




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

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$6,900 individual/ \$13,800 family for a network provider and \$13,800 individual/ \$27,600 family for an out-of-network provider .	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 , urgent care , office visits, pediatric vision services, ACA preventive drugs and Tier 1-4 prescription drugs by a network provider are covered before you meet your deductible .	This plan covers some items and services even if you haven't 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 healthcare.gov/coverage/preventive-care-benefits .
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	\$8,150 individual/ \$16,300 family for a network provider and \$ 24,450 individual/ \$48,900 family for an out-of-network provider .	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 , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Premiums , balance-billing charges, and health care this plan doesn't 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	Adult: \$40 copay /visit. Deductible does not apply. Pediatric: \$0 copay /visit. Deductible does not apply. (Age 0 through 18)	50% after deductible	None
	Specialist visit	\$80 copay /visit. Deductible does not apply.	50% after deductible	
	Preventive care/screening/immunization	No charge Deductible does not apply.	50% after deductible No charge for child immunizations through the 6th birthday.	
If you have a test	Diagnostic test (x-ray, blood work)	20% after deductible	50% after deductible	Failure to obtain pre-authorization of services, other than Emergency Care, will result in a penalty of the lesser of \$500 or 50%.
	Imaging (CT/PET scans, MRIs)	20% after deductible	50% after deductible	
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 .	ACA Preventive Drugs	\$0 copay . Deductible does not apply.	50% after deductible	Copays are per 30-day supply. Maintenance-eligible drugs are allowed up to a 90-day supply for three copays 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- to 34-day supply maximum. Some Specialty drugs may require prior authorization. 30-day supply only.
	Tier 1: Generic Drugs	\$15 copay . Deductible does not apply.	50% after deductible	
	Tier 2: Preferred Brand Name Drugs	\$55 copay . Deductible does not apply.	50% after deductible	
	Tier 3: Non-Preferred Brand Name Drugs	\$150 copay . Deductible does not apply.	50% after deductible	
	Tier 4: Specialty Drugs and Oral Chemotherapy Drugs	\$500 copay . Deductible does not apply.	50% after deductible	

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)	20% after <u>deductible</u>	50% after <u>deductible</u>	Failure to obtain pre-authorization of services, other than Emergency Care, will result in a penalty of the lesser of \$500 or 50%.
	Physician/surgeon fees	20% after <u>deductible</u>	50% after <u>deductible</u>	
If you need immediate medical attention	Emergency room care	\$750 <u>copay</u> /visit after <u>deductible</u>	\$750 <u>copay</u> /visit after <u>deductible</u>	Copay waived if episode results in hospitalization for the same condition within 24 hours.
	Emergency medical transportation	\$750 <u>copay</u> /service after <u>deductible</u>	\$750 <u>copay</u> /service after <u>deductible</u>	
	Urgent care	\$80 <u>copay</u> /visit. <u>Deductible</u> does not apply.	\$80 <u>copay</u> /visit. <u>Deductible</u> does not apply.	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% after <u>deductible</u>	50% after <u>deductible</u>	Failure to obtain pre-authorization of services, other than Emergency Care, will result in a penalty of the lesser of \$500 or 50%.
	Physician/surgeon fees	20% after <u>deductible</u>	50% after <u>deductible</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$40 <u>copay</u> /visit. <u>Deductible</u> does not apply. 20% after <u>deductible</u> for all other services.	50% after <u>deductible</u>	Failure to obtain pre-authorization of services, other than Emergency Care, will result in a penalty of the lesser of \$500 or 50%.
	Inpatient services	20% after <u>deductible</u>	50% after <u>deductible</u>	
If you are pregnant	Office visits	\$80 <u>copay</u> /visit. <u>Deductible</u> does not apply.	50% after <u>deductible</u>	Cost sharing does not apply for preventive services . Depending on the type of services, a copayment , coinsurance , or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% after <u>deductible</u>	50% after <u>deductible</u>	Failure to obtain pre-authorization of services, other than Emergency Care, will result in a

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	20% after <u>deductible</u>	50% after <u>deductible</u>	penalty of the lesser of \$500 or 50%.
If you need help recovering or have other special health needs	Home health care	20% after <u>deductible</u>	50% after <u>deductible</u>	Limited to 60 visits per plan year. Failure to obtain pre-authorization of services, other than Emergency Care, will result in a penalty of the lesser of \$500 or 50%.
	Rehabilitation services	\$80 <u>copay</u> /visit. <u>Deductible</u> does not apply.	50% after <u>deductible</u>	Limited to 35 combined visits per plan year for physical therapy, speech therapy, occupational therapy, and chiropractic services. Limits may not apply for Therapies for Children with Developmental Delays and Autism Spectrum Disorder. Failure to obtain pre-authorization of services, other than Emergency Care, will result in a penalty of the lesser of \$500 or 50%.
	Habilitation services	\$80 <u>copay</u> /visit. <u>Deductible</u> does not apply.	50% after <u>deductible</u>	
	Skilled nursing care	20% after <u>deductible</u>	50% after <u>deductible</u>	Limited to 25 days per plan year. Failure to obtain pre-authorization of services, other than Emergency Care, will result in a penalty of the lesser of \$500 or 50%.
	Durable medical equipment	20% after <u>deductible</u>	50% after <u>deductible</u>	Failure to obtain pre-authorization of services, other than Emergency Care, will result in a penalty of the lesser of \$500 or 50%.
	Hospice services	20% after <u>deductible</u>	50% after <u>deductible</u>	
If your child needs dental or eye care	Children's eye exam	\$80 <u>copay</u> /visit. <u>Deductible</u> does not apply.	50% after <u>deductible</u>	Limited to one eye exam per plan year.
	Children's glasses	\$80 <u>copay</u> . <u>Deductible</u> does not apply.	50% after <u>deductible</u>	Limited to one pair of glasses per plan year.
	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 (Adult and Child)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- 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 (Included in [Rehabilitation](#) and [Habilitation Services](#))
- Hearing aids (Limited to one device per ear every 3 years)
- Private-duty nursing (Limited to [Home Health Care](#) Services)

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 [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: Scott and White Health Plan, 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	\$6,900
■ Specialist copayment	\$80
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

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*)

Total Example Cost	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$5,000
Copayments	\$1,100
Coinsurance	\$2,000
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$8,160

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$6,900
■ Specialist copayment	\$80
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

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*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,500
Copayments	\$1,700
Coinsurance	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$3,660

Mia's Simple Fracture

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

■ The plan's overall deductible	\$6,900
■ Specialist copayment	\$80
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

This EXAMPLE event includes services like:

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

Total Example Cost	\$1,900
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$500
Copayments	\$1,300
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,900