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, 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 or call 1-800-321-7947 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network provider: $0 individual / $0 family; Non-Network provider: N/A ind. / N/A fam.	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 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/.
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 ind. / $6,000 per fam.; Non-Network provider: N/A ind. / N/A fam.	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?	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 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 provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay per visit	Not covered	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	$30 copay per visit	Not covered	
	Preventive care/screening/ immunization	No charge	Not covered	
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	For prior authorization requirements and penalties see swhp.org/ind-fam/tools-resources. Failure to obtain Prior Authorization will result in the lesser of $500 or 50% reduction in benefits.
	Imaging (CT/PET scans, MRIs)	$250 copay per visit	Not covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at swhp.org/en-us/members/manage-your-plan/pharmacy-information.	Preferred generic drugs	$20 copay per 30-day supply / retail $50 copay per 90-day supply / maintenance. Deductible does not apply	Not covered	Copays are per 30-day supply. 2.5 copays 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	$65 copay per 30-day supply / retail $162.50 copay per 90-day supply / maintenance. Deductible does not apply	Not covered	
	Non-preferred generic drugs and non-preferred brand drugs	$120 copay per 30-day supply / retail $300 copay per 90-day supply / maintenance. Deductible does not apply	Not covered	
	Specialty drugs	Tier 1: 20% of charges Tier 2: 20% of charges Tier 3: 30% of charges Deductible does not apply	Not covered	Some drugs may require prior authorization. 30-day supply only.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 copay per visit	Not covered	None
	Physician/surgeon fees	$500 copay per day	Not covered	
	Emergency room care	$500 copay per visit	$500 copay per visit	Copay 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	Emergency medical transportation	$500 copay per visit	$500 copay per visit	None
	Urgent care	$75 copay per visit	$75 copay per visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay per day	Not covered	For prior authorization requirements and penalties see swhp.org/ind-fam/tools-resources. 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	$500 copay per day	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay per visit	Not covered	None
	Inpatient services	$500 copay per day	Not covered	None
If you are pregnant	Office visits	$30 copay per visit	Not covered	Cost sharing does not apply to preventive services. No charge for prenatal visits; postnatal visits are covered at the specialist copay. Depending on the type of services, a copayment, coinsurance, or deductible may apply.
	Childbirth/delivery professional services	$500 copay per day	Not covered	
	Childbirth/delivery facility services	$500 copay per day	Not covered	None
If you need help recovering or have other special health needs	Home health care	$30 copay per visit	Not covered	60 visit limit per year.
	Rehabilitation services	$30 copay per visit	Not covered	35 visit limit per year.
	Habilitation services	$30 copay per visit	Not covered	35 visit limit per year.
	Skilled nursing care	$500 copay per day	Not covered	25 day limit per year.
	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	$30 copay 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 call1-866-444-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 call1-866-444-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 call1-866-444-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 plan's overall deductible** **$0**
- **Specialist copayment** **$30**
- **Hospital (facility) coinsurance** **$500**
- **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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$3,000
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,060**

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** **$30**
- **Hospital (facility) coinsurance** **$500**
- **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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,000
Coinsurance	$20
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,080**

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

- **The plan's overall deductible** **$0**
- **Specialist copayment** **$30**
- **Hospital (facility) coinsurance** **$500**
- **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	**$2,000**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$900
Coinsurance	$30
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$930**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Nondiscrimination Notice

Scott&White CARE PLANS

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.

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

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 है तो आपके लिए मुफ्त मे भाषा सहायता सेवाएं उपलब्ध है। 1-800-321-7947 (TTY: 711) पर कॉल करे।

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

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 નિ:શુલ્ક 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: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-321-7947 (TTY: 711).