



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. 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 800-321-7947 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|--|
| What is the overall deductible ? | \$1,000 per member / \$2,000 per family | 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 ACA preventive drugs 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 https://www.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 ? | \$4,500 per member / \$9,000 per family | 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 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 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 |
|---|--|--|---|---|
| | | Participating Provider (You will pay the least) | Non-Participating 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: No charge for the first non-preventive sick visit in the plan year. \$35 copayment per visit for subsequent visits in that plan year, deductible does not apply Pediatric: No charge per visit, deductible does not apply (Age 0 through 18) | Not covered | None |
| | Specialist visit | \$70 copayment per visit, deductible does not apply | Not covered | |
| | Preventive care/screening/immunization | No charge, deductible does not apply. | Not covered | |
| If you have a test | Diagnostic test (X-ray, blood work) | No charge; deductible does not apply | Not covered | None |
| | Imaging (CT/PET scans, MRIs) | 30% of charges; deductible does not apply | Not covered | Services requiring preauthorization that are not preauthorized will be denied. Refer to swhp.org or call 800-321-7947. |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://swhp.org/en-us/members/manage- | ACA preventive drugs | No charge, deductible does not apply | Not covered | Copayments are per 30-day supply. Maintenance drugs are allowed up to a 90-day supply for 2.5 copayments 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 specialty |
| | Tier 1: Preferred generic drugs | \$8 copayment per prescription, deductible does not apply | Not covered | |
| | Tier 2: Preferred brand name drugs | \$35 copayment per prescription, deductible 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) | |
| your-plan/pharmacy-information . | 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 | drugs may require preauthorization . 30-day supply only. |
| | Specialty drugs Tier 1 | \$200 <u>copayment</u> per prescription, <u>deductible</u> does not apply | Not covered | |
| | Specialty drugs Tier 2 | \$300 <u>copayment</u> per prescription, <u>deductible</u> does not apply | Not covered | |
| | Specialty drugs Tier 3 | \$400 <u>copayment</u> per prescription, <u>deductible</u> does not apply | Not covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 30% after <u>deductible</u> | Not covered | Services requiring preauthorization that are not preauthorized will be denied. Refer to swhp.org or call 800-321-7947. |
| | Physician/surgeon fees | 30% after <u>deductible</u> | Not covered | |
| If you need immediate medical attention | Emergency room care | \$500 <u>copayment</u> per visit, plus 30% of charges; <u>deductible</u> does not apply | \$500 <u>copayment</u> per visit, plus 30% of charges; <u>deductible</u> does not apply | Emergency room <u>copayment</u> waived if episode results in hospitalization for the same condition within 24 hours. None |
| | Emergency medical transportation | \$500 <u>copayment</u> per service, plus 30% of charges; <u>deductible</u> does not apply | \$500 <u>copayment</u> per service, plus 30% of charges; <u>deductible</u> does not apply | |
| | Urgent care | \$50 <u>copayment</u> per visit, <u>deductible</u> does not apply | \$50 <u>copayment</u> per visit, <u>deductible</u> does not apply | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 30% after <u>deductible</u> | Not covered | Services requiring preauthorization that are not preauthorized will be denied. Refer to swhp.org or call 800-321-7947. |
| | Physician/surgeon fees | 30% after <u>deductible</u> | Not covered | |
| If you need mental health, behavioral | Outpatient services | \$35 <u>copayment</u> per visit, <u>deductible</u> does not apply | Not covered | Services requiring preauthorization that are not preauthorized will be denied. Refer to swhp.org |

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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) | |
| health, or substance abuse services | Inpatient services | 30% after <u>deductible</u> | Not covered | or call 800-321-7947. |
| If you are pregnant | Office visits | \$35 <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 | 30% 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 | 30% after <u>deductible</u> | Not covered | |
| If you need help recovering or have other special health needs | <u>Home health care</u> | 30% 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 swhp.org or call 800-321-7947. |
| | <u>Rehabilitation services</u> | \$35 <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> | \$35 <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 swhp.org or call 800-321-7947. |
| | <u>Skilled nursing care</u> | 30% 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 swhp.org or call 800-321-7947. |
| | <u>Durable medical equipment</u> | 30% after <u>deductible</u> | Not covered | Services requiring <u>preauthorization</u> that are not <u>preauthorized</u> will be denied. Refer to swhp.org |

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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) | |
| | Hospice services | No charge; <u>deductible</u> does not apply | Not covered | or call 800-321-7947. |
| If your child needs dental or eye care | 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](#) \$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*)

| | |
|---------------------------|-----------------|
| Total Example Cost | \$12,700 |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$1,000 |
| Copayments | \$10 |
| Coinsurance | \$3,100 |
| What isn't covered | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$4,170 |

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](#) \$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*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$5,600 |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$800 |
| Copayments | \$700 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$1,520 |

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$1,000
- [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*)

| | |
|---------------------------|----------------|
| Total Example Cost | \$2,800 |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing | |
|-----------------------------------|----------------|
| Deductibles | \$1,000 |
| Copayments | \$1,000 |
| Coinsurance | \$40 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$2,040 |

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