



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://bswh.swhp.org/>, or call 1-844-843-3229. 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 view the Glossary at www.cciio.cms.gov or call 1-844-843-3229 to request a copy.

Important Questions	Answers	Why This Matters:																				
What is the overall deductible ?	<table border="1"> <thead> <tr> <th>INN</th> <th>Tier 1</th> <th>Tier 2</th> <th>Tier 3</th> </tr> </thead> <tbody> <tr> <td>EE</td> <td>\$2,000</td> <td>\$3,000</td> <td>\$4,000</td> </tr> <tr> <td>ES</td> <td>\$4,000</td> <td>\$6,000</td> <td>\$8,000</td> </tr> <tr> <td>EC</td> <td>\$4,000</td> <td>\$6,000</td> <td>\$8,000</td> </tr> <tr> <td>EF</td> <td>\$4,000</td> <td>\$6,000</td> <td>\$8,000</td> </tr> </tbody> </table> <p>Does not apply to preventive care.</p>	INN	Tier 1	Tier 2	Tier 3	EE	\$2,000	\$3,000	\$4,000	ES	\$4,000	\$6,000	\$8,000	EC	\$4,000	\$6,000	\$8,000	EF	\$4,000	\$6,000	\$8,000	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 policy, the overall family deductible must be met before the plan begins to pay. There is an aggregate deductible for coverage tiers Employee + Spouse (ES), Employee + Children (EC), Employee + Family (EF) coverage.
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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 ?	<table border="1"> <thead> <tr> <th>INN</th> <th>Tier 1</th> <th>Tier 2</th> <th>Tier 3</th> </tr> </thead> <tbody> <tr> <td>EE</td> <td>\$3,275</td> <td>\$6,550</td> <td>Unlimited</td> </tr> <tr> <td>ES</td> <td>\$6,550</td> <td>\$13,100</td> <td>Unlimited</td> </tr> <tr> <td>EC</td> <td>\$6,550</td> <td>\$13,100</td> <td>Unlimited</td> </tr> <tr> <td>EF</td> <td>\$6,550</td> <td>\$13,100</td> <td>Unlimited</td> </tr> </tbody> </table>	INN	Tier 1	Tier 2	Tier 3	EE	\$3,275	\$6,550	Unlimited	ES	\$6,550	\$13,100	Unlimited	EC	\$6,550	\$13,100	Unlimited	EF	\$6,550	\$13,100	Unlimited	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 , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. There is an embedded out-of-pocket limit for coverage tiers Employee + Spouse (ES), Employee + Children (EC), Employee + Family (EF) coverage.
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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://bswh.swhp.org/ or call 1-844-843-3229 for a list of network providers .	You pay the least if you use a provider in Preferred Network. You pay more if you use a provider in In-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
		Tier 1: Preferred Network Provider (You will pay the least)	Tier 2: In-Network Provider	Tier 3: 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	10% after <u>deductible</u>	50% after <u>deductible</u>	70% after <u>deductible</u>	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.
	<u>Specialist</u> visit	10% after <u>deductible</u>	50% after <u>deductible</u>	70% after <u>deductible</u>	
	<u>Preventive care/screening/immunization</u>	No Charge	No Charge	Not Covered	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% after <u>deductible</u>	50% after <u>deductible</u>	70% after <u>deductible</u>	None
	Imaging (CT/PET scans, MRIs)	10% after <u>deductible</u>	50% after <u>deductible</u>	70% after <u>deductible</u>	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at http://www.bsw.hsw.org/pharmacy-information .	Preferred generic drugs	\$3 <u>copay</u> after <u>deductible</u> per 30-day supply (retail); \$6 <u>copay</u> after <u>deductible</u> per 90-day supply (maintenance)	\$5 <u>copay</u> after <u>deductible</u> per 30-day supply (retail)	50% after <u>deductible</u>	<u>Copays</u> are per 30-day supply. Two <u>copays</u> apply for a 90-day supply if a maintenance drug is obtained through a Baylor Scott & White Health pharmacy OR when using the mail order prescription service. Specific preventive medications will be covered with no cost to the member.
	Preferred brand drugs	\$35 <u>copay</u> after <u>deductible</u> per 30-day supply (retail); \$70 <u>copay</u> after <u>deductible</u> per 90-day supply (maintenance)	\$50 <u>copay</u> after <u>deductible</u> per 30-day supply (retail)	50% after <u>deductible</u>	
	Non-preferred generic drugs and non-preferred brand drugs	Lesser of \$50 or 50% after <u>deductible</u> (retail); Lesser of \$100 or 50% after <u>deductible</u> (maintenance)	Lesser of \$75 or 50% after <u>deductible</u> (retail)	50% after <u>deductible</u>	If a brand name drug is dispensed when a generic is available, 50% after <u>deductible</u> applies.
	<u>Specialty drugs</u>	20% after <u>deductible</u> (\$200 max (retail))	Not Covered	Not Covered	Non-formulary drugs: 50% after <u>deductible</u> Some drugs may require prior authorization.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1: Preferred Network Provider (You will pay the least)	Tier 2: In-Network Provider	Tier 3: Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% after <u>deductible</u>	50% after <u>deductible</u>	70% after <u>deductible</u>	None
	Physician/surgeon fees	10% after <u>deductible</u>	50% after <u>deductible</u>	70% after <u>deductible</u>	
If you need immediate medical attention	Emergency room care	10% after <u>deductible</u>	10% after <u>deductible</u>	10% after <u>deductible</u>	None
	Emergency medical transportation	10% after <u>deductible</u>	10% after <u>deductible</u>	10% after <u>deductible</u>	
	Urgent care	10% after <u>deductible</u>	50% after <u>deductible</u>	50% after <u>deductible</u>	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% after <u>deductible</u>	50% after <u>deductible</u>	70% after <u>deductible</u>	None
	Physician/surgeon fees	10% after <u>deductible</u>	50% after <u>deductible</u>	70% after <u>deductible</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% after <u>deductible</u>	10% after <u>deductible</u>	70% after <u>deductible</u>	None
	Inpatient services	10% after <u>deductible</u>	10% after <u>deductible</u>	70% after <u>deductible</u>	None
If you are pregnant	Office visits	10% after <u>deductible</u>	50% after <u>deductible</u>	70% after <u>deductible</u>	No charge for prenatal visits for Tiers 1 and 2.
	Childbirth/delivery professional services	10% after <u>deductible</u>	50% after <u>deductible</u>	70% after <u>deductible</u>	Depending on the type of services, a copayment , coinsurance , or deductible may apply.
	Childbirth/delivery facility services	10% after <u>deductible</u>	50% after <u>deductible</u>	70% after <u>deductible</u>	None
	Home health care	10% after <u>deductible</u>	50% after <u>deductible</u>	70% after <u>deductible</u>	120 visit limit per year.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1: Preferred Network Provider (You will pay the least)	Tier 2: In-Network Provider	Tier 3: Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Rehabilitation services	10% after <u>deductible</u>	50% after <u>deductible</u>	70% after <u>deductible</u>	Combined OT/PT 60 visits max and 60 ST visits max per calendar year.
	Habilitation services	10% after <u>deductible</u>	50% after <u>deductible</u>	70% after <u>deductible</u>	Combined OT/PT 60 visits max and 60 ST visits max per calendar year.
	Skilled nursing care	10% after <u>deductible</u>	50% after <u>deductible</u>	70% after <u>deductible</u>	120 visit limit per year.
	Durable medical equipment	10% after <u>deductible</u>	50% after <u>deductible</u>	70% after <u>deductible</u>	None
	Hospice services	10% after <u>deductible</u>	50% after <u>deductible</u>	70% after <u>deductible</u>	None
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	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 .)		
• Cosmetic surgery	• Non-emergency care when traveling outside U.S.	• Routine foot care
• Dental care (Adult)	• Routine eye care (Adult)	• Weight loss programs
• Long-term care		

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
• Acupuncture (20 visit limit per calendar year)	• Hearing aids (1 device every 36 months)
• Bariatric surgery (Tier 1 and Tier 2 only)	• Infertility treatment (Limited to \$7,500 medical and \$7,500 pharmacy lifetime max)
• Chiropractic care (20 visit limit per calendar year)	• Private-duty nursing (120 visit limit per calendar year)

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: WageWorks, visit www.wageworks.com, or call (877)-502-6272; Department of Labor Employee Benefits Security Administration, visit <http://www.dol.gov/ebsa/healthreform>, or call 1-866-444-EBSA (3272). 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://bswh.swhp.org/>, or call 1-844-843-3229; Department of Labor Employee Benefits Security Administration, visit <http://www.dol.gov/ebsa/healthreform>, or call 1-866-444-EBSA (3272).

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 1-844-843-3229.

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	\$2,000
■ Specialist copayment	10%
■ 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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,000
Copayments	\$12
Coinsurance	\$1,260
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,332

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$2,000
■ Specialist copayment	10%
■ 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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,575
Copayments	\$991
Coinsurance	\$175
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Joe would pay is	\$2,796

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$2,000
■ Specialist copayment	10%
■ 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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,733
Copayments	\$0
Coinsurance	\$192
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,925

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 بتك تدهتت ركذا اللغة، نإف تامدخ دعاملا تيوغلا رفاوتت كلن اجملاب. لصتا مقرب 1-800-321-7947 (مقر فتاه مصلا مكبلو: 1-800-735-2989).
مزتلي Scott & White Health Plan نيناوقب قوقحا تيندما تيلار دفلا لومعلا اهبل لاو زيمي لءس اسأ قرعلا وانوللا وأ لصلأا ينطولا وانسلا وأ تقاعلا واسنجا.

Urdu:

رادربخ: رگا پ آ ودرآ ے تلود بیں، وت پ آ وک نابز کی کدم کی کتامدخ تدم نیم بایتسد نیپ۔ لاک
نیرک. 1-800-321-7947 (TTY: 1-800-735-2989).
Scott & White Health Plan باق ل قلاطی قافو یرہش قوقد ے ک نیناوق کی ک لیمعتا ترک ے پ
روا ہیک نسل، گنر، قومیت، عمر، یہ روذعم ایس نجی ک داینبر پ زایتما نیہن 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 हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-321-7947 (TTY: 1-800-735-2989) पर कॉल करें। Scott & White Health Plan लागू होने योग्य संघीय नागरिक अधिकार कानून का पालन करता है और जाति, रंग, राष्ट्रीय मूल, आयु, विकलांगता, या लिंग के आधार पर भेदभाव नहीं करता है।

Persian:

ی ندم لار دفاطویر متبعیت می مدنکو مهار فی مدشابه اب (TTY: 1-800-735-2989) 1-800-321-7947 س امتدیر یگه. هجوت: رگا بین ابز ی سرافوگتفگی مکنید، تلابهستی نایزت روسین اگیار ی اربامش لیاقی مندوشه. هنوگچیهی ضیعیتربس اسانژاد، گنر پوست، تیلصاملیتی، سن، ی ناوتادیات یسنجدار فا Scott & White Health Plan زان یناوقه وقد

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:

નુચના: જો તમે ગુજરાતી બોલતા હો, તો િન:નુલક ભાષા સહાય સેવાઓ તમારા માટ ઉપલબ્ધ છે. ફોન કરો 1-800-321-7947 (TTY: 1-800-735-2989). Scott & White Health Plan લાનુ પડતા સમવાયી નાગરક અધિકાર કાયદા સાથે નુસંગત છે અને નિત, રંગ, રાષ્ટ્રન્ય નૂળ, નમર, અશક્તતા અથવા નલગના આધારને 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:

ໂບດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອ ອຳນາດພາສາ, ໂດຍບໍ່ເສຍຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-800-321-7947 (TTY: 1-800-735-2989). Scott & White Health Plan ປະຕິບັດຕາມກົດໝາຍວ່າດ້ວຍສິດທິພົນລະເມັດ ອາດຊ່ວຍຮັບບາບກາງທີ່ບັງຄັບໃຊ້ ແລະບໍ່ຈຳແນກໂດຍອີງໃສ່ພື້ນຖານດ້ານເຊື້ອຊາດ, ີສຜິວ, ຊາດກຳເນີດ, ອາຍຸ, ຄວາມພິການ, ຫຼື ເພດ.