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

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>In-network: $0 Employee Only (EE) / $0 Employee &amp; Family (EF); Out-of-network: not covered</td>
<td>Generally, if your plan has a deductible, 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.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Preventive care and primary care services are covered before you meet your deductible.</td>
<td>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/.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You do not have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>In-network: $3,000 Employee Only (EE) / $6,000 Employee &amp; Family (EF); Out-of-network: not covered</td>
<td>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). Deductible included in out-of-pocket max.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billing charges, and health care this plan does not cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See bswh.swhp.org or call 1-800-321-7947 for a list of network providers.</td>
<td>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.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>In-Network (You will pay the least)</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$10 copay per visit</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$40 copay per visit</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/ immunization</td>
<td>No charge</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>X-ray: $75 copay per visit; Labs: 20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$100 copay per visit for PET, CT, CAT, etc. $150 copay per visit for MRI</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Preferred generic drugs</td>
<td>BSWH Pharmacy: $3 copay per 30-day supply / retail; $6 copay per 90-day supply / maintenance Contracted Pharmacy: $5 copay per 30-day supply / retail</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>BSWH Pharmacy: $25 copay per 30-day supply / retail; $50 copay per 90-day supply / maintenance Contracted Pharmacy: $50 copay per 30-day supply / retail</td>
</tr>
<tr>
<td></td>
<td>Non-preferred generic drugs and non-preferred brand drugs</td>
<td>BSWH Pharmacy: lesser of $50 or 50% coinsurance (retail); lesser of $100 or 50% coinsurance (maintenance)</td>
</tr>
</tbody>
</table>

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-Network (You will pay the least)</td>
<td>Out-of-Network (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Contracted Pharmacy:</strong></td>
<td><strong>BSWH Pharmacy:</strong></td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>lesser of $75 or 50% coinsurance (retail)</td>
<td>$100 copay per 30-day supply</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$150 copay per visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>0% after applicable copay</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$250 copay per visit</td>
<td>$250 copay per visit</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>$250 copay per visit</td>
<td>$250 copay per visit</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$50 copay per visit</td>
<td>$50 copay per visit</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>$150 copay per day (maximum of 5 days), then 0% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>0% after applicable copay</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>$10 copay per visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>$150 copay per day (maximum of 5 days), then 0% coinsurance</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>$10 copay per visit (PCP visit); $40 copay per visit (Specialist visit)</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>0% after applicable copay</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

Depending on the type of services, a copayment or coinsurance may apply.
### Common Medical Event | Services You May Need | What You Will Pay | Limitations, Exceptions, & Other Important Information
---|---|---|---
**If you need help recovering or have other special health needs**
| Childbirth/delivery facility services | $150 copay per day (maximum of 5 days), then 0% coinsurance | Not covered | None
| Home health care | 10% coinsurance | Not covered | 120 visits per calendar year.
| Rehabilitation services | $40 copay per visit | Not covered | Combined occupational/physical therapy 60 visits max per calendar year, speech therapy 60 visits max per calendar year.
| Habilitation services | $40 copay per visit | Not covered | Combined occupational/physical therapy 60 visits max per calendar year, speech therapy 60 visits max per calendar year.
| Skilled nursing care | 10% coinsurance | Not covered | 120 day max per calendar year
| Durable medical equipment | 10% coinsurance | Not covered | None
| Hospice services | 10% coinsurance | Not covered | None

**If your child needs dental or eye care**
| Children’s eye exam | Not covered | Not covered | None
| 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.)
- 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
- 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 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 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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)</th>
<th>Managing Joe’s type 2 Diabetes (a year of routine in-network care of a well-controlled condition)</th>
<th>Mia’s Simple Fracture (in-network emergency room visit and follow up care)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The plan’s overall deductible</td>
<td>The plan’s overall deductible</td>
<td>The plan’s overall deductible</td>
</tr>
<tr>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Specialist copayment</td>
<td>Specialist copayment</td>
<td>Specialist copayment</td>
</tr>
<tr>
<td>$40</td>
<td>$40</td>
<td>$40</td>
</tr>
<tr>
<td>Hospital (facility) copay</td>
<td>Hospital (facility) copay</td>
<td>Hospital (facility) copay</td>
</tr>
<tr>
<td>$150</td>
<td>$150</td>
<td>$150</td>
</tr>
<tr>
<td>Other coinsurance</td>
<td>Other coinsurance</td>
<td>Other coinsurance</td>
</tr>
<tr>
<td>10%</td>
<td>10%</td>
<td>10%</td>
</tr>
</tbody>
</table>

This EXAMPLE event includes services like:

### Peg is Having a Baby
- Specialist office visits (prenatal care)
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests (ultrasounds and blood work)
- Specialist visit (anesthesia)

**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** $12,800

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0</td>
<td>$400</td>
<td>$400</td>
<td></td>
</tr>
</tbody>
</table>

What isn’t covered:
- Limits or exclusions $60

The total Peg would pay is $860

---

<table>
<thead>
<tr>
<th>Mia’s Simple Fracture (in-network emergency room visit and follow up care)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The plan’s overall deductible</td>
</tr>
<tr>
<td>Specialist copayment</td>
</tr>
<tr>
<td>Hospital (facility) copay</td>
</tr>
<tr>
<td>Other coinsurance</td>
</tr>
</tbody>
</table>

This EXAMPLE event includes services like:

### Mia’s Simple Fracture
- Emergency room care (including medical supplies)
- Diagnostic test (x-ray)
- Durable medical equipment (crutches)
- Rehabilitation services (physical therapy)

**Sample Care Costs**
- Emergency room visit and follow up care
- Diagnostic tests (x-ray)
- Durable medical equipment (crutches)
- Rehabilitation services (physical therapy)

**Total Example Cost** $2,000

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0</td>
<td>$1,100</td>
<td>$60</td>
<td></td>
</tr>
</tbody>
</table>

What isn’t covered:
- Limits or exclusions $0

The total Mia would pay is $1,160

---

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.
Nondiscrimination Notice

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


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.
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:

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:

Arabic:
هاتف المساعدة باللغة العربية: إذا كنت تتحدث اللغة، فإن خدمات المساعدة اللغوية تتوفر لك بالمجاني. اتصل بنا رقم 1-314-334-668 (رقم)

Urdu:

Tagalog:

French:

Hindi:
पत्ता: यही आप ही बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं | 1-800-321-7947 (TTY: 711) पर कॉल करें।

Persian:
فرینم می یانش ؛ (711) 1-800-321-7947-800 تلگرام. توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما

German:

Gujarati:
સુધીની પાસ આપણા સહાય સેવાઓ માટે ઉપલભ છે. કોલ 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:
โปรดโทรที่: 711 หรือ 1-800-321-7947 (TTY: 711).