



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://swhp.org/plandocs>, or call 1-800-321-7947. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary at www.cciio.cms.gov.

| Important Questions | Answers | Why This Matters: |
|---|---|--|
| What is the overall deductible ? | Network Provider : N/A individual / N/A family; Non-Network Provider: N/A | 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 . |
| 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 ? | Network Provider : \$3,000 per individual / \$6,000 per family; Non-Network Provider: N/A | 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 , the overall family out-of-pocket limit must be met. |
| 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 www.swhp.org or call 1-800-321-7947 for a list of network providers . | 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. |
| 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 |
|---|---|---|--|--|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you visit a health care <u>provider's</u> office or clinic | Primary care visit to treat an injury or illness | \$15 <u>copay</u> | Not Covered | You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. |
| | <u>Specialist</u> visit | \$15 <u>copay</u> | Not Covered | |
| | <u>Preventive care/screening/immunization</u> | No Charge | Not Covered | |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | No Charge | Not Covered | None |
| | Imaging (CT/PET scans, MRIs) | \$150 <u>copay</u> | Not Covered | |
| If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at http://swhp.org/en-us/members/manage-your-plan/pharmacy-information . | Preferred generic drugs | \$15 <u>copay</u> per 30 day supply / retail \$30 <u>copay</u> per 90 day supply / maintenance | Not Covered | <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 pharmacy OR when using the mail order prescription service. Specific preventative medications will be covered with no cost to the member. Non-formulary drugs: 50% of charges |
| | Preferred brand drugs | \$50 <u>copay</u> per 30 day supply / retail \$100 <u>copay</u> per 90 day supply / maintenance | Not Covered | |
| | Non-preferred generic drugs and non-preferred Brand drugs and all other Drugs | \$100 <u>copay</u> per 30 day supply / retail \$200 <u>copay</u> per 90 day supply / maintenance | Not Covered | |
| | Preferred <u>Specialty drugs</u> | 25% of charges | Not Covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | \$250 <u>copay</u> | Not Covered | None |
| | Physician/surgeon fees | \$250 <u>copay</u> | Not Covered | |
| If you need immediate medical attention | <u>Emergency room care</u> | \$250 <u>copay</u> | \$250 <u>copay</u> | None |
| | <u>Emergency medical transportation</u> | \$250 <u>copay</u> | \$250 <u>copay</u> | |
| | <u>Urgent care</u> | \$75 <u>copay</u> | \$75 <u>copay</u> | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | \$250 <u>copay</u> per day | Not Covered | Max 5 day(s) <u>copay</u> due. For prior authorization requirements and penalties see http://www.swhp.org/ind-fam/tools-resources . Failure to obtain Prior |
| | Physician/surgeon fees | \$250 <u>copay</u> per day | Not Covered | |

* For more information about limitations and exceptions, see the plan or policy document at <http://www.swhp.org>

| 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) | |
| | | | | 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. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$15 <u>copay</u> | Not Covered | None |
| | Inpatient services | \$250 <u>copay</u> per day | Not Covered | Max 5 day(s) <u>copay</u> due. |
| If you are pregnant | Office visits | \$15 <u>copay</u> | Not Covered | No charge for prenatal visits; postnatal visits are covered at the specialist <u>copay</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. |
| | Childbirth/delivery professional services | \$250 <u>copay</u> | Not Covered | |
| | Childbirth/delivery facility services | \$250 <u>copay</u> per day | Not Covered | Max 5 day(s) <u>copay</u> due. |
| If you need help recovering or have other special health needs | Home health care | \$15 <u>copay</u> | Not Covered | None |
| | Rehabilitation services | \$15 <u>copay</u> | Not Covered | None |
| | Habilitation services | \$15 <u>copay</u> | Not Covered | None |
| | Skilled nursing care | \$250 <u>copay</u> per day | Not Covered | Max 5 day(s) <u>copay</u> due. |
| | Durable medical equipment | 50% of charges | Not Covered | None |
| | Hospice services | No Charge | Not Covered | None |
| If your child needs dental or eye care | Children's eye exam | \$15 <u>copay</u> | 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 Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services .) | | |
|---|--|------------------------|
| • Acupuncture | • Infertility treatment | • Routine foot care |
| • Bariatric surgery | • Long-term care | • Weight loss programs |
| • Cosmetic surgery | • Non-emergency care when traveling outside U.S. | |
| • Dental care (Child and Adult) | • Private-duty nursing | |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.) |
|--|
| • Manipulative therapy (35 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: Scott and White Health Plan, visit <http://www.swhp.org>, or call 1-800-321-7947; Department of Labor Employee Benefits Security Administration, visit <http://www.dol.gov/ebsa/healthreform>, or call 1-866-444-EBSA (3272); Department of Health and Human Services, Center for Consumer Information, visit <http://www.cciio.com.gov>, or call 1-877-267-2323 x61565; Texas Department of Insurance, visit <http://www.tdi.texas.gov>, or call 1-800-578-4677. 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://www.swhp.org>, or call 1-800-321-7947; Department of Labor Employee Benefits Security Administration, visit <http://www.dol.gov/ebsa/healthreform>, or call 1-866-444-EBSA (3272); Texas Department of Insurance, visit <http://www.tdi.texas.gov>, or call 1-800-252-3439.

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 1-800-321-7947.

————— *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 | N/A |
| ■ Specialist copayment | \$15 |
| ■ Hospital (facility) coinsurance | \$250 |
| ■ Other coinsurance | 250 |

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|--------------|
| Deductibles | \$0 |
| Copayments | \$730 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$790 |

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

| | |
|---|-------|
| ■ The plan's overall deductible | N/A |
| ■ Specialist copayment | \$15 |
| ■ Hospital (facility) coinsurance | \$250 |
| ■ Other coinsurance | 250 |

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$0 |
| Copayments | \$1,745 |
| Coinsurance | \$131 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$55 |
| The total Joe would pay is | \$1,931 |

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

| | |
|---|-------|
| ■ The plan's overall deductible | N/A |
| ■ Specialist copayment | \$15 |
| ■ Hospital (facility) coinsurance | \$250 |
| ■ Other coinsurance | 250 |

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$0 |
| Copayments | \$920 |
| Coinsurance | \$118 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$271 |
| The total Mia would pay is | \$1,309 |

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:

ملحوظة: إذا كنت تتحدث ذاكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-321-7947 (رقم هاتف الصم أو لبيكم: 1-800-735-2989). يلتزم Scott & White Health Plan بقوانين الحقوق المدنية الفدرالية المعمول بها ولا يميز على أساس العرق أو اللون أو الأصل الوطني أو السن أو الإعاقة أو الجنس.

Urdu:

خبرراد: اگر پآ ودرآ بولتے ہیں، تو پآ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں (TTY: 1-800-735-2989) 1-800-321-7947 Scott & White Health Plan قابلِ طلاق وفاقى یرہش حقوق کے قوانین کی تعمیل کرتا ہے روا یہ کہ نسل، رنگ، قومیت، عمر، معذروى یا جنس کی بنیاد پر امتیاز نہیں 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 ि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 नागरक अधिकार कानून का पालन करता हैऔर जाित, रंग, राष्ट्रीय मूल, आयु, िवकलांगता, या िलंग के आधार पर भेदभाव नहीं करता है।

Persian:

مربطوه تبعیت می کند و فهار می باشد. با(1-800-321-7947 (TTY: 1-800-735-2989) تماس بگیرید. توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بستر واریگان بارى شما قابل نمی شود. هیچگونه تبعیضی بر اساس نژاد، رنگ پوست، اصلیت ملیتی، سن، ناتوانی یا جنسیت اقدار Scott & White Health Plan ز اقاونین حقوق مدنی فلارد

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:

સુચના: જો તમે સુજરાતી બોલતા હો, તો િન:સુક ભાષા સહાય સેવાઓ તમારા માટ ઉપલબ્ધ છે. કોન કરો 1-800-321-7947 (TTY: 1-800-735-2989). Scott & White Health Plan લાનું પડતા સમવાયી નાગરક અિધકાર કાયદા સાથે સુસંગત છે અને સિત, રગ, રાજીસ્ય સૂળ, સમર, અશક્તતા અથવા નલનાના આધારન ભેદભાવ રાખવામાં આવતી 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:

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-800-321-7947 (TTY: 1-800-735-2989). Scott & White Health Plan ປະຕິບັດຕາມກົດໝາຍວ່າດ້ວຍສິດທິພົນລະເມືອງຂອງຮູບພາບກາງທີ່ບັງຄັບໃຊ້ ແລະບໍ່ຈຳແນກໂດຍອີງໃສ່ພື້ນຖານດ້ານເຊື້ອຊາດ, ີສຜິວ, ຊາດກຳເນີດ, ອາຍຸ, ຄວາມພິການ, ຫຼື ເພດ.