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. For more information about your coverage, or to get a copy of the complete terms of coverage, visit http://bellcounty.swhp.org/benefits, or call 1-800-321-7947. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary at www.cciio.cms.gov.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$500 individual / $1,000 family; Doesn't apply to preventive care	Generally, you must pay all of the costs from **providers** up to the **deductible** amount before this **plan** begins to pay. If you have other family members on the **plan**, each family member must meet their own individual **deductible** until the total amount of **deductible** expenses paid by all family members meets the overall family **deductible**.
Are there services covered before you meet your deductible?	Yes. **Preventive care** and primary care services are covered before you meet your **deductible**.	This **plan** covers some items and services even if you have not 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 do not have to meet **deductibles** for specific services.
What is the out-of-pocket limit for this plan?	$3,750 individual / $7,500 family	The **out-of-pocket limit** is the most you could pay in a year for covered services. If you have other family members in this **plan**, the overall family **out-of-pocket limit** must be met.
What is not included in the out-of-pocket limit?	**Copayments** on certain services, **premiums, balance-billing** charges, and health care this **plan** does not 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 http://bellcounty.swhp.org/benefits or call 1-800-321-7947 for a list of **network providers**.	This **plan** uses a **provider network**. You will pay less if you use a **provider** in the **plan's network**. You will pay the most if you use an **out-of-network provider**, and you might receive a bill from a **provider** for the difference between the **provider's** charge and what your **plan** pays (**balance billing**). Be aware your **network provider** might use an **out-of-network provider** for some services (such as lab work). Check with your **provider** before you get services.
Do you need a referral to see a specialist?	No	You can see the **specialist** you choose without a **referral**.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's **office or clinic**	Primary care visit to treat an injury or illness	$30 copay /visit	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
	Specialist visit	$30 copay /visit	Not Covered	
	Preventive care/screening/ immunization	No Charge	Not Covered	
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	None
	Imaging (CT/PET scans, MRIs)	10% after deductible	Not Covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://bellcounty.swhp.org/pharmacy-information.	Preferred generic drugs	$10 copay per 30 day supply / retail $20 copay per 90 day supply / maintenance	Not Covered	Copays are per 30-day supply. Two copays apply for a 90-day supply if a maintenance drug is obtained through a Baylor Scott & White pharmacy OR when using the mail order prescription service. Specific preventative medications will be covered with no cost to the member. Non-formulary drugs: Greater of $100 or 50%. Maintenance not covered.
	Preferred brand drugs	$40 copay per 30 day supply / retail $80 copay per 90 day supply / maintenance	Not Covered	
	Non-preferred generic drugs and non-preferred Brand drugs and all other Drugs	Lesser of $100 or 50% / retail Lesser of $200 or 50% / maintenance	Not Covered	
	Preferred Specialty drugs	Level 1: 10% of charges Level 2: 20% of charges Level 3: 30% of charges Level 4: 50% of charges	Not Covered	Medical deductible does not apply. Some Specialty drugs may require prior authorization.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% after deductible	Not Covered	None
	Physician/surgeon fees	10% after deductible	Not Covered	
If you need immediate medical attention	Emergency room care	$250 copay plus 10% of charges	$250 copay plus 10% of charges	None
	Emergency medical transportation	10% after deductible	10% after deductible	

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)	
	Urgent care	$75 copay per visit	$75 copay per visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% after deductible	Not Covered	For prior authorization requirements and penalties see http://bellcounty.swhp.org/tools-and-resources. Failure to obtain Prior Authorization will result in the lesser of $500 or 50% reduction in benefits, or denial in the case of Health Care Services, other than Emergency Care, provided by an In-Network Provider.
	Physician/surgeon fees	10% after deductible	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay per visit	Not Covered	None
	Inpatient services	10% after deductible	Not Covered	Requires referral and approval of Medical Director.
If you are pregnant	Office visits	$30 copay per visit	Not Covered	No charge for prenatal visits; postnatal visits are covered at the specialist copay. Depending on the type of services, a **copayment**, **coinsurance**, or **deductible** may apply.
	Childbirth/delivery professional services	10% after deductible	Not Covered	
	Childbirth/delivery facility services	10% after deductible	Not Covered	None
If you need help recovering or have other special health needs	Home health care	$30 copay	Not Covered	None
	Rehabilitation services	$30 copay per visit	Not Covered	Benefit maximum of 20 visits per calendar year, based upon medical necessity; additional 10 visits in home only
	Habilitation services	$30 copay per visit	Not Covered	Benefit maximum of 20 visits per calendar year, based upon medical necessity; additional 10 visits in home only
	Skilled nursing care	10% after deductible	Not Covered	Pre-certification required
	Durable medical equipment	50% after deductible	Not Covered	None
	Hospice services	No Charge	Not Covered	None

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)	
If your child needs dental or eye care	Children's eye exam	$30 copay	Not Covered	One exam limit per year.
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Altered sexual characteristics including sex change operations or any related services
- Blood, blood plasma, and other blood products
- Cosmetic and reconstructive procedures and treatments undertaken to improve or modify a Member's appearance except for mastectomy reconstruction following breast cancer surgery
- Custodial or domiciliary care
- Dental care
- Elective abortions, which are not necessary to preserve the health of the Member
- Elective treatment or elective surgery
- Experimental or investigational treatment
- Genetic testing
- Infertility treatment including any drug whose primary purpose is the treatment of infertility
- Mental health services or disorders are limited to those described in your evidence of coverage
- Non-covered benefits or services
- Cost of services in excess of the usual, customary, and reasonable charges
- Personal comfort items
- Physical and mental exams for employment, licenses, insurance, educational purposes or services for non-medically necessary special education and developmental programs
- Reversal of voluntary surgically-induced sterility; artificial insemination, in-vitro fertilization or family planning therapies
- Rehabilitation services and therapies are limited to those recommended by a Participating or Referral Physician as medically necessary
- Storage of bodily fluids and other body parts
- Experimental organ transplants and associated donor/procurement costs and artificial organs; e.g., heart
- Treatment received in State or Federal facilities or institutions or services or supplies provided by an employer or governmental agency or entity
- Vision corrective surgery including laser application
- War, insurrection, riot, disaster or epidemic
- Weight reduction surgery

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

- Manipulative therapy (35 visit limit per calendar year, 5 visit limit per month)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Scott and White Health Plan, visit http://www.swhp.org , or call 1-800-321-7947; Department of Labor Employee Benefits Security Administration, visit http://www.dol.gov/ebsa/healthreform , or call1-866-444-EBSA (3272); Department of Health and Human Services, Center for Consumer Information, visit http://www.cciio.com.gov, or call 1-877-267-2323 x61565; Texas Department of Insurance, visit http://www.tdi.texas.gov, or call1-800-578-4677. 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: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Scott and White Health Plan, visit http://www.swhp.org , or call 1-800-321-7947; Department of Labor Employee Benefits Security Administration, visit http://www.dol.gov/ebsa/healthreform , or call 1-866-444-EBSA (3272); Texas Department of Insurance, visit http://www.tdi.texas.gov , or call 1-800-252-3439.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-800-321-7947.

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

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	$500
Specialist copayment	$30
Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:

Sample Care Costs
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	**$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$610
Coinsurance	$912
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,082**

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

The plan's overall deductible	$500
Specialist copayment	$30
Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:

Sample Care Costs
Primary care physician office visits (including disease education)
Diagnostic tests (blood work)
Prescription drugs
Durable medical equipment (glucose meter)

Total Example Cost	**$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,550
Coinsurance	$363
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,968**

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

The plan's overall deductible	$500
Specialist copayment	$30
Hospital (facility) coinsurance	10%
Other coinsurance	10%

This EXAMPLE event includes services like:

Sample Care Costs
Emergency room care (including medical supplies)
Diagnostic test (x-ray)
Durable medical equipment (crutches)
Rehabilitation services (physical therapy)

Total Example Cost	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$500
Copayments	$960
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,560**

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

English:

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-321-7947 (TTY: 1-800-735-2989). Scott & White Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Spanish:

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-321-7947 (TTY: 1-800-735-2989). Scott & White Health Plan cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

Vietnamese:

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800 321-7947 (TTY: 1-800-735-2989). Scott & White Health Plan tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.

Chinese:

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-321-7947 (TTY：1-800-735-2989）。Scott & White Health Plan 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。

Korean:

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-321-7947 (TTY: 1-800-735-2989) 번으로 전화해 주십시오. Scott & White Health Plan 은(는) 관련 연방 공민권법을 준수하며 인종, 피부색, 출신 국가, 연령, 장애 또는 성별을 이유로 차별하지 않습니다.

Arabic:

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-321-7947 (رقم هاتف الصم والبكم: 1-800-735-2989).
يلتزم Scott & White Health Plan بقوانين الحقوق المدنية الفدرالية المعمول بها ولا يميز على أساس العرق أو اللون أو الأصل الوطني أو السن أو الإعاقة أو الجنس.

Urdu:

رادربخ: رگا پ آ ودرا ےتلوب ہیں، وت پ آ وک ںابز یک ددم یک تامدخ تفم ںیم بایتسد ںیہ ۔ لاک
ںیرک .1-800-321-7947 (TTY: 1-800-735-2989)
Scott & White Health Plan باق لِ قلاطا یقافو یرہش قوقح ےک نیناوق یک لیمعت اترک ےہ
روا هیہ ےک نسل، گنر ، قومیت، عمر، ی روذعم ایسنج یک دایبن رپ زایتما ںیہن اترک

Tagalog:

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-3217947 (TTY: 1-800-735-2989). Sumusunod ang Scott & White Health Plan sa mga naaangkop na Pederal na batas sa karapatang sibil at hindi nandidiskrimina batay sa lahi, kulay, bansang pinagmulan, edad, kapansanan o kasarian.

French:

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-321-7947 (ATS: 1-800-7352989). Scott & White Health Plan respecte les lois fédérales en vigueur relatives aux droits civiques et ne pratique aucune discrimination basée sur la race, la couleur de peau, l'origine nationale, l'âge, le sexe ou un handicap.

Hindi:

ध्यान दें: यदि आप िहंदी बोलते हैं तो आपके िलए मुफ्त में भाषा सहायता सेवाएंउपलब्ध हैं। 1-800-321-7947 (TTY: 1-800-735-2989) पर कॉल करें। Scott & White Health Plan लागू होनेयोग्य संघीय नागरक अिधकार क़ानून का पालन करता हैऔर जाित, रंग, राष्ट्रीय मूल, आयु, िवकलांगता, या िलंग के आधार पर भेदभाव नहीं करता है।

Persian:

هجوت: رگا هبنابز یسرافوگتفگیمکنید،تلایهستینابزت روصبناگیار ی اربامش هطوبرمتیعبتیمدنکو مهارفیمدشاب. اب(1-800-321-7947 (TTY: 1-800-735-2989سامتدیریگب.
Scott & White Health Plan زانیناوقوقحیندمالاردف اقیسنجداریتیاتاذناوتی، سن، تیلصاملیتی،تسوپ رنگ، داژناسارسبردیعبتضیعبی هیچگونه. شدومندیقایل

German:

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-321-7947 (TTY: 1-800-735-2989). Scott & White Health Plan erfüllt geltenden bundesstaatliche Menschenrechtsgesetze und lehnt jegliche Diskriminierung aufgrund von Rasse, Hautfarbe, Herkunft, Alter, Behinderung oder Geschlecht ab.

Gujarati:
ધ્યાન: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-321-7947 (TTY: 1-800-735-2989). Scott & White Health Plan લાગુ પડતા સમવાયી નાગરિક અધિકાર કાયદા સાથે સુસંગત છે અને જાતિ, રંગ,રાષ્ટ્રીય મૂળ, ઉમર,અશક્તતા અથવા લિંગના આધારે ભેદભાવ રાખવામાં આવતો નથી.

Russian:
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-321-7947 (телетайп: 1-800-735-2989). Scott & White Health Plan соблюдает применимое федеральное законодательство в области гражданских прав и не допускает дискриминации по признакам расы, цвета кожи, национальной принадлежности, возраста, инвалидности или пола.

Japanese:
注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。1-800-321-7947 (TTY:1-800-735-2989) まで、お電話にてご連絡ください。Scott & White Health Plan は適用される連邦公民権法を遵守し、人種、肌の色、出身国、年齢、障害または性別に基づく差別をいたしません。

Laotian:
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍ ລິ ການຊ່ ວຍເຫຼື ອດ້ານພາສາ, ໂດຍບໍ່ ເສັ ງຄ່ າ, ແມ່ ນມີ ພ້ອມໃຫ້ທ່ ານ. ໂທຣ 1-800-321-7947 (TTY: 1-800-735-2989). Scott & White Health Plan ປະຕິ ບັດຕາມກົດໝາຍວ່ າດ້ວຍສິ ດທິ ພົນລະເມື ອງຂອງຣັຖບານກາງທີ່ ບັງຄັບໃຊ້ ແລະບໍ່ ຈໍ າແນກໂດຍອີ ງໃສ່ ພື້ ນຖານດ້ານເຊື້ ອຊາດ, ສີຜິ ວ, ຊາດກໍ າເນີ ດ, ອາຍຸ , ຄວາມພິ ການ, ຫຼື ເພດ.