



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 [swhp.org/plandocs](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. You can view the Glossary at [cciio.cms.gov](http://cciio.cms.gov) or call 1-800-321-7947 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<a href="#">Network provider</a> : \$0 individual / \$0 family; Non-Network provider: N/A ind. / N/A fam.	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> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> and primary care services are covered before you meet your <a href="#">deductible</a> .	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 <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="http://healthcare.gov/coverage/preventive-care-benefits/">healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You do not have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<a href="#">Network provider</a> : \$3,000 per ind. / \$6,000 per fam.; Non-Network provider: N/A ind. / N/A fam.	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.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> does not cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://swhp.org">swhp.org</a> or call 1-800-321-7947 for a list of <a href="#">network providers</a> .	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.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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	\$15 <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	\$15 <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	For prior authorization requirements and penalties see <a href="http://swhp.org/ind-fam/tools-resources">swhp.org/ind-fam/tools-resources</a> . Failure to obtain Prior Authorization will result in the lesser of \$500 or 50% reduction in benefits.
	Imaging (CT/PET scans, MRIs)	\$150 <a href="#">copay</a> per visit	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://swhp.org/en-us/members/manage-your-plan/pharmacy-information">swhp.org/en-us/members/manage-your-plan/pharmacy-information</a> .	Preferred generic drugs	\$10 <a href="#">copay</a> per 30-day supply / retail \$25 <a href="#">copay</a> per 90-day supply / maintenance. <a href="#">Deductible</a> does not apply	Not covered	<a href="#">Copays</a> are per 30-day supply. 2.5 <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.
	Preferred brand drugs	\$45 <a href="#">copay</a> per 30-day supply / retail \$112.50 <a href="#">copay</a> per 90-day supply / maintenance. <a href="#">Deductible</a> does not apply	Not covered	
	Non-preferred generic drugs and non-preferred brand drugs	\$85 <a href="#">copay</a> per 30-day supply / retail \$212.50 <a href="#">copay</a> per 90-day supply / maintenance. <a href="#">Deductible</a> does not apply	Not covered	
	<a href="#">Specialty drugs</a>	Tier 1: 15% of charges Tier 2: 15% of charges Tier 3: 25% of charges <a href="#">Deductible</a> does not apply	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$250 <a href="#">copay</a> per visit	Not covered	None
	Physician/surgeon fees	\$250 <a href="#">copay</a> per day	Not covered	
	<a href="#">Emergency room care</a>	\$250 <a href="#">copay</a> per visit	\$250 <a href="#">copay</a> per visit	<a href="#">Copay</a> waived if admitted.

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 need immediate medical attention	<a href="#">Emergency medical transportation</a>	\$250 <u>copay</u> per visit	\$250 <u>copay</u> per visit	None
	<a href="#">Urgent care</a>	\$75 <u>copay</u> per visit	\$75 <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	For prior authorization requirements and penalties see <a href="http://swhp.org/ind-fam/tools-resources">swhp.org/ind-fam/tools-resources</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 <a href="#">provider</a> .
	Physician/surgeon fees	\$250 <u>copay</u> per day	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$15 <u>copay</u> per visit	Not covered	None
	Inpatient services	\$250 <u>copay</u> per day	Not covered	None
If you are pregnant	Office visits	\$15 <u>copay</u> per visit	Not covered	Cost sharing does not apply to <a href="#">preventive services</a> .
	Childbirth/delivery professional services	\$250 <u>copay</u> per day	Not covered	No charge for prenatal visits; postnatal visits are covered at the <a href="#">specialist copay</a> .
	Childbirth/delivery facility 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.
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	\$15 <u>copay</u> per visit	Not covered	60 visit limit per year.
	<a href="#">Rehabilitation services</a>	\$15 <u>copay</u> per visit	Not covered	35 visit limit per year.
	<a href="#">Habilitation services</a>	\$15 <u>copay</u> per visit	Not covered	35 visit limit per year.
	<a href="#">Skilled nursing care</a>	\$250 <u>copay</u> per day	Not covered	25 day limit per year.
	<a href="#">Durable medical equipment</a>	50% 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	\$15 <u>copay</u> per visit	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
- Bariatric surgery
- Cosmetic surgery
- Dental care (Child and Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside U.S.
- Private-duty nursing
- 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.)

- Chiropractic care (limited to 35 visits per Calendar year)
- Hearing aids (limited to one per ear every three years for covered members 18 years of age or younger)
- Routine eye care (Adult) (limited to annual eye exam conducted by a licensed ophthalmologist or optometrist)

**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 & White Care Plans , visit [swhp.org](#) , or call 1-800-321-7947; 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; Department of Labor Employee Benefits Security Administration, visit [dol.gov/ebsa/healthreform](#) , or call 1-866-444-EBSA (3272).

**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 & White Care Plans , visit [swhp.org](#) , or call 1-800-321-7947; Texas Department of Insurance, visit [tdi.texas.gov](#) , or call 1-800-252-3439; 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 1-800-321-7947.

—————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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist</a> copayment	\$15
■ Hospital (facility) <a href="#">coinsurance</a>	\$250
■ Other <a href="#">coinsurance</a>	\$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)

<b>Total Example Cost</b>	<b>\$12,800</b>
---------------------------	-----------------

In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$3,000
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,060</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist</a> copayment	\$15
■ Hospital (facility) <a href="#">coinsurance</a>	\$250
■ Other <a href="#">coinsurance</a>	\$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)

<b>Total Example Cost</b>	<b>\$7,400</b>
---------------------------	----------------

In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$900
<a href="#">Coinsurance</a>	\$20
What isn't covered	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$980</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist</a> copayment	\$15
■ Hospital (facility) <a href="#">coinsurance</a>	\$250
■ Other <a href="#">coinsurance</a>	\$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)

<b>Total Example Cost</b>	<b>\$2,000</b>
---------------------------	----------------

In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$860
<a href="#">Coinsurance</a>	\$30
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$890</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.



# 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 & White Care Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Scott & White Care Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Scott & White Care Plans:

- 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 & White Care Plans Compliance Officer at 1-254-820-8888 or send an email to [SWHPComplianceDepartment@BSWHealth.org](mailto:SWHPComplianceDepartment@BSWHealth.org).

If you believe that Scott & White Care Plans 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:

Compliance Officer, Scott & White Care Plans  
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 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/ Asistencia de idiomas



## 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:

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

## Urdu:

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

## 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:

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

## 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 ວ່າ ທ່ານ ເວົ້າ ພາສາ ລາວ, ການບໍ່ ຈ່າ ການຊ່ວຍເຫຼືອ ອັດຕະໂນ ພາສາ, ໂດຍບໍ່ ເສັ້ນຄ່າ, ແມ່ນ ມີ ພ້ອມໃຫ້ ທ່ານ. ໂທ 1-800-321-7947 (TTY: 711).