



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, call 800-321-7947 or visit us at [swhp.org/plandocs](http://swhp.org/plandocs). 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 800-321-7947 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$1,000 per member / \$2,000 per 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> and ACA preventive drugs 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 certain <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="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.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> ?	\$3,500 per member / \$7,000 per 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> 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 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
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	<a href="#">Primary care</a> visit to treat an injury or illness	Adult: No charge for the first non-preventive sick visit in the plan year. \$25 <a href="#">copayment</a> per visit for subsequent visits in that plan year, <a href="#">deductible</a> does not apply Pediatric: No charge per visit, <a href="#">deductible</a> does not apply (Age 0 through 18)	Not covered	None
	<a href="#">Specialist</a> visit	\$50 <a href="#">copayment</a> per 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	
If you have a test	<a href="#">Diagnostic test</a> (X-ray, blood work)	No charge; <a href="#">deductible</a> does not apply	Not covered	None
	Imaging (CT/PET scans, MRIs)	10% of charges; <a href="#">deductible</a> does not apply	Not covered	Services requiring <a href="#">preauthorization</a> that are not <a href="#">preauthorized</a> will be denied. Refer to <a href="#">swhp.org</a> or call 800-321-7947.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="https://swhp.org/en-us/members/manage-">https://swhp.org/en-us/members/manage-</a>	ACA preventive drugs	No charge, <a href="#">deductible</a> does not apply	Not covered	<a href="#">Copayments</a> are per 30-day supply. Maintenance drugs are allowed up to a 90-day supply for 2.5 <a href="#">copayments</a> if obtained through a Baylor Scott and White Pharmacy or participating pharmacy. 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</a>
	Tier 1: Preferred generic drugs	\$8 <a href="#">copayment</a> per prescription, <a href="#">deductible</a> does not apply	Not covered	
	Tier 2: Preferred brand name drugs	\$35 <a href="#">copayment</a> per prescription, <a href="#">deductible</a> does not apply	Not covered	

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [swhp.org](#).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
<a href="#">your-plan/pharmacy-information</a> .	Tier 3: Non-preferred generic drugs and non-preferred brand name drugs	\$70 <u>copayment</u> per prescription, <u>deductible</u> does not apply	Not covered	<a href="#">drugs</a> may require <a href="#">preauthorization</a> . 30-day supply only.
	<a href="#">Specialty drugs</a> Tier 1	\$200 <u>copayment</u> per prescription, <u>deductible</u> does not apply	Not covered	
	<a href="#">Specialty drugs</a> Tier 2	\$300 <u>copayment</u> per prescription, <u>deductible</u> does not apply	Not covered	
	<a href="#">Specialty drugs</a> Tier 3	\$400 <u>copayment</u> per prescription, <u>deductible</u> does not apply	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% after <u>deductible</u>	Not covered	Services requiring <a href="#">preauthorization</a> that are not <a href="#">preauthorized</a> will be denied. Refer to <a href="#">swhp.org</a> or call 800-321-7947.
	Physician/surgeon fees	10% after <u>deductible</u>	Not covered	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$500 <u>copayment</u> per visit, plus 10% of charges; <u>deductible</u> does not apply	\$500 <u>copayment</u> per visit, plus 10% of charges; <u>deductible</u> does not apply	Emergency room <u>copayment</u> waived if episode results in <a href="#">hospitalization</a> for the same condition within 24 hours.  None
	<a href="#">Emergency medical transportation</a>	\$500 <u>copayment</u> per service, plus 10% of charges; <u>deductible</u> does not apply	\$500 <u>copayment</u> per service, plus 10% of charges; <u>deductible</u> does not apply	
	<a href="#">Urgent care</a>	\$50 <u>copayment</u> per visit, <u>deductible</u> does not apply	\$50 <u>copayment</u> per visit, <u>deductible</u> does not apply	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	10% after <u>deductible</u>	Not covered	Services requiring <a href="#">preauthorization</a> that are not <a href="#">preauthorized</a> will be denied. Refer to <a href="#">swhp.org</a> or call 800-321-7947.
	Physician/surgeon fees	10% after <u>deductible</u>	Not covered	
<b>If you need mental health, behavioral</b>	Outpatient services	\$25 <u>copayment</u> per visit, <u>deductible</u> does not apply	Not covered	Services requiring <a href="#">preauthorization</a> that are not <a href="#">preauthorized</a> will be denied. Refer to <a href="#">swhp.org</a>

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
<b>health, or substance abuse services</b>	Inpatient services	10% after <u>deductible</u>	Not covered	or call 800-321-7947.
<b>If you are pregnant</b>	Office visits	\$25 <u>copayment</u> per visit, <u>deductible</u> does not apply	Not covered	<u>Cost sharing</u> does not apply for <u>preventive care</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	10% after <u>deductible</u>	Not covered	Inpatient care for the mother and newborn child in a health care facility is covered for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarean section.
	Childbirth/delivery facility services	10% after <u>deductible</u>	Not covered	
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	10% after <u>deductible</u>	Not covered	Limited to 60 visits per <u>plan</u> year. Services requiring <u>preauthorization</u> that are not <u>preauthorized</u> will be denied. Refer to <a href="http://swhp.org">swhp.org</a> or call 800-321-7947.
	<u>Rehabilitation services</u>	\$25 <u>copayment</u> per visit, <u>deductible</u> does not apply	Not covered	Limited to 35 visits for <u>rehabilitation services</u> and 35 visits for <u>habilitation services</u> per <u>plan</u> year. Limit is combined for physical therapy, occupational therapy, and speech therapy.
	<u>Habilitation services</u>	\$25 <u>copayment</u> per visit, <u>deductible</u> does not apply	Not covered	Limits may not apply for therapies for children with developmental delays, autism spectrum disorder and mental health services. Services requiring <u>preauthorization</u> that are not <u>preauthorized</u> will be denied. Refer to <a href="http://swhp.org">swhp.org</a> or call 800-321-7947.
	<u>Skilled nursing care</u>	10% after <u>deductible</u>	Not covered	Limited to 25 days per <u>plan</u> year. Services requiring <u>preauthorization</u> that are not <u>preauthorized</u> will be denied. Refer to <a href="http://swhp.org">swhp.org</a> or call 800-321-7947.
	<u>Durable medical equipment</u>	10% after <u>deductible</u>	Not covered	Services requiring <u>preauthorization</u> that are not <u>preauthorized</u> will be denied. Refer to <a href="http://swhp.org">swhp.org</a>

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [swhp.org](http://swhp.org).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
	<a href="#">Hospice services</a>	No charge; <u>deductible</u> does not apply	Not covered	or call 800-321-7947.
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

\* For more information about limitations and exceptions, see the [plan](#) or policy document at [swhp.org](#).

## 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 and Child)
- 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 [plan](#) year)
- Hearing aids (Limited to one device per ear every 3 years and limited to members through the age of 18.)
- Private duty nursing (Limited to 60 visits per [plan](#) year when [medically necessary](#) and [preauthorized](#))

**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 at 800-321-7947 or [swhp.org](#); Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or [www.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 [www.HealthCare.gov](#) or call 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 on how 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 at 800-321-7947 or [swhp.org](#); Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](#); Texas Department of Insurance at 1-800-578-4677 or [tdi.texas.gov](#).

### Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

### 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 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](#) \$1,000
- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

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>\$12,700</b>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$1,000
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$1,000
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,070</b>

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$1,000
- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

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>\$5,600</b>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$800
<a href="#">Copayments</a>	\$700
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,520</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$1,000
- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 10%
- Other [coinsurance](#) 10%

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>\$2,800</b>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$1,000
<a href="#">Copayments</a>	\$900
<a href="#">Coinsurance</a>	\$10
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,910</b>

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