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 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 ciio.cms.gov or call 1-844-843-3229 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	INN Tier 1 Tier 2 Tier 3 EE $1000 $2,000 $5,000 EF $2,000 $4,000 10,000 Does not 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. There is an embedded deductible for coverage tier Employee + Family (which includes Employee + Spouse and Employee + Children).
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 preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at 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?	INN Tier 1 Tier 2 Tier 3 EE $4,000 $6,750 Unlimited EF $8,000 $13,500 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 tier Employee + Family (which includes Employee + Spouse and Employee + Children). For Tier 1 and Tier 2, deductible included in out-of-pocket max.
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 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	$35 copay per visit; deductible does not apply	$70 copay per visit; deductible does not apply.	70% after deductible	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	$60 copay per visit; deductible does not apply	$100 copay per visit; deductible does not apply	70% after deductible	
	Preventive care/screening/ immunization	No charge	No charge	Not covered	
If you have a test	Diagnostic test (x-ray, blood work)	10% after deductible	50% after deductible	70% after deductible	For prior authorization requirements see bswh.swhp.org/tools-and-resources.
	Imaging (CT/PET scans, MRIs)	10% after deductible	50% after deductible	70% after deductible	For prior authorization requirements see bswh.swhp.org/tools-and-resources.

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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at bswh.swhp.org/pharmacy-information.	Preferred generic drugs	$3 copay per 30-day supply (retail); $6 copay per 90-day supply (maintenance). Deductible does not apply.	$5 copay per 30-day supply (retail). Deductible does not apply.	50% after deductible	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 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 copay per 30-day supply (retail); $70 copay per 90-day supply (maintenance). Deductible does not apply.	$50 copay per 30-day supply (retail). Deductible does not apply.	50% after deductible	
	Non-preferred generic drugs and non-preferred brand drugs	Lesser of $50 or 50% coinsurance (retail); Lesser of $100 or 50% coinsurance (maintenance). Deductible does not apply.	Lesser of $75 or 50% coinsurance (retail). Deductible does not apply.	50% after deductible	
	Specialty drugs	20% coinsurance ($200 max; retail). Deductible does not apply.	Not Covered	Not covered	Available through Baylor Scott & White pharmacy only. Some drugs may require prior authorization. 30-day supply only.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% after deductible	50% after deductible	70% after deductible	None
	Physician/surgeon fees	10% after deductible	50% after deductible	70% after deductible	
If you need immediate medical attention	Emergency room care	$250 copay per visit; deductible does not apply	$250 copay per visit; deductible does not apply	$250 copay per visit; deductible does not apply	Copayment waived if admitted. Emergency transportation includes ground and air ambulance.
	Emergency medical transportation	$250 copay; deductible does not apply	$250 copay; deductible does not apply	$250 copay; deductible does not apply	

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)	
	Urgent care	$75 copay per visit; deductible does not apply	$100 copay per visit; deductible does not apply	$100 copay per visit; deductible does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% after deductible	50% after deductible	70% after deductible	None
	Physician/surgeon fees	10% after deductible	50% after deductible	70% after deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35 copay per visit; deductible does not apply	$70 copay per visit; deductible does not apply	70% after deductible	None
	Inpatient services	10% after deductible	50% after deductible	70% after deductible	None
If you are pregnant	Office visits	$35 copay per visit (PCP visit); $60 copay per visit (Specialist visit); deductible does not apply.	$70 copay per visit (PCP visit); $100 per visit (Specialist visit); deductible does not apply.	70% after deductible	No charge for prenatal visits for Tiers 1 and 2. Depending on the type of services, a copayment, coinsurance, or deductible may apply.
	Childbirth/delivery professional services	10% after deductible	50% after deductible	70% after deductible	None
	Childbirth/delivery facility services	10% after deductible	50% after deductible	70% after deductible	
If you need help recovering or have other special health needs	Home health care	10% after deductible	50% after deductible	70% after deductible	120 visit limit per calendar year.
	Rehabilitation services	10% after deductible	50% after deductible	70% after deductible	Combined OT/PT 60 visits max and 60 ST visits max per calendar 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)	
	Habilitation services	10% after deductible	50% after deductible	70% after deductible	Combined OT/PT 60 visits max and 60 ST visits max per calendar year,
	Skilled nursing care	10% after deductible	50% after deductible	70% after deductible	120 visit limit per calendar year.
	Durable medical equipment	10% after deductible	50% after deductible	70% after deductible	None
	Hospice services	10% after deductible	50% after deductible	70% after deductible	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: Optum, adminservices.optumhealthfinancial.com, or call 866-301-6681; Department of Labor Employee Benefits Security Administration, visit dol.gov/ebsa/healthreform , or call1-866-444-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 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 bswh.swhp.org/ , or call 1-844-843-3229; Department of Labor Employee Benefits Security Administration, visit 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	$1,000
Specialist copayment	$60
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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$80
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,240**

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	$60
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	**$7,500**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$1,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,060**

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

The plan's overall deductible	$1,000
Specialist copayment	$60
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	**$2,000**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$200
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,400**

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

Nondiscrimination Notice

Scott&White HEALTH PLAN
PART OF BAYLOR SCOTT & WHITE HEALTH

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-321-7947 (TTY: 711).

Scott and 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 Scott and White Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Scott and White Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print and accessible electronic formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Scott and White Health Plan (SWHP) Compliance Officer at 1-254-820-8888 or send an email to SWHPComplianceDepartment@BSWHealth.org.

If you believe that Scott and White Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

SWHP Compliance Officer
1206 West Campus Drive, Suite 151
Temple, Texas 76502

Compliance HelpLine; 1-888-484-6977 or https://app.mycompliancereport.com/report.aspx?cid=swhp

You can file a grievance in person or by mail, online, or email. If you need help filing a grievance, the SWHP Compliance Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at https://www.hhs.gov/civil-rights/filing-a-complaint/index.html.

Language Assistance

English:
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-321-7947 (TTY: 711).

Spanish:
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-321-7947 (TTY: 711).

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: 711).

Chinese:
注意：如果 使用繁體中文, 可以免費獲得語言援助服務。請致電 1-800-321-7947(TTY：711)。

Korean:
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-321-7947 (TTY: 711) 번으로 전화해 주십시오.

Arabic:
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-321-7947 (TTY: 711). هاتف الصم والبكم: 866-334-3141 (رقم

Urdu:
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال 1-800-321-7947 (TTY: 711). کریں

Tagalog:
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-321-7947 (TTY: 711).

French:
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-321-7947 (ATS : 711).

Hindi:
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-321-7947 (TTY: 711) पर कॉल करें।

Persian:
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-321-7947 (TTY: 711) تماس بگیرید.

German:
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-321-7947 (TTY: 711).

Gujarati:
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-321-7947 (TTY: 711).

Russian:
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-321-7947 (телетайп: 711).

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:711) まで、お電話にてご連絡ください。

Laotian:
ໂປດຊາບ: ຖ້າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ ທ່ານ. ໂທຣ 1-800-321-7947 (TTY: 711).