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?	INN Tier 1 Tier 2 Tier 3 EE $2,000 $3,000 $4,000 ES $3,750 $5,750 $8,000 EC $3,250 $5,250 $8,000 EF $4,000 $6,000 $8,000 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 tiers Employee + Spouse (ES), Employee + Children (EC), Employee + Family (EF) coverage.
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?	INN Tier 1 Tier 2 Tier 3 EE $3,425 $6,850 Unlimited ES $6,850 $13,700 Unlimited EC $5,137 $10,275 Unlimited EF $6,850 $13,700 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.
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	$25 copay per visit. Deductible does not apply.	$75 copay per visit. Deductible does not apply.	70% after deductible	Tier 2 copays and Tier 3 deductible/coinsurance for Primary care visits and Specialist care visits are not eligible for HRA payment. 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	$50 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	70% after deductible	
If you have a test	Diagnostic test (x-ray, blood work)	10% after deductible	50% after deductible	70% after deductible	None
	Imaging (CT/PET scans, MRIs)	10% after deductible	50% after deductible	70% after deductible	None

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 http://www.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. If a brand name drug is dispensed when a generic is available, 50% coinsurance applies. Non-formulary drugs: 50% coinsurance Some drugs may require prior authorization.
	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	
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 for first visit per covered member, then 10% after deductible for additional visits.	$250 copay for first visit per covered member, then 10% after deductible for additional visits.	$250 copay for first visit per covered member, then 10% after deductible for additional visits.	None

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)	
	Emergency medical transportation	10% after deductible	10% after deductible	10% after deductible	None
	Urgent care	$50 copay per visit. Deductible does not apply.	$100 copay per visit. Deductible does not apply.	$100 copay per visit. Deductible does not apply.	Tier 2 and 3 copays not eligible for HRA payment.
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	$25 copay per visit. Deductible does not apply.	$25 copay per visit. Deductible does not apply.	70% after deductible	Tier 3 deductible/coinsurance not eligible for HRA payment.
	Inpatient services	10% after deductible	10% after deductible	70% after deductible	None
If you are pregnant	Office visits	$25 copay per visit (PCP visit); $50 copay per visit (Specialist visit). Deductible does not apply.	$75 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 copays. Depending on the type of services, a **copayment**, **coinsurance**, or **deductible** may apply. Tier 2 copays and Tier 3 deductible/coinsurance not eligible for HRA payment.

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)	
	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	None
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 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.
	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 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
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside U.S.
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

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	$50
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	$2,000
Copayments	$424
Coinsurance	$1,001
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,485**

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	$50
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	$761
Copayments	$1,216
Coinsurance	$85
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2,117**

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

The plan's overall deductible	$2,000
Specialist copayment	$50
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	$967
Copayments	$400
Coinsurance	$163
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,530**

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:

ملاحظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية المجانية متاحة لك بالاتصال بالرقم 1-800-321-7947 (الهاتف النصي: 1-800-735-2989). تلتزم شركة Scott & White Health Plan بقوانين الحقوق المدنية الاتحادية المعمول بها ولا تميز على أساس العرق أو اللون أو الأصل القومي أو العمر أو الإعاقة أو الجنس.

Urdu:

استقبال: اگر آپ انگلش بولتے ہیں تو، زبان کی مدد کی خدمات، مفت چارج، آپ کے لئے دستیاب ہیں.1-800-321-7947 کال کریں (TTY: 1-800-735-2989). سکاٹ اور وائٹ ہیلتھ منصوبہ قابل اطلاق وفاقی شہری حقوق کے قوانین کے مطابق ہے اور نسل، رنگ، قومی آبادی، عمر، معذوری، یا جنسی کی بنیاد پر متصاب نہیں ہے.

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: 1-800-735-2989). Sumusunod ang Scott & WhiteHealth 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 : 1-800-735-2989). 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: यिद 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 नागरिक अिधकार क़ानून का पालन करता हैऔर जाित, रंग, राष्ट्रीय मूल, आयु, िवकलांगता, या िलंग के आधार पर भेदभाव नहीं करता है।

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.

Persian:
توجه: اگر به زبان انگلیسی صحبت می کنید، خدمات رایگان زبان، برای شما رایگان است. با شماره 1-800-321-7947 (TTY: 1-800-735-2989) تماس بگیرید. برنامه سلامتی اسکات و سفید مطابق با قوانین مدنی فدرال می باشد و براساس نژاد، رنگ، منشا ملی، سن، ناتوانی جنسی یا جنسیت تبعیض آمیز نیست.

Gujarati:
સાવધાન: જો તમે ઇંગલિશ બોલતા હો, ભાષા સહાય સેવાઓ, નિઃશુલ્ક, તમારા માટે ઉપલબ્ધ છે. 1-800-321-7947 પર કૉલ કરો (TTY: 1-800-735-2989). સ્કોટ એન્ડ વ્હાઇટ હેલ્થ પ્લાન લાગુ ફેડરલ નાગરિક અધિકાર કાયદાઓનું પાલન કરે છે અને જાતિ, રંગ, રાષ્ટ્રીય મૂળ, ઉંમર, અપંગતા, અથવા જાતિના આધારે ભેદભાવ નથી કરતા.

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 & WhiteHealth 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, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-321-7947 (TTY: 1-800-735-2989). Scott & WhiteHealth Plan ປະຕິບັດຕາມກົດໝາຍວ່າດ້ວຍສິດທິພົນລະເມືອງຂອງຣັຖບານກາງທີ່ບັງຄັບໃຊ້ ແລະບໍ່ຈຳແນກໂດຍອີງໃສ່ພື້ນຖານດ້ານເຊື້ອຊາດ, ສີຜິວ, ຊາດກຳເນີດ, ອາຍຸ, ຄວາມພິການ, ຫຼື ເພດ.