

 **This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at [www.swhp.org](http://www.swhp.org) or by calling 1-800-321-7947.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	<b>\$2,500</b> person / <b>\$5,000</b> family in-network, <b>\$5,000 / \$10,000</b> out of network. Doesn't apply to preventative.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	Yes, <b>\$500</b> per admission deductible.	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this plan begins to pay for these benefits.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. For in-network <b>\$6,600</b> person / <b>\$13,200</b> family, out of network <b>\$13,200/\$26,400</b>	The <u>out-of-pocket limit</u> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. See <a href="http://www.swhp.org">www.swhp.org</a> or call 1-800-321-7947 for a list of participating providers.	If you use an in-network doctor or other health care <u>provider</u> , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	No. You don't need a referral to see a specialist.	You can see the <u>specialist</u> you choose without permission from this plan.
Are there services this	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan

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plan doesn't cover? document for additional information about **excluded services**.



- **Copayments** are fixed dollar amounts (for example, \$30) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care <b>provider's</b> office or clinic	Primary care visit to treat an injury or illness	\$35 copay/visit	50% coinsurance	—————none—————
	Specialist visit	\$60 copay/visit	50% coinsurance	—————none—————
	Other practitioner office visit	\$60 copay/ visit	50% coinsurance	Physician Assistant, Nurse Practitioner
	Preventive care/screening/immunization	No charge	50% coinsurance	—————none—————
If you have a test	Diagnostic test (x-ray, blood work)	No charge	50% coinsurance	—————none—————
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	—————none—————

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Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
<b>If you need drugs to treat your illness or condition</b>  More information about <u>prescription drug coverage</u> is available at <a href="http://www.swhp.org">www.swhp.org</a> .	Generic drugs	\$10 copay/retail \$20 copay/maintenance	\$10 copay/retail \$20 copay/maintenance	Covers up to a 34-day supply (retail prescription); 31-90 day supply (mail order prescription).
	Preferred brand drugs	\$40 copay/retail \$80 copay/maintenance	\$40 copay/retail \$80 copay/maintenance	If a brand name drug is dispensed when a generic is available, 50% coinsurance applies.
	Non-preferred brand drugs	Lesser of \$100 or 50% / retail Lesser of \$200 or 50% / maintenance	Lesser of \$100 or 50% / retail Lesser of \$200 or 50% / maintenance	Non-formulary: Greater of \$100 or 50% in-network, not covered out of network
	Specialty drugs	20% copay	50% copay	Medical deductible applies. Some Specialty drugs may require prior authorization
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	—————none—————
	Physician/surgeon fees	30% coinsurance	50% coinsurance	—————none—————
<b>If you need immediate medical attention</b>	Emergency room services	\$200 copay , plus 30% of charges	\$200 copay , plus 30% of charges	Copay waived if admitted. OON ER Care you may be balanced billed.
	Emergency medical transportation	30% coinsurance	30% coinsurance	—————none—————
	Urgent care	\$50 copay / visit	\$50 copay / visit	OON UR Care you may be balanced billed.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	\$500 deductible per admission, plus 30% of charges	\$500 deductible per admission, plus 50% of charges	—————none—————
	Physician/surgeon fee	30% coinsurance	50% coinsurance	—————none—————

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# City of Killeen – Mid Plan

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

Coverage Period: 10/01/16-09/30/17  
 Coverage for: Family | Plan Type: POS

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-Participating Provider	Limitations & Exceptions
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	\$35 copay/visit	50% coinsurance	—————none—————
	Mental/Behavioral health inpatient services	\$500 deductible per admission, plus 30% of charges	\$500 deductible per admission, plus 50% of charges	Requires referral and preauthorization
	Substance use disorder outpatient services	\$35 copay/visit	50% coinsurance	—————none—————
	Substance use disorder inpatient services	\$500 deductible per admission, plus 30% of charges	\$500 deductible per admission, plus 50% of charges	Requires referral and preauthorization
<b>If you are pregnant</b>	Prenatal and postnatal care	Prenatal: No charge Postnatal: \$35/\$60	Pre & Postnatal: 50% coinsurance	—————none—————
	Delivery and all inpatient services	\$500 deductible per admission, plus 30% of charges	\$500 deductible per admission, plus 50% of charges	—————none—————
<b>If you need help recovering or have other special health needs</b>	Home health care	\$60 copay/visit	50% coinsurance	Benefit maximum of 65 visits per calendar year
	Rehabilitation services	\$60 copay/visit	50% coinsurance	Benefit maximum of 35 visits per calendar year
	Habilitation services	\$60 copay/visit	50% coinsurance	Benefit maximum of 35 visits per calendar year
	Skilled nursing care	\$500 deductible per admission, plus 30% of charges	\$500 deductible per admission, plus 50% of charges	Benefit maximum of 25 days per calendar year. Pre-Certification Required
	Durable medical equipment	50% coinsurance	50% coinsurance	—————none—————
	Hospice service	No charge	50% coinsurance	—————none—————
<b>If your child needs dental or eye care</b>	Eye exam	\$60 copay/visit	50% coinsurance	Limited to one exam per year
	Glasses	Not covered	Not covered	—————none—————
	Dental check-up	Not covered	Not covered	—————none—————

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Excluded Services & Other Covered Services:

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

- Acupuncture, Bariatric surgery, Non-emergency care when traveling outside the U.S., Cosmetic surgery, Dental care (Adult), Routine foot care, Infertility treatment, Long-term care, Private-duty nursing, Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Adult eye care( routine), Telemedicine ( benefit applied as \$0 charge), Chiropractic ( refer Manipulative Therapy) 35 visit limit per calendar year

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## Your Rights to Continue Coverage:

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

For more information on your rights to continue coverage, contact the plan at 800-321-7947. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or [www.dol.gov/ebsa](http://www.dol.gov/ebsa), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov).

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: 800-321-7947.

Para asistencia en Español, usted puede contactarnos al 254-298-3489 durante el horario de 7:00 am a 9:00 pm.

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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

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## About these Coverage Examples:

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



**This is not a cost estimator.**

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

See the next page for important information about these examples.

### Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$5,310
- Patient pays \$2,230

#### Sample care costs:

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

#### Patient pays:

Deductibles	\$500
Copays	\$20
Coinsurance	\$1560
Limits or exclusions	\$150
<b>Total</b>	<b>\$2,230</b>

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

- Amount owed to providers: \$5,400
- Plan pays \$2,940
- Patient pays \$2,460

#### Sample care costs:

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

#### Patient pays:

Deductibles	\$1040
Copays	\$1340
Coinsurance	\$0
Limits or exclusions	\$80
<b>Total</b>	<b>\$2,460</b>

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

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

### What does a Coverage Example show?

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

### Does the Coverage Example predict my own care needs?

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

### Does the Coverage Example predict my future expenses?

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

providers charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

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

### Are there other costs I should consider when comparing plans?

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

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