem transplants for: - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	Nothing
National Transplant Program (NTP) - Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.	
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All Charges*
Anesthesia	**Standard**
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing

Section 5(c). Services provided by a hospital or other facility, and ambulance services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You Pay
Inpatient hospital	**Standard**
Room and board, such as • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	$250 per day/$750 copay max per admit
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	Included in Inpatient hospital fee
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All Charges*

Benefit Description	You Pay
Outpatient hospital or ambulatory surgical center	**Standard**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service • Vasectomies • Laparoscopies Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	$250 per visit/procedure
Not covered: Blood and blood derivatives not replaced by the member	*All Charges*
Extended care benefits/Skilled nursing care facility benefits	**Standard**
• Extended care benefit • Skilled nursing facility (SNF)	$250 per day/$750 copay max per admit
Not Covered: Custodial care	*All Charges*
Hospice care	**Standard**
Hospice services consist of medically necessary Hospice care that is recommended by a designated Participating Physician, approved in advance by the Medical Director, and provided by a licensed Hospice agency with which Health Plan has arranged for you or your covered dependent's care and treatment.	Nothing
Not covered: Independent nursing, homemaker services.	*All Charges*
Ambulance	**Standard**
• Local professional ambulance service when medically appropriate	$125 per trip

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

Emergencies within our service area

If you have symptoms of heart attack or stroke, or feel that your "life or limb" is in danger, go immediately to the emergency room or call 911. If you have any of the following, go to the emergency room or call 911:

- Chest pain or pressure
- Uncontrolled bleeding
- Sudden or severe pain
- Coughing or vomiting blood
- Difficulty breathing or shortness of breath
- Sudden dizziness, weakness, or changes in vision
- Severe or persistent vomiting or diarrhea
- Changes in mental status, such as confusion

Emergencies outside our service area

In all emergency situations, you are encouraged to seek care with the nearest SWHP approved provider; however, if the time needed to reach a SWHP approved provider might endanger your health, go to the nearest emergency room. Medically necessary emergency care is covered. If you are hospitalized as a result of the emergency, you should contact the SWHP Health Services Department within 24-48 hours of any admission at 888-316-7947.

Benefit Description	You pay
Emergency within our service area	**Standard**
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient at a hospital, including doctors' services Note: We waive the ER copay if you are admitted to the hospital.	$20 PCP, $45 Specialist $50 per visit to an Urgent Care Center $250 per visit to an Emergency Room (waived if admitted)
Not covered: Elective care or non-emergency care	*All charges*
Emergency outside our service area	**Standard**
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient at a hospital, including doctors' services Note: We waive the ER copay if you are admitted to the hospital.	$20 PCP, $45 Specialist $50 per visit to an Urgent Care Center $250 per visit to an Emergency Room (waived if admitted)
Not covered: • *Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*
Ambulance	**Standard**
Professional ambulance service when medically appropriate Note: See 5(c) for non-emergency service.	$125
Not covered: Health Plan will not cover air transportation if ground transportation is medically appropriate and more economical.	*All Charges*

Section 5(e). Mental health and substance abuse benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness.OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Benefit Description	You Pay
Professional services	**Standard**
We cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists. • Physician services	$20 per visit
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	$20 per visit
Inpatient hospital or other covered facility	**Standard**
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services	$250 per day/$750 copay max per admit

Benefit Description	You Pay
Outpatient hospital or other covered facility	**Standard**
Outpatient services provided and billed by a hospital or other covered facility • Services in approved treatment programs, such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment	$20 per visit

Precertification If your provider requests out-of-network services, they must be preauthorized by the SWHP Medical Director for you to receive any benefits. Emergency admissions must be reported within two business days following the day of admission even if you have been discharged. Otherwise, there will be no coverage. See Section 3 for details.

See these sections of the brochure for more valuable information about these benefits:

- Section 4, *Your cost for covered services*, for information about catastrophic protection for these benefits.
- Section 7, *Filing a claim for covered services*, for information about submitting out-of-network claims.

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Members must make sure their physicians obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

We cover prescribed drugs and medications, as described in the chart beginning on the next page.

There are important features you should be aware of. These include:

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed or certified Physician Assistant, Nurse Practitioner and Psychologist must prescribe your medication.
- **Where you can obtain them.** SWHP has a network of pharmacies available within Central, North and West Texas and the SWHP Provider Area to accommodate the needs of our members. SWHP also owns and operates its own mail order facility. SWHP also contracts with most major retail pharmacies for those members where a SWHP pharmacy is not located.
  - up to a 30 day supply - Member pays – Preferred Generic drug $6/Preferred Brand name drug $50/Non-preferred and non-formulary drug $100 or 50%/ Specialty drug $250
  - Contraceptives are covered with no cost sharing.
- **Mail Order Prescription Drugs –** 90 day supply - Member pays – Preferred Generic drug $12/Preferred Brand name drug $100/Non-preferred, non-formulary and specialty drugs not covered through mail order

  Members can receive 30 or 90 day quantities through mail-order by ordering online at https://swhp.org or by calling the pharmacy at 800-707-3477 or 254-947-7555. Mail order is provided by the SWHP Salado Pharmacy, 3525 FM 2484, Salado, TX 76571. Before leaving the pharmacy, your order is verified by a registered pharmacist and sealed in tamper resistant packaging. We offer:
  - State-of-the-art facility utilizing robotics and software specifically developed for mail order operations
  - Software to track problem prescriptions and monitor turnaround time
  - Medication shipped via U.S. First Class Mail, postage paid, all medication should arrive to members within 7-10 business days
  - Facility is owned and operated by Scott & White Health Plan
  - Toll free access to Scott & White Salado Express representatives
  - Toll free automated refill line
  - On-line refill request through My Pharmacy Connect located on SWHP website
  - Pharmacy staff will contact physician if there are no refills on the prescription or if there are questions.
- **We use a formulary.** SWHP uses a standard formulary. We also cover non-formulary drugs prescribed by a Plan doctor.

  If your licensed prescriber believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from the formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost.

- **These are the dispensing limitations.** There may be limitations on drugs that require prior authorization. "Prior Authorization Required" drugs are usually those that have multiple uses, have high potential for waste, or require close monitoring by the physician. A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If a brand-name medication is dispensed when a **generic** is available, member will be responsible for the non-formulary copay. These are the dispensing limitations:
  - **Prior Authorization**: SWHP requires you or your physician to get prior authorization before filling certain drugs. Drugs needing prior authorization are noted on the formulary by a "PA" next to the drug name.
  - **Step Therapy**: In some cases, SWHP requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. Drugs with step therapy are noted on the formulary by an "ST" next to the drug name.
  - **Drug Exception**: A medication may require a drug exception for a variety of reasons, i.e.; may be limited to certain specialty prescribers, limited to certain pharmacies, may be a medication that is part of the therapeutic interchange programs, or various other reasons. Please contact our customer service department for questions regarding these medications. Drugs with drug restriction are noted on the formulary by a "DE" next to the drug name.
  - **Quantity Limit**: For certain drugs, SWHP limits the amount of medication covered. Quantity limits help ensure the appropriate use of medications. Quantity limits are often applied for safety reasons (e.g. limiting products containing acetaminophen to maximum safe limits). Drugs with quantity limits are noted on the formulary by a "QL" next to the drug name.
  - **Age Restriction**: There are certain medications which may be limited to a certain age group. Drugs with age restrictions are noted on the formulary by an "AL" next to the drug name.
- **Why use generic drugs?** As a rule, generic drugs are about 30 to 80 percent& less expensive than brand name drugs. When a drug goes off patent, other companies can apply for approval to sell the drug as a generic. The generic is chemically the same as the brand name drug. Because there is competition among the generic manufacturers, the cost is typically much lower.
- **When you do have to file a claim?** For services provided by non-participating providers you will need to file a claim for reimbursement directly to the Scott & White Health Plan at: Scott & White Health Plan, Attn: Pharmacy Claims Dept., 1206 West Campus Drive, Temple, TX 76502.

Benefits Description	You Pay
Covered medications and supplies	**Standard**
We cover the following medications based on the US Preventive Services Task Force A and B recommendations. The following medications and supplies must be prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • **Drugs and medicines** that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered* • **Insulin** • **Diabetic supplies** limited to: - Disposable needles, strips, and syringes for the administration of covered medications • **Drugs for sexual dysfunction** **Preventive Care** medications to promote better health as recommended by ACA. The following drugs and supplements are covered without cost-share, even if over-the-counter, are prescribed by a health care professional and filled at a network pharmacy. • Aspirin (81 mg) for men age 45-79 and women age 55-79 and women of childbearing age • Folic acid supplements for women of childbearing age 400 & 800 mcg	• $6 (preferred generics) up to a 30 day supply • $12 (preferred generics) maintenance quantities • $50 (preferred brands) up to a 30 day supply • $100 (preferred brands) maintenance quantities • $100 or 50% (non-preferred and non formulary) whichever is greater ($250 max) - up to a 30 day supply, not available in maintenance quantities • $250 (preferred specialty drugs) - up to a 30 day supply, not available in maintenance quantities Note: If there is no generic equivalent available, you will still have to pay the brand name copay.

Covered medications and supplies - continued on next page

Benefits Description	You Pay
Covered medications and supplies (cont.)	**Standard**
• Liquid iron supplements for children age 6 months -1 year • Vitamin D supplements (prescription strength)(400 & 1000 units) for members 65 or older • Fluoride tablets, solution (not toothpaste, rinses) for children age 0-6 Note: To receive this benefit a prescription from a doctor must be presented to pharmacy.	• $6 (preferred generics) up to a 30 day supply • $12 (preferred generics) maintenance quantities • $50 (preferred brands) up to a 30 day supply • $100 (preferred brands) maintenance quantities • $100 or 50% (non-preferred and non formulary) whichever is greater ($250 max) - up to a 30 day supply, not available in maintenance quantities • $250 (preferred specialty drugs) - up to a 30 day supply, not available in maintenance quantities Note: If there is no generic equivalent available, you will still have to pay the brand name copay.
Mail Order Prescription Drugs – 90 day supply	• $12 (preferred generics) • $100 (preferred brands) • Non-preferred, non-formulary and specialty drugs not covered through mail order
Women's contraceptive drugs and devices Morning after pill (this is an over-the-counter emergency contraceptive drug)	Nothing Morning after pill is covered at no cost to the member if prescribed by a physician and purchased at a network pharmacy.
Not covered: • Drugs and supplies for cosmetic purposes • *Drugs to enhance athletic performance* • *Fertility drugs* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Vitamins, nutrients and food supplements not listed as a covered benefit even if a physician prescribes or administers them* • *Nonprescription medicines* *Note: Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco cessation benefit. (See page 33.)*	*All Charges*

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

Accidental injury benefit	You Pay
Accidental injury benefit	**Standard**
We only cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. **The need for these services must result from an accidental injury.** **We have no other dental benefits.**	$45 outpatient
Dental benefits	**Standard**
Not covered: Routine/Restorative	*All charges*

Section 5(h). Special features

Special feature	Description
24 hour nurse line	For any of your health concerns, 24 hours a day, 7 days a week, you may call and talk with a registered nurse who will discuss treatment options and answer your health questions. Our nurses can give you information about how to take care of yourself at home or can help you decide if an appointment, an urgent care visit or an emergency room visit is best for your symptoms. If you want to talk to a nurse, call **877-505-7947.** The nurse advice line is available to all SWHP members.
Services for deaf and hearing impaired	SWHP utilizes a toll free TTY number **800-735-2989** to assist with communication services for Members with hearing or speech difficulties.
Appointment Advocates	Scott & White Health Plan will help you get an appointment when you need to be seen! If you are having difficulty getting an appointment to see one of our participating providers, please call us. Our personalized service will get you an appointment to see a clinician when you need to be seen. Please call us at **254-298-3000 or 800-321-7947**.
Language Line	In an effort to improve communication with non-English speaking members, SWHP uses the interpretive services of AT&T. Members do not have to call a special line for this service. When contacting SWHP, Members may notify the Health Services (HSD) staff and/or Customer Advocates of their primary language and the call will be completed with the help of an AT&T interpreter at no charge to the Member. SWHP HSD staff follows established internal SWHP policies related to provision of interpretive services for SWHP members.
Additional services	We also offer other valuable services to our members 24/7 including: • Health Coaches - **877-505-7947** - call anytime you need information on a health issue • Dialog Center - https://fehb.swhp.org - includes shared decision making, e-mail a health coach, interactive tools • SWHP Member Portal - https://fehb.swhp.org - check on your claims and benefits

Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them.** Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. For more information, please call **800-290-0523** or visit **https://fehb.swhp.org**.

Careington POS Dental Network

- Save 20% to 50% on most dental procedures including routine oral exams, unlimited cleanings and major work such as dentures, root canals and crowns.
- 20% savings on orthodontics including braces and retainers for children and adults
- 20% reduction on specialists' normal fees. Specialties include Endodontics, Oral Surgery, Pediatric Dentistry, Periodontics and Prosthodontics where available.
- Cosmetic dentistry such as bonding and veneers also included.

ChooseHealthy - Chiropractic & Alternative Medicine

With the ChooseHealthy® program, members will have access to a wide variety of complementary health care services.

- Utilize a nationwide network of more than 28,000 credentialed complementary health care providers, including more than 20,000 chiropractors.
- Members will receive a 25% discount off normal fees for services. Our complementary health care network includes chiropractors, massage therapists, acupuncturists and registered dietitians.
- Receive discounts on a wide variety of health and wellness products including vitamins, minerals, herbal supplements, homeopathic remedies, sports nutrition products, health-related books and DVDs, fitness products and skin care items, with free shipping on most orders.

ChooseHealthy – Fitness Only

With the ChooseHealthy® program, you have access to a wide variety of fitness facilities, as well as health and wellness products.

- Access more than 15,000 fitness clubs and exercise centers nationwide.
- Receive a minimum 10% discount off initiation and/or monthly dues (may apply to new health club members only).
- Receive discounts on a wide variety of health and wellness products including vitamins, minerals, herbal supplements, homeopathic remedies, sports nutrition products, health-related books and DVDs, fitness products and skin care items, with free shipping on most items.

Newport Audiology

Careington members have access to hearing aid discounts from 15% to 35% at 2,000 Newport Audiology network providers nationwide. Newport Audiology Centers also offer the latest technology for hearing aids and accessories as well as wireless capabilities for television and cellular devices.

Members will also receive additional services at no extra charge: (Valued at over $1,000)

- Free initial audiology screening (valued at $119)
- Two-year supply of batteries per instrument (valued at $98)
- Two-year manufacturer's warranty including loss or damage (valued at $350)
- Unlimited follow-up visits (valued at $439 assuming a minimum of 6 visits)

Section 6. General exclusions – things we don't cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure.

Although we may list a specific service as a benefit, we will not cover it unless it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For information on obtaining prior approval for specific services, such as transplants, see Section 3 When you need prior Plan approval for certain services.

We do not cover the following:

- Care by non-plan providers except for authorized referrals or emergencies (see *Emergency services/accidents*).
- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services, drugs, or supplies not medically necessary.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice.
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants).
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies related to sex transformations.
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.
- Services, drugs, or supplies you receive without charge while in active military service.
- Services or supplies furnished by yourself, immediate relatives or household members, such as spouse, parents, children, brothers or sisters by blood, marriage or adoption.

Section 7. Filing a claim for covered services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment or coinsurance. This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment or coinsurance.

You will only need to file a claim when you receive emergency services from non-plan providers. Sometimes these providers bill us directly. Check with the provider. If you need to file the claim, here is the process:

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, contact us at 800-321-7947, or at our website at https://fehb.swhp.org.

When you must file a claim – such as for services you received outside the Plan's service area – submit it on the CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name, date of birth, address, phone number and ID number
- Name and address of the physician or facility that provided the service or supplies
- Dates you received the services or supplies
- Diagnosis
- Type of each service or supply
- The charge for each service or supply
- A copy of the explanation of benefits, payments, or denial from any primary payor – such as the Medicare Summary Notice (MSN)
- Receipts, if you paid for your services

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills. Submit your claims to:

Scott and White Health Plan
Attn: Claims Department
1206 West Campus Drive
Temple, TX 76502

Prescription drugs

Submit your claims to:

Scott and White Health Plan
Attn: Pharmacy Claims Department
1206 West Campus Drive
Temple, TX 76502

Other supplies or services

Submit your claims to:

Scott and White Health Plan
Attn: Claims Department
1206 West Campus Drive
Temple, TX 76502

Deadline for filing your claim	Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.
Post-service claims procedures	We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected. If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information. If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.
Authorized Representative	You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, we will permit a health care professional with knowledge of your medical condition to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.
Notice Requirements	If you live in a county where at least 10 percent of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language. Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes.

Section 8. The disputed claims process

You may be able to appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please visit https://fehb.swhp.org.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3 *If you disagree with our pre-service claim decision,* we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing to:

Scott and White Health Plan
Attn: Dispute Resolution Department
1206 West Campus Drive
Temple, TX 76502

or calling (800) 321-7947.

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/ investigational), we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration decision will not afford deference to the initial decision and will be conducted by a plan representative who is neither the individual who made the initial decision that is the subject of the reconsideration, nor the subordinate of that individual.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

1 Ask us in writing to reconsider our initial decision. You must:

- Write to us within 6 months from the date of our decision; and
- Send your request to us at: Scott and White Health Plan, Attn: Dispute Resolution Department, 1206 West Campus Drive, Temple, TX 76502; and
- Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and
- Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
- Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly.

We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.

In the case of a post-service claim, we have 30 days from the date we receive your request to:

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- Pay the claim or
- Write to you and maintain our denial or
- Ask you or your provider for more information

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

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If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance x, 1900 E Street, NW, Washington, DC 20415-3630.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call;
- Your email address, if you would like to receive OPM’s decision via email. Please note that by providing your email address, you may receive OPM’s decision more quickly.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

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OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

If you do not agree with OPM’s decision, your only recourse is to file a lawsuit. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not file a lawsuit until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at800-321-7947. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 3 at 202-606-0737 between 8 a.m. and 5 p. m. Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a dependent is covered under this plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payor or and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit our website at .http://fehb.swhp.org.

When we are the primary payor, we will pay the benefits described in this brochure.

When we are the secondary payor, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

- **TRICARE and CHAMPVA**

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. IF TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

- **Workers' Compensation**

We do not cover services that:

- You (or a covered family member) need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.

- **Medicaid**

When you have this Plan and Medicaid, we pay first.

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, State, or Federal government agency directly or indirectly pays for them.

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical trials

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy.
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care.
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

When you have Medicare

- **What is Medicare?**

Medicare is a health insurance program for:

- People 65 years of age or older
- Some people with disabilities under 65 years of age
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant)

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 800-MEDICARE (800-633-4227), (TTY: 877-486-2048) for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. For more information about this extra help, visit the Social Security Administration online at www.socialsecurity.gov, or call them at 800-772-1213, TTY: 800-325-0778.

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 800-772-1213, (TTY: 800-325-0778) to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage.

It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage. If you do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10 % increase in premium for every 12 months you are not enrolled. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payor, we process the claim first. When Original Medicare is the primary payor, Medicare processes your claim first.

In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 800-321-7947 or see our website at https://fehb.swhp.org.

We waive some costs if the Original Medicare Plan is your primary payor – We will waive some out-of-pocket costs as follows:

- Medical services and supplies provided by physicians and other health care professionals.

- **Tell us about your Medicare coverage**

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country.

To learn more about Medicare Advantage plans, contact Medicare at 800-MEDICARE (800-633-4227), (TTY: 877-486-2048) or at www.medicare.gov.

If you enroll in a Medicare Advantage plan, the following options are available to you:

This Plan and our Medicare Advantage plan: You may enroll in our plan's Medicare Advantage plan and also remain enrolled in our FEHB plan.

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers). However, we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓*	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

Section 10. Definitions of terms we use in this brochure

Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Clinical trials cost categories	An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application. • Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's cancer, whether the patient is in a clinical trial or is receiving standard therapy • Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care • Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 21.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 21.
Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.
Covered services	Care we provide benefits for, as described in this brochure.
Experimental or investigational services	"**Experimental**" **or** "**Investigational**" means, in the opinion of the Medical Director, Treatment that has not been proven successful in improving the health of patients.
Group health coverage	Health coverage, such as FEHB, that is provided through an employer group.
Health care professional	A physician or other healthcare professional licensed, accredited, or certified to perform specified health services consistent with state law.
Medical necessity	Those Health Care Services which, in the opinion of Member's Primary Care Physician or Referral Physician, whose opinions are subject to the review, approval or disapproval, and actions of the Medical Director or the Quality Assurance Committee in their appointed duties, are: 1. Essential to preserve the health of Member; and 2. Consistent with the symptoms or diagnosis and Treatment of the Member's condition, disease, ailment or injury; and 3. Appropriate with regard to standards of good medical practice within the surrounding community; and 4. Not solely for the convenience of the Member, Member's Physician, Hospital, or other health care provider; and 5. The most appropriate supply or level of service which can be safely provided to the Member.

Plan allowance

Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance as follows:

Our plan allowance is the amount our contracted providers have agreed to accept as payment in full. For emergency care received at any doctor's office, outside our Plan's service area, our Plan's allowance is the amount SWHP has determined to be the allowable prevailing charge for a particular professional service in the geographical area in which the service is performed.

Post-service claims

Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.

Pre-service claims

Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.

Urgent care claims

A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent care claims usually involve Pre-service claims and not Post-service claims. We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at **800-321-7947.** You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Us/We

Us and We refer to Scott and White Health Plan.

You

You refers to the enrollee and each covered family member.

Section 11. Other Federal Programs

Please note, the following programs are not part of your FEHB benefits. They are separate Federal programs that complement your FEHB benefits and can potentially reduce your annual out-of-pocket expenses. These programs are offered independent of the FEHB Program and require you to enroll separately with no government contribution.

Important information about three Federal programs that complement the FEHB Program

First, the **Federal Flexible Spending Account Program**, also known as FSAFEDS, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. Participating employees save an average of about 30% on products and services they routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)** provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under FEDVIP you may choose self only, self plus one, or self and family coverage for yourself and any eligible dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** can help cover long term care costs, which are not covered under the FEHB Program.

The Federal Flexible Spending Account Program – FSAFEDS

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $100. The maximum annual election for a health care flexible spending account (HCFSA) or a limited expense health care spending account (LEX HCFSA) is $2,550 per person. The maximum annual election for a dependent care flexible spending account (DCFSA) is $5,000 per household.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible out-of-pocket health care expenses (such as copayments, deductibles, prescriptions, **physician prescribed** over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26).

  FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.
- **Limited Expense Health Care FSA (LEX HCFSA**) – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to out-of-pocket dental and vision care expenses for you and your tax dependents including adult children (through the end of the calendar year in which they turn 26).
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible **non-medical** day care expenses for your children under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.
- If you are a new or newly eligible employee you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1, you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?	Visit **www.FSAFEDS.com** or call an FSAFEDS Benefits Counselor toll-free at 877-FSAFEDS, (877- 372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time. TTY: 866-353-8058

The Federal Employees Dental and Vision Insurance Program – *FEDVIP*

Important Information	The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program. This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment. FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.
Dental Insurance	All dental plans provide a comprehensive range of services, including: • Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays. • Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments. • Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures. • Class D (Orthodontic) services with up to a 12-month waiting period. Most FEDVIP dental plans cover adult orthodontia. Review your FEDVIP dental plan's brochure for information on this benefit.
Vision Insurance	All vision plans provide comprehensive eye examinations and coverage for your choice of either lenses and frames or for contact lenses. Other benefits such as discounts on LASIK surgery may also be available.
Additional Information	You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/dental and www.opm.gov/vision. This site also provide links to each plan's website, where you can view detailed information about benefits and preferred providers.
How do I enroll?	You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 877-888-3337, (TTY: 877-889-5680).

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection	The Federal Long Term Care Insurance Program (FLTCIP) can help pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment such as Alzheimer's disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives are eligible to apply. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more information, call 800-LTC-FEDS (800-582-3337), (TTY: 800-843-3557), or visit www.ltcfeds.com.

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Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

Notes

Notes

Summary of benefits for the Standard Option of Scott and White Health Plan - 2017

Do not rely on this chart alone. All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.

- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

Standard Option Benefits	You Pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: $20 primary care; $45 specialist	25
Services provided by a hospital:		
• Inpatient	$250 per day/$750 copay max per admit	39
• Outpatient	$250 per visit/procedure	39
Emergency benefits:		
• In and out of area	$250 per visit to an emergency room (waived if admitted)	41
Mental health and substance abuse treatment:	• Physician services - $20 per visit • Inpatient - 10% of charges • Outpatient - $20 per visit	43
Prescription drugs:		
• Retail pharmacy or mail order Note: Non-preferred, non-formulary, and specialty drugs are not covered through mail order.	• $6 (preferred generics) • $12 (preferred generics) maintenance quantities • $50 (preferred brands) • $100 (preferred brands) maintenance quantities • $100 or 50% (non-preferred and non formulary) whichever is greater ($250 max) • $250 (preferred specialty drugs)	45
Dental care:		
• Accidental injury benefit only	$45 outpatient	48
Vision care:		
• Annual eye refraction	$45	30
Special features:	• 24 hour nurse line • Customer Service Advocates • Free health and wellness programs	49
Protection against catastrophic costs (out-of-pocket maximum)**:**	$4,500 self only, $9,000 self plus one, $9,000 self and family	21

To compare your FEHB health plan options please go to www.opm.gov/fehbcompare.

For 2017 health premium information, please see: https://www.opm.gov/healthcare-insurance/tribal-employers/benefits-premiums/ or contact your tribe's Human Resources department.