Baylor Scott & White Health (BSWH): BSWH Plan

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

Coverage Period: 01/01/2017 – 12/31/2017

Coverage for: EE, ES, EC, EF | **Plan Type:** PPO

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 or by calling 844-843-3229.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	INN: EE $800, ES $1,600, EC $1,200, EF $1,600 / Tier 1: EE $1,200, ES $2,400, EC $1,800, EF $2,400 / Tier 2: EE $1,600, ES $3,200, EC $2,400, EF $3,200 / Tier 3 Doesn't apply to preventive care.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. There is an embedded **deductible** for coverage tiers ES, EC, EF. Copays don't count toward the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. INN: EE $3,300, ES $6,600, EC $4,950, EF $6,600 / Tier 1: EE $6,850, ES $13,700, EC $10,275, EF $13,700 / Tier 2: EE Unlimited, ES Unlimited, EC Unlimited, EF Unlimited / Tier 3	The **out-of-pocket limit** 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. There is an embedded **out-of-pocket limit** for coverage tiers ES, EC, and EF, which means that no one person in your family has to pay more than the individual limit, even if together you have not met the family **out-of-pocket limit**.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, and any health care services this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.bswh.swhp.org or call 844-843-3229** for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call 844-843-3229 or visit us at **www.bswh.swhp.org.**
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.swhp.org/glossary** or call 844-843-3229 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Tier 1 Provider	Your Cost If You Use a Tier 2 Provider	Your Cost If You Use a Tier 3 Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay	$70 copay	70% coinsurance	——————None——————
	Specialist visit	$40 copay	$100 copay	70% coinsurance	——————None——————
	Other practitioner office visit	$40 copay for chiropractor and 10% coinsurance for acupuncture	$100 copay for chiropractor and 50% coinsurance for acupuncture	70% coinsurance for chiropractor and acupuncture	20 visits per calendar year each.
	Preventive care/screening/immunization	No charge	No charge	Not Covered	——————None——————
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	50% coinsurance /35% coinsurance	70% coinsurance	Tier 2, 35% coinsurance for freestanding facility and independent labs. If performed as part of physician's office visit, included with office visit copay.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	50% coinsurance	70% coinsurance	——————None——————

Common Medical Event	Services You May Need	Your Cost If You Use a Tier 1 Provider	Your Cost If You Use a Tier 2 Provider	Your Cost If You Use a Tier 3 Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bswh.swhp.org.	Generic drugs	$3 copay (retail) $6 copay (mail order)	$5 copay (retail)	50% coinsurance	Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription).
	Preferred brand drugs	$35 copay (retail) $70 copay (mail order)	$50 copay (retail)	50% coinsurance	Some drugs may require pre-authorization.
	Non-preferred brand drugs	Lesser of $50 or 50% coinsurance (retail)/ Lesser of $100 copay or 50% coinsurance (mail order)	Lesser of $75 or 50% coinsurance (retail)	50% coinsurance	If a brand name drug is dispensed when a generic is available, 50% coinsurance applies. Non-preferred brand and Generic drugs.
	Specialty drugs	20% coinsurance $200 max (retail)	Not Covered	Not Covered	——————None——————
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	50% coinsurance	70% coinsurance	——————None——————
	Physician/surgeon fees	10% coinsurance	50% coinsurance	70% coinsurance	——————None——————
If you need immediate medical attention	Emergency room services	$200 copay	$200 copay	$200 copay	Non-emergency use is not covered.
	Emergency medical transportation	10% coinsurance	10% coinsurance	10% coinsurance	——————None——————
	Urgent care	$50 copay	$100 copay	$100 copay	——————None——————
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	50% coinsurance	70% coinsurance	——————None——————
	Physician/surgeon fee	10% coinsurance	50% coinsurance	70% coinsurance	——————None——————

Common Medical Event	Services You May Need	Your Cost If You Use a Tier 1 Provider	Your Cost If You Use a Tier 2 Provider	Your Cost If You Use a Tier 3 Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$25 copay	$25 copay	70% coinsurance	None
	Mental/Behavioral health inpatient services	10% coinsurance	10% coinsurance	70% coinsurance	None
	Substance use disorder outpatient services	$25 copay	$25 copay	70% coinsurance	None
	Substance use disorder inpatient services	10% coinsurance	10% coinsurance	70% coinsurance	None
If you are pregnant	Prenatal and postnatal care	Prenatal: $0 Postnatal: $25 PCP copay / $40 Specialist copay	Prenatal: $0 Postnatal: $70 PCP copay / $100 Specialist copay	70% coinsurance	None
	Delivery and all inpatient services	10% coinsurance	50% coinsurance	70% coinsurance	None
If you need help recovering or have other special health needs	Home health care	10% coinsurance	50% coinsurance	70% coinsurance	120 visits max per calendar year.
	Rehabilitation services	10% coinsurance	50% coinsurance	70% coinsurance	Combined OT/PT 60 visits max and 60 ST visits max per calendar year.
	Habilitation services	10% coinsurance	50% coinsurance	70% coinsurance	Combined OT/PT 60 visits max and 60 ST visits max per calendar year.
	Skilled nursing care	10% coinsurance	50% coinsurance	70% coinsurance	120 visits max per calendar year.
	Durable medical equipment	10% coinsurance	35% coinsurance	70% coinsurance	None
	Hospice service	10% coinsurance	50% coinsurance	70% coinsurance	None
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	Not Covered	None
	Glasses	Not Covered	Not Covered	Not Covered	None
	Dental check-up	Not Covered	Not Covered	Not Covered	None

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.)**

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- 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.)**

- Acupuncture - 20 visits per calendar year
- Bariatric surgery - Tier 1 & Tier 2 only
- Chiropractic care - 20 visits per calendar year
- Infertility treatment – Limited to $7,500 medical and $7,500 pharmacy lifetime max
- Hearing aids - 1 device every 36 months
- Private-duty nursing - 120 visits per calendar year

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 844-843-3229. 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, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or 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: Customer Services at 844-843-3229. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Language Access Services

Spanish (Español): Para obtener asistencia en Español, llame al 1-254-298-3489 durante el horario de 7:00 am a 9:00 pm.

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.

About these Coverage Examples:

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

This is not a cost estimator.

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

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,100
- **Patient pays** $1,440

Sample care costs:

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

Patient pays:

Deductibles	$800
Copays	$0
Coinsurance	$490
Limits or exclusions	$150
Total	**$1,440**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,500
- **Patient pays** $900

Sample care costs:

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

Patient pays:

Deductibles	$800
Copays	$20
Coinsurance	$0
Limits or exclusions	$80
Total	**$900**

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.