




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.** Please read the FEHB Plan brochure (RI 73-881) that contains the complete terms of this plan. **All benefits are subject to the definitions, limitations, and exclusions set forth in the FEHB Plan brochure.** Benefits may vary if you have other coverage, such as Medicare. 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 get the FEHB Plan brochure at <http://fehbsw.org/open-enrollment>, and view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov). You can call 1-800-321-7947 to request a copy of either document.

Important Questions	Answers	Why This Matters:
<p><b>What is the overall <a href="#">deductible</a>?</b></p>	<p>\$0 / Self Only \$0 / Self Plus One \$0 / Self and Family</p>	<p>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>.</p>
<p><b>Are there services covered before you meet your <a href="#">deductible</a>?</b></p>	<p>Yes. <a href="#">Preventive care</a> and primary care services are covered before you meet your <a href="#">deductible</a>.</p>	<p>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></p>
<p><b>Are there other <a href="#">deductibles</a> for specific services?</b></p>	<p>No.</p>	<p>You do not have to meet <a href="#">deductibles</a> for specific services.</p>
<p><b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b></p>	<p>\$5,250 / Self Only \$10,500 / Self Plus One \$10,500 / Self and Family</p>	<p>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.</p>
<p><b>What is not included in the <a href="#">out-of-pocket limit</a>?</b></p>	<p><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.</p>	<p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>
<p><b>Will you pay less if you use a <a href="#">network provider</a>?</b></p>	<p>Yes. See <a href="http://fehbsw.org/">http://fehbsw.org/</a> or call 1-800-321-7947 for a list of <a href="#">network providers</a>.</p>	<p>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.</p>
<p><b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b></p>	<p>No</p>	<p>You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a>.</p>



 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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$25 <a href="#">copay</a> per 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	\$45 <a href="#">copay</a> per visit	Not Covered	
	<a href="#">Preventive care/screening/immunization</a>	No Charge	Not Covered	
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	No Charge	Not Covered	None
	Imaging (CT/PET scans, MRIs)	\$150 <a href="#">copay</a> per procedure	Not Covered	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://fehbswhp.org/open-enrollment">http://fehbswhp.org/open-enrollment</a>	Generic drugs	Retail: \$8 <a href="#">copay</a> per 30 day supply Maintenance: \$16 <a href="#">copay</a> per 90 day supply	Not Covered	<a href="#">Copays</a> 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.  Non-formulary medications are subject to prior authorization and if medically necessary will be allowed at the non-preferred copay.  Failure to obtain preauthorization may result in the denial of coverage for this service. Please consult <a href="http://fehbswhp.org">http://fehbswhp.org</a> or call 1-800-321-7947 to verify preauthorization requirements.  Specialty drugs limited to 30-day supply.
	Preferred brand drugs	Retail: \$60 <a href="#">copay</a> per 30 day supply Maintenance: \$120 <a href="#">copay</a> per 90 day supply	Not Covered	
	Non-preferred brand drugs	Retail: \$150 <a href="#">copay</a> or 50% of charges, whichever is greater. \$300 cap. Maintenance: \$300 <a href="#">copay</a> or 50% of charges, whichever is greater.	Not Covered	
	<a href="#">Specialty drugs</a>	\$300 <a href="#">copay</a> / non-maintenance	Not Covered	

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$250 <u>copay</u> per procedure	Not Covered	None
	Physician/surgeon fees	No Charge	Not Covered	
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$250 <u>copay</u> per visit	\$250 <u>copay</u> per visit	None
	<a href="#">Emergency medical transportation</a>	\$125 <u>copay</u> per visit	\$125 <u>copay</u> per visit	
	<a href="#">Urgent care</a>	\$50 <u>copay</u> per visit	\$50 <u>copay</u> per visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 <u>copay</u> per day	Not Covered	\$1,250 maximum. For prior authorization requirements and penalties see <a href="http://fehb.swhp.org/open-enrollment">http://fehb.swhp.org/open-enrollment</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	No Charge	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <u>copay</u> per visit	Not Covered	None
	Inpatient services	\$250 <u>copay</u> per day	Not Covered	\$1,250 maximum
If you are pregnant	Office visits	\$45 <u>copay</u> per visit	Not Covered	No charge for prenatal visits; postnatal visits are covered at the <a href="#">specialist copay</a> .
	Childbirth/delivery professional services	\$250 <u>copay</u> per day	Not Covered	Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> , or <a href="#">deductible</a> may apply.
	Childbirth/delivery facility services	\$250 <u>copay</u> per day	Not Covered	
If you need help recovering or have	<a href="#">Home health care</a>	\$45 <u>copay</u> per visit	Not Covered	None
	<a href="#">Rehabilitation services</a>	\$45 <u>copay</u> per visit	Not Covered	60 visit limit per year.
	<a href="#">Habilitation services</a>	\$45 <u>copay</u> per visit	Not Covered	60 visit limit per year.

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)	
other special health needs	<a href="#">Skilled nursing care</a>	\$250 <u>copay</u> per day	Not Covered	Requires pre-authorization. 60 visit limit per year. \$1,250 maximum.
	<a href="#">Durable medical equipment</a>	30% of charges	Not Covered	None
	<a href="#">Hospice services</a>	No Charge	Not Covered	None
If your child needs dental or eye care	Children's eye exam	\$45 <u>copay</u> per exam	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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Chiropractic Care</li> <li>Routine Dental Care</li> </ul>	<ul style="list-style-type: none"> <li>Private Duty Nursing</li> <li>Long-term care</li> </ul>	<ul style="list-style-type: none"> <li>Non-emergency care when traveling outside U.S.</li> <li>Personal Comfort Items</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)
<ul style="list-style-type: none"> <li>Routine Eye Care (Adult)</li> </ul>

**Your Rights to Continue Coverage:** You can get help if you want to continue your coverage after it ends. See the FEHB Plan brochure, contact your HR office/retirement system, contact your plan at [contact number] or visit [www.opm.gov/insure/health](http://www.opm.gov/insure/health). Generally, if you lose coverage under the plan, then, depending on the circumstances, you may be eligible for a 31-day free extension of coverage, a conversion policy (a non-FEHB individual policy), spouse equity coverage, or receive temporary continuation of coverage (TCC). 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:** If you are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal. For information about your appeal rights please see Section 3, "How you get care," and Section 8 "The disputed claims process," in your plan's FEHB brochure. If you need assistance, you can contact our Customer Service Department by writing to: Scott and White Health Plan Attn: Dispute Resolution Department 1206 West Campus Drive Temple, TX 76502 or calling (800) 321-794.

### 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

For more information about limitations and exceptions, see the FEHB Plan brochure RI 73-881 at <http://fehb.swhp.org>.

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.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-321-7947.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-321-7947.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-321-7947.

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*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

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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](#) \$0
- [Specialist](#) [copayment](#) \$45
- Hospital (facility) [coinsurance](#) \$250
- Other [coinsurance](#) 0%

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	\$0
Copayments	\$927
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$987</b>

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist](#) [copayment](#) \$45
- Hospital (facility) [coinsurance](#) \$250
- Other [coinsurance](#) 0%

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	\$1,996
Coinsurance	\$218
<i>What isn't covered</i>	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$2,269</b>

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist](#) [copayment](#) \$45
- Hospital (facility) [coinsurance](#) \$250
- Other [coinsurance](#) 0%

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	\$0
Copayments	\$1,865
Coinsurance	\$22
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,887</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:**

1-800-735-2989 (النصي الهاتفي): 1-800-321-7947 بالرقم اتصل بك بالخدمة المجانية المجانية اللغة خدمة الإذاعة لزيادة، اللغة ت تحدث ك أنت إذا ملاحظة القومي الأصل أو اللون أو العرق أساس على يميز ولا الفيدرالية الاتحادية الامنية القوانين مع ي تماشي م سدشي هيلث وايت و سكوت ب ردامج إن (2989). الجنس أو الإعاقة أو العمر أو

## 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 & 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 : 1-800-735-2989). 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: 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:

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

## 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:**

સાવધાન: જો તમે ઇંગલિશ બોલતા હો, ભાષા સહાય સેવાઓ, નિ:શુલ્ક, તમારા માટે ઉપલબ્ધ છે. 1-800-321-7947 પર કોલ 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. ໂທ 1-800-321-7947 (TTY: 1-800-735-2989). Scott & WhiteHealth Plan ປະຕິບັດຕາມກົດໝາຍວ່າດ້ວຍສິດທິພົນລະເມືອງຂອງຣັຖບານກາງທີ່ບັງຄັບໃຊ້ ແລະບໍ່ຈຳແນກໂດຍອີງໃສ່ພື້ນຖານດ້ານເຊື້ອຊາດ, ສີເຜິ້ວ, ຊາດກຳເນີດ, ອາຍຸ, ຄວາມພິການ, ຫຼື ເພດ.