



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 <https://www.swhp.org/>. 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](https://www.healthcare.gov/sbc-glossary) or call 800-321-7947 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	\$0 per member / \$0 per family 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> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	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/">healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	\$8,550 per member / \$17,100 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.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<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> .
<b>Will you pay less if you use a <a href="#">network provider</a>?</b>	Yes. See <a href="https://www.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.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	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 office</a> or clinic	<a href="#">Primary care</a> visit to treat an injury or illness	Adult: \$40 <a href="#">copayment</a> per visit Pediatric: No charge (Age 0 through 18)	Not covered	None
	<a href="#">Specialist</a> visit	\$70 <a href="#">copayment</a> per visit	Not covered	
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not covered	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . 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)	\$250 <a href="#">copayment</a> per visit for X-rays, \$100 <a href="#">copayment</a> per visit for Labs	Not covered	None
	Imaging (CT/PET scans, MRIs)	\$250 <a href="#">copayment</a> per visit	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-your-plan/pharmacy-information">https://swhp.org/en-us/members/manage-your-plan/pharmacy-information</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 three (3) <a href="#">copayments</a> if obtained through a Baylor Scott & 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 drugs</a> may require <a href="#">preauthorization</a> . 30-day supply only.
	Tier 1: Generic drugs	\$15 <a href="#">copayment</a> per prescription	Not covered	
	Tier 2: Preferred brand drugs	\$55 <a href="#">copayment</a> per prescription	Not covered	
	Tier 3: Non-preferred drugs	\$150 <a href="#">copayment</a> per prescription	Not covered	
	Tier 4: <a href="#">Specialty drugs</a> and oral anticancer medications	\$500 <a href="#">copayment</a> per prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$500 <a href="#">copayment</a> per visit	Not covered	Services requiring <a href="#">preauthorization</a> that are not <a href="#">preauthorized</a> will be denied. Refer to

\* 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)	
	Physician/surgeon fees	\$250 <u>copayment</u> per visit	Not covered	<a href="http://swhp.org">swhp.org</a> or call 800-321-7947.
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$750 <u>copayment</u> per visit	\$750 <u>copayment</u> per visit	Emergency room <u>copayment</u> waived if episode results in <u>hospitalization</u> for the same condition within 24 hours.
	<a href="#">Emergency medical transportation</a>	\$750 <u>copayment</u> per service	\$750 <u>copayment</u> per service	None
	<a href="#">Urgent care</a>	\$70 <u>copayment</u> per visit	\$70 <u>copayment</u> per visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$1,000 <u>copayment</u> per day (not to exceed \$5,000)	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> or call 800-321-7947.
	Physician/surgeon fees	\$1,000 <u>copayment</u> per day (not to exceed \$5,000)	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$40 <u>copayment</u> per office visit, \$500 <u>copayment</u> per visit for all other outpatient services.	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> or call 800-321-7947.
	Inpatient services	\$1,000 <u>copayment</u> per day (not to exceed \$5,000)	Not covered	
If you are pregnant	Office visits	\$40 <u>copayment</u> per visit	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	\$1,000 <u>copayment</u> per day (not to exceed \$5,000)	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	\$1,000 <u>copayment</u> per day (not to exceed \$5,000)	Not covered	

\* 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)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	10% of charges	Not covered	Limited to 60 visits per <a href="#">plan</a> year. 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.
	<a href="#">Rehabilitation services</a>	\$40 <u>copayment</u> per visit	Not covered	Limited to 35 visits for <a href="#">rehabilitation services</a> and 35 visits for <a href="#">habilitation services</a> per <a href="#">plan</a> year. Limit is combined for physical therapy, occupational therapy, speech therapy, and, and chiropractic care. Limits may not apply for therapies for children with developmental delays, autism spectrum disorder and mental health services. 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.
	<a href="#">Habilitation services</a>	\$40 <u>copayment</u> per visit	Not covered	Limited to 25 days per <a href="#">plan</a> year. 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.
	<a href="#">Skilled nursing care</a>	\$500 <u>copayment</u> per day	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.
	<a href="#">Durable medical equipment</a>	10% of charges	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.
	<a href="#">Hospice services</a>	10% of charges	Not covered	
<b>If your child needs dental or eye care</b>	Children's eye exam	\$70 <u>copayment</u> per visit	Not covered	Limited to one eye exam per <a href="#">plan</a> year.
	Children's glasses	\$70 <u>copayment</u> per pair	Not covered	Limited to one pair of glasses per <a href="#">plan</a> year.
	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)
- 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 Services](#) and [Habilitation Services](#))
- Hearing aids (Limited to one device per ear every 3 years)
- 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 and White Health Plan 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 and White Health Plan 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](#) \$0
- [Specialist copayment](#) \$70
- Hospital (facility) [coinsurance](#) \$1,000
- 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>
<b>In this example, Peg would pay:</b>	
<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$2,000
<a href="#">Coinsurance</a>	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,460</b>

### 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](#) \$70
- Hospital (facility) [coinsurance](#) \$1,000
- 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>
<b>In this example, Joe would pay:</b>	
<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1,400
<a href="#">Coinsurance</a>	\$80
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,500</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$70
- Hospital (facility) [coinsurance](#) \$1,000
- 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>
<b>In this example, Mia would pay:</b>	
<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1,800
<a href="#">Coinsurance</a>	\$70
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,870</b>

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

# Nondiscrimination Notice

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

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

Scott and White Health Plan:

- 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 Scott and White Health Plan (SWHP) Compliance Officer at 1-214-820-8888 or send an email to [SWHPComplianceDepartment@BSWHealth.org](mailto:SWHPComplianceDepartment@BSWHealth.org)

If you believe that Scott and White Health Plan 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:

SWHP 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 SWHP 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 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 નિઃશુલ્ક 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:

ໄປດຊາບ: ຖ້າ ວ່າ ທ່ານ ເວົ້າ ພາສາ ລາວ, ການບໍລິການ ຊ່ວຍເຫຼືອ ວ່າ ພາສາ, ໂດຍບໍ່ເສຍຄ່າ, ຈະ ສະ ບັດ ຈໍາ ງັດ ນັ້ນ ມີ ພ້ອມ ໃຫ້ ທ່ານ. ໂທ 1-800-321-7947 (TTY: 711).