




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) 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 [healthcare.gov/sbc-glossary](http://healthcare.gov/sbc-glossary) or call 1-800-321-7947 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$6,000 individual / \$12,000 family	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> , <a href="#">urgent care</a> , office visits, pediatric eye exam, and <a href="#">prescription drugs</a> are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't 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 don't 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> ?	\$7,150 individual / \$14,300 family	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> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been 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> doesn't 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)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$50 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	Not covered	None
	<a href="#">Specialist</a> visit	\$70 <a href="#">copay</a> /visit. <a href="#">Deductible</a> does not apply.	Not covered	
	<a href="#">Preventive care/screening/immunization</a>	No charge <a href="#">Deductible</a> does not apply.	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.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	Not covered	Services that are not <a href="#">preauthorized</a> will be denied. Refer to <a href="#">swhp.org</a> or Customer Service at 1-800-321-7947.
	Imaging (CT/PET scans, MRIs)	30% of charges; <a href="#">deductible</a> does not apply	Not covered	Services that are not <a href="#">preauthorized</a> will be denied.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="#">swhp.org/en-us/members/manage-your-plan/pharmacy-information.</a>	ACA Preventive Drugs	\$0 <a href="#">copay</a> . <a href="#">Deductible</a> does not apply.	Not covered	<a href="#">Copays</a> are per 30-day supply. Maintenance-eligible drugs are allowed up to a 90-day supply for 2.5 <a href="#">copays</a> if obtained through a Baylor Scott & White Pharmacy or participating 90-day retail or mail order pharmacy provider. Mail Order: Available for a 1- to 90-day supply. Non-maintenance drugs obtained through mail order are limited to a 30-day supply maximum. Some <a href="#">Specialty drugs</a> may require prior authorization. 30-day supply only. Chronic preventive medications are not subject to <a href="#">deductible</a> .
	Tier 1: Preferred Generic Drugs	\$15 <a href="#">copay</a> . <a href="#">Deductible</a> does not apply.	Not covered	
	Tier 2: Preferred Brand Name Drugs	\$55 <a href="#">copay</a> . <a href="#">Deductible</a> does not apply.	Not covered	
	Tier 3: Non-Preferred Generic / Brand Name Drugs	\$100 <a href="#">copay</a> . <a href="#">Deductible</a> does not apply.	Not covered	
	<a href="#">Specialty Drugs</a>	T1: 15% T2: 15% T3: 25% <a href="#">Deductible</a> does not apply.	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)	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	30% after <u>deductible</u>	Not covered	Services that are not <a href="#">preauthorized</a> will be denied. Refer to <a href="#">swhp.org</a> or Customer Service at 1-800-321-7947.
	Physician/surgeon fees	30% after <u>deductible</u>	Not covered	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$250 <u>copay</u> /visit, then 30% of charges. <u>Deductible</u> does not apply.	\$250 <u>copay</u> /visit, then 30% of charges. <u>Deductible</u> does not apply.	None
	<a href="#">Emergency medical transportation</a>	30% after <u>deductible</u>	30% after <u>deductible</u>	
	<a href="#">Urgent care</a>	\$75 <u>copay</u> /visit. <u>Deductible</u> does not apply.	\$75 <u>copay</u> /visit. <u>Deductible</u> does not apply.	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	30% after <u>deductible</u>	Not covered	Services that are not <a href="#">preauthorized</a> will be denied.
	Physician/surgeon fees	30% after <u>deductible</u>	Not covered	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$50 <u>copay</u> /visit. <u>Deductible</u> does not apply. 30% after <u>deductible</u> for all other services.	Not covered	Services that are not <a href="#">preauthorized</a> will be denied. Refer to <a href="#">swhp.org</a> or Customer Service at 1-800-321-7947.
	Inpatient services	30% after <u>deductible</u>	Not covered	Services that are not <a href="#">preauthorized</a> will be denied.
<b>If you are pregnant</b>	Office visits	\$70 <u>copay</u> /visit. <u>Deductible</u> does not apply.	Not covered	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> , or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	30% after <u>deductible</u>	Not covered	Services that are not <a href="#">preauthorized</a> will be denied. Refer to <a href="#">swhp.org</a> or Customer Service at 1-800-

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)	
	Childbirth/delivery facility services	30% after <u>deductible</u>	Not covered	321-7947.
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	30% after <u>deductible</u>	Not covered	Limited to 60 visits per <a href="#">plan</a> year. Services that are not <a href="#">preauthorized</a> will be denied.
	<a href="#">Rehabilitation services</a>	\$70 <u>copay</u> /visit. <u>Deductible</u> does not apply.	Not covered	Limited to 35 visits per <a href="#">plan</a> year. Limits may not apply for Therapies for Children with Developmental Delays and Autism Spectrum Disorder. Services that are not <a href="#">preauthorized</a> will be denied.
	<a href="#">Habilitation services</a>	\$70 <u>copay</u> /visit. <u>Deductible</u> does not apply.	Not covered	Limited to 35 visits per <a href="#">plan</a> year. Limits may not apply for Therapies for Children with Developmental Delays and Autism Spectrum Disorder. Services that are not <a href="#">preauthorized</a> will be denied.
	<a href="#">Skilled nursing care</a>	30% after <u>deductible</u>	Not covered	Limited to 25 days per <a href="#">plan</a> year. Services that are not <a href="#">preauthorized</a> will be denied.
	<a href="#">Durable medical equipment</a>	50% after <u>deductible</u>	Not covered	Services that are not <a href="#">preauthorized</a> will be denied.
	<a href="#">Hospice services</a>	No Charge	Not covered	Services that are not <a href="#">preauthorized</a> will be denied. Refer to <a href="#">swhp.org</a> or Customer Service at 1-800-321-7947.
	<b>If your child needs dental or eye care</b>	Children's eye exam	\$70 <u>copay</u> /visit. <u>Deductible</u> does not apply.	Not covered
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
- Private-duty nursing
- Bariatric surgery
- Long-term care
- Routine foot care
- Cosmetic surgery
- Non-emergency care when traveling outside the U.S.
- Weight loss programs
- Dental care (Adult and Child)

### 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 [plan](#) 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 an 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: Insurance Company of Scott and White, visit [swhp.org](#), or call 1-800-321-7947; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [dol.gov/ebsa/healthreform](#). 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.

**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: Insurance Company of Scott and White, visit [swhp.org](#), or call 1-800-321-7947; Texas Department of Insurance, visit [tdi.texas.gov](#) or call 1-800-578-4677; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [dol.gov/ebsa/healthreform](#), Texas Department of Insurance Texas Health Options at 1-800-252-3439 or [texashealthoptions.com](#).

### 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](#) \$6,000
- [Specialist copayment](#) \$70
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

**This EXAMPLE event includes services like:**

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:**

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$3,700
<a href="#">Copayments</a>	\$800
<a href="#">Coinsurance</a>	\$2,700
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$7,260</b>

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

- The [plan's](#) overall [deductible](#) \$6,000
- [Specialist copayment](#) \$70
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

**This EXAMPLE event includes services like:**

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:**

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,200
<a href="#">Copayments</a>	\$2,000
<a href="#">Coinsurance</a>	\$520
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$3,780</b>

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

- The [plan's](#) overall [deductible](#) \$6,000
- [Specialist copayment](#) \$70
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

**This EXAMPLE event includes services like:**

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$1,900</b>
---------------------------	----------------

**In this example, Mia would pay:**

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$980
<a href="#">Copayments</a>	\$500
<a href="#">Coinsurance</a>	\$420
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,900</b>

# Nondiscrimination Notice

---



ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-321-7947 (TTY: 711).

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

Insurance Company of Scott and White:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - 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 Insurance Company of Scott and White Compliance Officer at 1-214-820-8888 or send an email to [SWHPComplianceDepartment@BSWHealth.org](mailto:SWHPComplianceDepartment@BSWHealth.org)

If you believe that Insurance Company of Scott and White 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:

Insurance Company of Scott and White, Compliance Officer  
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>.



**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 800-321-7947-1)

**Urdu:**

کریں۔ (1-800-321-7947 (TTY: 711) 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 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: ຖ້າ ວ່າ ທ່ານ ວ່າ ພາສາ ລາວ, ການບໍລິການ ວ່າ ພາສາ, ໂດຍບໍ່ເສຍຄ່າ, ຈຳນວນ ວ່າ ພາສາ, ໂດຍບໍ່ເສຍຄ່າ, ແມ່ນ ມີ ພ້ອມ ທີ່ ທ່ານ. ໂທ 1-800-321-7947 (TTY: 711).