The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. Please read the FEHB Plan brochure ([insert brochure number]) that contains the complete terms of this plan. **All benefits are subject to the definitions, limitations, and exclusions set forth in the FEHB Plan brochure.** Benefits may vary if you have other coverage, such as Medicare. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can get the FEHB Plan brochure at https://www.truehealthnewmexico.com/federal-employees/, and view the Glossary at https://www.truehealthnewmexico.com/wp-content/uploads/2020/09/uniform-glossary.pdf . You can call 1-800-508-4677 to request a copy of either document.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$ 250/Self Only $ 500/Self Plus One $ 500/Self and Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. Copayments and coinsurance amounts do not count toward your deductible, which generally starts over January 1. When a covered service/supply is subject to a deductible, only the Plan allowance for the service/supply counts toward the deductible. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care, Primary care, Specialty care, Urgent care, Emergency care, Hospital care, Behavioral health	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$ 6,000/Self Only $ 12,000/Self Plus One $ 12,000/Self and Family	The out-of-pocket limit, or catastrophic maximum, is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See https://www.truehealthnewmexico.com/federal-employees/ or call 1-	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance

	844-508-4677 for a list of network providers.	billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10/visit; deductible does not apply	Not covered	None
	Specialist visit	$30/visit; deductible does not apply	Not covered	None
	Preventive care/screening/ immunization	No charge; deductible does not apply	Not covered	None
If you have a test	Diagnostic test (x-ray, blood work)	No charge; deductible does not apply	Not covered	None
	Imaging (CT/PET scans, MRIs)	$100/test; deductible does not apply	Not covered	Failure to obtain Prior Approval may result in a denial of coverage.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.[insert].com	Generic drugs	Retail: $5/prescription Mail: $10/prescription Deductible does not apply	Not covered	Covers up to a 30-day retail supply. 90-day mail order supply, in-network only. THNM offers $0 copayment medications for select drugs from in-network participating pharmacies. To view a complete listing of these drugs refer to the THNM formulary. Insulin or a Medically Necessary alternative will not exceed $25.00 for a 30-day supply or a $50 copay maximum for insulin purchased through Mail Order (90-day supply).
	Preferred brand drugs	Retail: $30/prescription Mail: $60/prescription Deductible does not apply	Not covered	
	Non-preferred brand drugs	Retail: $70/prescription Mail: $140/prescription Deductible does not apply	Not covered	
	Specialty drugs	$350/prescription	Not covered	Failure to obtain Prior Approval may result in a denial of coverage.
	Non-preferred specialty drugs	$450/prescription	Not covered	Failure to obtain Prior Approval may result in a denial of coverage.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250/visit; deductible does not apply	Not covered	Failure to obtain Prior Approval may result in a denial of coverage.
	Physician/surgeon fees	No charge, covered in facility fee; deductible does not apply	Not covered	Failure to obtain Prior Approval may result in a denial of coverage.
If you need immediate medical attention	Emergency room care	$150/visit; deductible does not apply	$150/visit; deductible does not apply	Copayment waived if admitted to the hospital.
	Emergency medical transportation	10% coinsurance	10% coinsurance	None
	Urgent care	$30/visit; deductible does not apply	$30/visit; deductible does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$500/admission; deductible does not apply	Not covered	Failure to obtain Prior Approval may result in a denial of coverage.
	Physician/surgeon fees	No charge, covered in facility fee; deductible does not apply	Not covered	Failure to obtain Prior Approval may result in a denial of coverage.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge; deductible does not apply	Not covered	Failure to obtain Prior Approval may result in a denial of coverage.
	Inpatient services	$500/admission; deductible does not apply	Not covered	Failure to obtain Prior Approval may result in a denial of coverage.
If you are pregnant	Office visits	$30/visit; deductible does not apply	Not covered	Up to a maximum of $300 copayment/pregnancy.
	Childbirth/delivery professional services	No charge, covered in facility fee; deductible does not apply	Not covered	Home birth not covered.
	Childbirth/delivery facility services	$500/admission; deductible does not apply	Not covered	Home birth not covered.
If you need help recovering or have	Home health care	10% coinsurance	Not covered	Coverage is limited to 100 visits per calendar year.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most, plus you may be balance billed)	
other special health needs	Rehabilitation services	$10/visit; deductible does not apply	Not covered	Failure to obtain Prior Approval may result in a denial of coverage.
	Habilitation services	$10/visit; deductible does not apply	Not covered	Failure to obtain Prior Approval may result in a denial of coverage.
	Skilled nursing care	10% coinsurance	Not covered	Coverage is limited to 60 days/visits per calendar year.
	Durable medical equipment	10% coinsurance	Not covered	Failure to obtain Prior Approval may result in a denial of coverage. The Plan covers hearing aids and the evaluation for the fitting of Hearing Aids only for Dependent children up to age eighteen (18), or up to age twenty-one (21) if still attending high school.
	Hospice services	10% coinsurance	Not covered	Failure to obtain Prior Approval may result in a denial of coverage.
If your child needs dental or eye care	Children's eye exam	No charge; deductible does not apply	50% coinsurance; deductible does not apply	Coverage is limited to one exam per calendar year.
	Children's glasses	No charge; deductible does not apply	50% coinsurance; deductible does not apply	Coverage is limited to one exam per calendar year.
	Children's dental check-up	Not covered	Not covered	

Excluded Services & Other Covered Services:

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

- Cosmetic surgery
- Dental care (Adult)
- Hearing aids (Adult)
- Home births
- Infertility treatment (except for diagnosis and medically indicated treatments for physical conditions)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Weight loss programs (Unless for medically necessary treatment for morbid obesity)

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

- Acupuncture (Max of 25 visits/year)
- Bariatric surgery
- Chiropractic care (Max of 25 visits/year)
- Routine foot care (diabetics only)

Your Rights to Continue Coverage: You can get help if you want to continue your coverage after it ends. See the FEHB Plan brochure, contact your HR office/retirement system, contact your plan at [contact number] or visit www.opm.gov.insure/health. Generally, if you lose coverage under the plan, then, depending on the circumstances, you may be eligible for a 31-day free extension of coverage, a conversion policy (a non-FEHB individual policy), spouse equity coverage, or temporary continuation of coverage (TCC). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: If you are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal. For information about your appeal rights please see Section 3, "How you get care," and Section 8 "The disputed claims process," in your FEHB Plan brochure. If you need assistance, you can contact: [insert applicable contact information from instructions].

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-844-508-4677.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-508-4677.

Chinese (中文): 如果需要中文的帮助， 请拨打这个号码1-844-508-4677.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-508-4677.

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$250
Specialist *[cost sharing]*	$30
Hospital (facility) *[cost sharing]*	$500
Other *[cost sharing]*	%10

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1050
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$1,110

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

The plan's overall deductible	$250
Specialist *[cost sharing]*	$30
Hospital (facility) *[cost sharing]*	$500
Other *[cost sharing]*	%10

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	$250
Copayments	$700
Coinsurance	$200
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$1,210

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

The plan's overall deductible	$250
Specialist *[cost sharing]*	$30
Hospital (facility) *[cost sharing]*	$500
Other *[cost sharing]*	%10

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$100
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$450

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