




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](http://www.cciio.cms.gov).

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$1,000 individual / \$2,000 family; Doesn't apply to preventive care	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> and primary care services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you have not yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
Are there other <a href="#">deductibles</a> for specific services?	No.	You do not have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$3,750 individual / \$7,500 family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , the overall family <a href="#">out-of-pocket limit</a> must be met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Copayments</a> on certain services, <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> does not cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://bellcounty.swhp.org/benefits">http://bellcounty.swhp.org/benefits</a> or call 1-800-321-7947 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$30 <a href="#">copay</a> /visit	Not Covered	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
	<a href="#">Specialist</a> visit	\$30 <a href="#">copay</a> /visit	Not Covered	
	<a href="#">Preventive care/screening/immunization</a>	No Charge	Not Covered	
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No Charge	Not Covered	None
	Imaging (CT/PET scans, MRIs)	20% after <a href="#">deductible</a>	Not Covered	
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://bellcounty.swhp.org/pharmacy-information">http://bellcounty.swhp.org/pharmacy-information</a> .	Preferred generic drugs	\$10 <a href="#">copay</a> per 30 day supply / retail \$20 <a href="#">copay</a> per 90 day supply / maintenance	Not Covered	Copays are per 30-day supply. Two <a href="#">copays</a> 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.
	Preferred brand drugs	\$40 <a href="#">copay</a> per 30 day supply / retail \$80 <a href="#">copay</a> 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	Non-formulary drugs: Greater of \$100 or 50%. Maintenance not covered.
	<a href="#">Preferred Specialty drugs</a>	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 <a href="#">Specialty drugs</a> may require prior authorization.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% after <a href="#">deductible</a>	Not Covered	None
	Physician/surgeon fees	20% after <a href="#">deductible</a>	Not Covered	
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$250 <a href="#">copay</a> plus 20% of charges	\$250 <a href="#">copay</a> plus 20% of charges	None
	<a href="#">Emergency medical transportation</a>	20% after <a href="#">deductible</a>	20% after <a href="#">deductible</a>	

\* For more information about limitations and exceptions, see the plan or policy document at <http://bellcounty.swhp.org/>

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)	
	<a href="#">Urgent care</a>	\$75 <u>copay</u> per visit	\$75 <u>copay</u> per visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% after <u>deductible</u>	Not Covered	For prior authorization requirements and penalties see <a href="http://bellcounty.swhp.org/tools-and-resources">http://bellcounty.swhp.org/tools-and-resources</a> . 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	20% after <u>deductible</u>	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$30 <u>copay</u> per visit	Not Covered	None
	Inpatient services	20% after <u>deductible</u>	Not Covered	Requires referral and approval of Medical Director.
If you are pregnant	Office visits	\$30 <u>copay</u> per visit	Not Covered	No charge for prenatal visits; postnatal visits are covered at the specialist <u>copay</u> .
	Childbirth/delivery professional services	20% after <u>deductible</u>	Not Covered	Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply.
	Childbirth/delivery facility services	20% after <u>deductible</u>	Not Covered	None
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	\$30 <u>copay</u>	Not Covered	None
	<a href="#">Rehabilitation services</a>	\$30 <u>copay</u> per visit	Not Covered	Benefit maximum of 20 visits per calendar year, based upon medical necessity; additional 10 visits in home only
	<a href="#">Habilitation services</a>	\$30 <u>copay</u> per visit	Not Covered	Benefit maximum of 20 visits per calendar year, based upon medical necessity; additional 10 visits in home only
	<a href="#">Skilled nursing care</a>	20% after <u>deductible</u>	Not Covered	Pre-certification required
	<a href="#">Durable medical equipment</a>	50% after <u>deductible</u>	Not Covered	None
	<a href="#">Hospice services</a>	No Charge	Not Covered	None

\* For more information about limitations and exceptions, see the plan or policy document at <http://bellcounty.swhp.org/>

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 <u>copay</u>	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 <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)			
<ul style="list-style-type: none"> <li>Altered sexual characteristics including sex change operations or any related services</li> </ul>	<ul style="list-style-type: none"> <li>Infertility treatment including any drug whose primary purpose is the treatment of infertility</li> </ul>	<ul style="list-style-type: none"> <li>Storage of bodily fluids and other body parts</li> </ul>	
<ul style="list-style-type: none"> <li>Blood, blood plasma, and other blood products</li> </ul>	<ul style="list-style-type: none"> <li>Mental health services or disorders are limited to those described in your evidence of coverage</li> </ul>	<ul style="list-style-type: none"> <li>Experimental organ transplants and associated donor/procurement costs and artificial organs; e.g., heart</li> </ul>	
<ul style="list-style-type: none"> <li>Cosmetic and reconstructive procedures and treatments undertaken to improve or modify a Member's appearance except for mastectomy reconstruction following breast cancer surgery</li> </ul>	<ul style="list-style-type: none"> <li>Non-covered benefits or services</li> </ul>	<ul style="list-style-type: none"> <li>Treatment received in State or Federal facilities or institutions or services or supplies provided by an employer or governmental agency or entity</li> </ul>	
<ul style="list-style-type: none"> <li>Custodial or domiciliary care</li> </ul>	<ul style="list-style-type: none"> <li>Cost of services in excess of the usual, customary, and reasonable charges</li> </ul>	<ul style="list-style-type: none"> <li>Vision corrective surgery including laser application</li> </ul>	
<ul style="list-style-type: none"> <li>Dental care</li> </ul>	<ul style="list-style-type: none"> <li>Personal comfort items</li> </ul>	<ul style="list-style-type: none"> <li>War, insurrection, riot, disaster or epidemic</li> </ul>	
<ul style="list-style-type: none"> <li>Elective abortions, which are not necessary to preserve the health of the Member</li> </ul>	<ul style="list-style-type: none"> <li>Physical and mental exams for employment, licenses, insurance, educational purposes or services for non-medically necessary special education and developmental programs</li> </ul>	<ul style="list-style-type: none"> <li>Weight reduction surgery</li> </ul>	
<ul style="list-style-type: none"> <li>Elective treatment or elective surgery</li> </ul>	<ul style="list-style-type: none"> <li>Reversal of voluntary surgically-induced sterility; artificial insemination, in-vitro fertilization or family planning therapies</li> </ul>		
<ul style="list-style-type: none"> <li>Experimental or investigational treatment</li> </ul>	<ul style="list-style-type: none"> <li>Rehabilitation services and therapies are limited to those recommended by a Participating or Referral Physician as medically necessary</li> </ul>		
<ul style="list-style-type: none"> <li>Genetic testing</li> </ul>			
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)			
<ul style="list-style-type: none"> <li>Manipulative therapy (35 visit limit per calendar year, 5 visit limit per month)</li> </ul>			

\* For more information about limitations and exceptions, see the plan or policy document at <http://bellcounty.swhp.org/>

**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 call 1-866-444-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 call 1-800-578-4677. 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](http://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](#) \$1,000
- [Specialist](#) [copayment](#) \$30
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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)

<b>Total Example Cost</b>	<b>\$12,731</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$610
Coinsurance	\$1,825
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,495</b>

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

- The [plan's](#) overall [deductible](#) \$1,000
- [Specialist](#) [copayment](#) \$30
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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)

<b>Total Example Cost</b>	<b>\$7,389</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1,550
Coinsurance	\$363
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$1,968</b>

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

- The [plan's](#) overall [deductible](#) \$1,000
- [Specialist](#) [copayment](#) \$30
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 20%

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)

<b>Total Example Cost</b>	<b>\$1,925</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$658
Copayments	\$960
Coinsurance	\$183
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,800</b>

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:**

تظوظلم: اذا تكتتحدثت ركذا اللغة، نإفتمدخ دةعاسملا تميؤغلا رفاوئتد كلكن اجملاب. لصتا مقرب 1-800-321-7947 (مقر فتاه مصلا مكبلاو: 1-800-735-2989).  
مزتلب Scott & White Health Plan نيناوقب قوقحلا تيندملا تيلاردفلا لومعملا اهدلاو زيميى لعس اسأ قرعلا وأنوللا وأ لصلأا ينطولا وأنسلا وأ تقاعلا أو أسنجا.

**Urdu:**

رادربخ: رگا پ آ ودر اے تلو ب ہیں، و تپ آ وک نابز ی ک ددم ی ک تامدخ ت فم یم بایتسد یمب - لاک  
1-800-321-7947 (TTY: 1-800-735-2989) یرک  
Scott & White Health Plan باقل ِل قلاطی قافو یر هشد قوقد ے ک نیناوق ے ک لیمعت اترک ے پ  
روا هیه ک نسل، گنر ، قومیت، عمر، ی روذعم ایس نجی ک داینر پ زایتما یمب 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 nandiskrimina 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 सेवाएं उपलब्ध हैं। 1-800-321-7947 (TTY: 1-800-735-2989) पर कॉल करें। Scott & White Health Plan लागू होनेयोग्य संघीय नागरक अधिकार कानून का पालन करता है और जाित, रंग, राष्ट्रीय मूल, आयु, िवकलांगता, या िलंग के आधार पर भेदभाव नहीं करता है।

**Persian:**

مطوبر متيعبتی مدنکو مهارفی مدشایر اب (1-800-321-7947 (TTY: 1-800-735-2989) س امتدیر یگیب. مچوت: رگا مین ابز ی سرافوگتفگی مکنید، تلابهست ی نابز ت روصین اگیار ی اربامش  
لیاقی مندوش. مچوگیه ی ضیعبتن بس اسانژ اد، گنر پوست، تیلصاملیتی، سن، ی ناوتادایت بیسنجدار فا Scott & White Health Plan زانیناوقه وقحی ندم لاردف

**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:**

સુચના: 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 લાંબા પડતા સમવાયી નાગરિક અધિકાર કાયદા સાથે સુસંગત છે અને નિત, રંગ, રાષ્ટ્રીય સ્ત્રી, સ્કી, અશક્તતા અથવા નિલ્લાના આધારે ભેદભાવ રાખવામાં આવતી 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, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີ ພ້ອມໃຫ້ທ່ານ. ໂທ 1-800-321-7947 (TTY: 1-800-735-2989). Scott & White Health Plan ປະຕິບັດຕາມກົດໝາຍວ່າດ້ວຍສິດທິພົນລະເມືອງຂອງຮູບພາບກາງທີ່ບັງຄັບໃຊ້ ແລະບໍ່ຈຳແນກໂດຍອີງໃສ່ພື້ນຖານດ້ານເຊື້ອຊາດ, ີສີ, ວ, ຊາດກຳເນີດ, ອາຍຸ, ຄວາມພິການ, ຫຼື ເພດ.