




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 844-843-3229 or visit us at [bswh.swhp.org](http://bswh.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](http://healthcare.gov/sbc-glossary) or call 844-843-3229 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	INN Tier 1 Tier 2 Tier 3 EE \$1,000 \$2,000 \$5,000 EF \$2,000 \$4,000 \$10,000 Does not apply to <a href="#">preventive care</a>	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> . There is an embedded <a href="#">deductible</a> for coverage tier Employee + Family (which includes Employee + Spouse and Employee + Children).
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. <a href="#">Preventive care</a> , office visits, 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> .
<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>	INN Tier 1 Tier 2 Tier 3 EE \$4,000 \$6,750 Unlimited EF \$8,000 \$13,500 Unlimited	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. There is an embedded <a href="#">out-of-pocket limit</a> for coverage tier Employee + Family (which includes Employee + Spouse and Employee + Children). For Tier 1 and Tier 2, deductible included in <a href="#">out-of-pocket</a> max.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Copayments</a> on certain services, <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> does not 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="http://bswh.swhp.org">bswh.swhp.org</a> or call 844-843-3229 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
		Tier 1 Participating Provider (You will pay the least)	Tier 2 Participating Provider (You will pay more)	Tier 3 Non-Participating Provider (You will pay the most)	
If you visit a health care <a href="#">provider's office or clinic</a>	<a href="#">Primary care</a> visit to treat an injury or illness	\$35 <a href="#">copayment</a> per visit <a href="#">Deductible</a> does not apply	\$70 <a href="#">copayment</a> per visit <a href="#">Deductible</a> does not apply	70% after <a href="#">deductible</a>	None
	<a href="#">Specialist</a> visit	\$60 <a href="#">copayment</a> per visit <a href="#">Deductible</a> does not apply	\$100 <a href="#">copayment</a> per visit <a href="#">Deductible</a> does not apply	70% after <a href="#">deductible</a>	
	<a href="#">Preventive care/screening/immunization</a>	No charge <a href="#">Deductible</a> does not apply	No charge <a href="#">Deductible</a> does not apply	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)	10% after <a href="#">deductible</a>	50% after <a href="#">deductible</a>	70% after <a href="#">deductible</a>	None
	Imaging (CT/PET scans, MRIs)	10% after <a href="#">deductible</a>	50% after <a href="#">deductible</a>	70% after <a href="#">deductible</a>	Services requiring <a href="#">preauthorization</a> that are not preauthorized will be denied. Refer to <a href="http://bswh.swhp.org/tools-and-resources">bswh.swhp.org/tools-and-resources</a> or call 844-843-3229.

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Participating Provider (You will pay the least)	Tier 2 Participating Provider (You will pay more)	Tier 3 Non-Participating Provider (You will pay the most)	
<p><b>If you need drugs to treat your illness or condition</b>            More information about <a href="#">prescription drug coverage</a> is available at <a href="http://bswh.swhp.org/pharmacy-information">bswh.swhp.org/pharmacy-information</a>.</p>	ACA preventive drugs	No charge <u>Deductible</u> does not apply	No charge <u>Deductible</u> does not apply	50% after <u>deductible</u>	<p><a href="#">Copayments</a> are per 30-day supply. 90- day supply is available if a maintenance drug is obtained through a Baylor Scott &amp; White pharmacy OR when using the mail order prescription service.</p> <p>The ACA Preventive Drugs based on Health Care Reform regulations.</p> <p>You have access to Baylor Scott &amp; White Pharmacies and Contracted Pharmacies, such as CVS, Kroger, Walgreens, Wal-Mart and more.</p>
	Tier 1: Preferred generic drugs	\$3 <u>copayment</u> per prescription per 30-day supply (retail) \$6 <u>copayment</u> per prescription per 90-day supply (maintenance) <u>Deductible</u> does not apply	\$10 <u>copayment</u> per prescription per 30-day supply (retail) <u>Deductible</u> does not apply	50% after <u>deductible</u>	
	Tier 2: Preferred brand name drugs	\$35 <u>copayment</u> per prescription per 30-day supply (retail) \$70 <u>copayment</u> per prescription per 90-day supply (maintenance) <u>Deductible</u> does not apply	\$50 <u>copayment</u> per prescription per 30-day supply (retail) <u>Deductible</u> does not apply	50% after <u>deductible</u>	
	Tier 3: Non-preferred generic drugs and non-preferred brand name drugs	Lesser of \$50 <u>copayment</u> or 50% <u>coinsurance</u> per prescription per 30-day supply (retail) Lesser of \$100 <u>copayment</u> or 50% <u>coinsurance</u> per prescription per 90-day supply (maintenance) <u>Deductible</u> does not apply	Lesser of \$75 or 50% <u>coinsurance</u> per prescription (retail) <u>Deductible</u> does not apply	50% after <u>deductible</u>	

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Participating Provider (You will pay the least)	Tier 2 Participating Provider (You will pay more)	Tier 3 Non-Participating Provider (You will pay the most)	
	<a href="#">Specialty drugs</a> and Oral Chemotherapy Drugs	20% <u>coinsurance</u> \$200 maximum per prescription per 30-day supply (retail) <u>Deductible</u> does not apply.	Not covered	Not covered	Available through Baylor Scott & White pharmacy only. Some drugs may require prior authorization. 30-day supply only.  <a href="#">Specialty drugs</a> covered under medical: You pay 20% (\$200 max) for Tier 1 and Tier 2 participating <a href="#">providers</a> , and 70% after <a href="#">deductible</a> for Tier 3 non-participating <a href="#">providers</a> .
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% after <u>deductible</u>	50% after <u>deductible</u>	70% after <u>deductible</u>	Services requiring <a href="#">preauthorization</a> that are not preauthorized will be denied. Refer to <a href="http://bswh.swhp.org/tools-and-resources">bswh.swhp.org/tools-and-resources</a> or call 844-843-3229.
	Physician/surgeon fees	10% after <u>deductible</u>	50% after <u>deductible</u>	70% after <u>deductible</u>	
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$250 <u>copayment</u> per visit <u>Deductible</u> does not apply	\$250 <u>copayment</u> per visit <u>Deductible</u> does not apply	\$250 <u>copayment</u> per visit <u>Deductible</u> does not apply	Emergency room <a href="#">copayment</a> waived if episode results in <a href="#">hospitalization</a> for the same condition within 24 hours.
	<a href="#">Emergency medical transportation</a>	\$250 <u>copayment</u> per visit <u>Deductible</u> does not apply	\$250 <u>copayment</u> per visit <u>Deductible</u> does not apply	\$250 <u>copayment</u> per visit <u>Deductible</u> does not apply	Emergency transportation includes ground and air ambulance.
	<a href="#">Urgent care</a>	\$75 <u>copayment</u> per visit <u>Deductible</u> does not apply	\$100 <u>copayment</u> per visit <u>Deductible</u> does not apply	\$100 <u>copayment</u> per visit <u>Deductible</u> does not apply	None

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Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Participating Provider (You will pay the least)	Tier 2 Participating Provider (You will pay more)	Tier 3 Non-Participating Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% after <u>deductible</u>	50% after <u>deductible</u>	70% after <u>deductible</u>	Services requiring <a href="#">preauthorization</a> that are not preauthorized will be denied. Refer to <a href="http://bswh.swhp.org/tools-and-resources">bswh.swhp.org/tools-and-resources</a> or call 844-843-3229.
	Physician/surgeon fees	10% after <u>deductible</u>	50% after <u>deductible</u>	70% after <u>deductible</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$35 <u>copayment</u> per visit <u>Deductible</u> does not apply	\$70 <u>copayment</u> per visit <u>Deductible</u> does not apply	70% after <u>deductible</u>	Services requiring <a href="#">preauthorization</a> that are not preauthorized will be denied. Refer to <a href="http://bswh.swhp.org/tools-and-resources">bswh.swhp.org/tools-and-resources</a> or call 844-843-3229.
	Inpatient services	10% after <u>deductible</u>	50% after <u>deductible</u>	70% after <u>deductible</u>	
If you are pregnant	Office visits	PCP: \$35 <u>copayment</u> per visit Specialist: \$60 <u>copayment</u> per visit <u>Deductible</u> does not apply.	PCP: \$70 <u>copayment</u> per visit Specialist: \$100 <u>copayment</u> per visit <u>Deductible</u> does not apply.	70% after <u>deductible</u>	No charge for prenatal visits for Tiers 1 and 2.  <a href="#">Cost sharing</a> does not apply for <a href="#">preventive care</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	0% after applicable <u>copay</u>	50% after <u>deductible</u>	70% after <u>deductible</u>	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.

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Participating Provider (You will pay the least)	Tier 2 Participating Provider (You will pay more)	Tier 3 Non-Participating Provider (You will pay the most)	
	Childbirth/delivery facility services	\$1,200 <u>copayment</u> <u>Deductible</u> does not apply	50% after <u>deductible</u>	70% after <u>deductible</u>	<u>Copayment</u> applies to Room & Board charges. All other charges (e.g., anesthesia, OBGYN, pathology, etc.) driven by maternity/delivery DRG are covered at 100% including well-baby charges. Services that are not <u>preauthorized</u> will be denied.
If you need help recovering or have other special health needs	<u>Home health care</u>	10% after <u>deductible</u>	50% after <u>deductible</u>	70% after <u>deductible</u>	Limited to 120 visits per <u>calendar</u> year. Services requiring <u>preauthorization</u> that are not preauthorized will be denied. Refer to <a href="https://bswh.swhp.org/tools-and-resources">bswh.swhp.org/tools-and-resources</a> or call 844-843-3229.
	<u>Rehabilitation services</u>	10% after <u>deductible</u>	50% after <u>deductible</u>	70% after <u>deductible</u>	Combined OT/PT 60 visits max and 60 ST visits max per <u>calendar</u> year. Limits may not apply for therapies for children with developmental delays, autism spectrum disorder and mental health services. Services that are not preauthorized will be denied.
	<u>Habilitation services</u>	10% after <u>deductible</u>	50% after <u>deductible</u>	70% after <u>deductible</u>	Combined OT/PT 60 visits max and 60 ST visits max per <u>calendar</u> year. Limits may not apply for therapies for children with developmental delays, autism spectrum disorder and mental health services. Services that are not preauthorized will be denied.

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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Participating Provider (You will pay the least)	Tier 2 Participating Provider (You will pay more)	Tier 3 Non-Participating Provider (You will pay the most)	
	<a href="#">Skilled nursing care</a>	10% after <u>deductible</u>	50% after <u>deductible</u>	70% after <u>deductible</u>	Limited to 120 days per <a href="#">calendar year</a> . Services requiring <a href="#">preauthorization</a> that are not preauthorized will be denied. Refer to <a href="#">bswh.swhp.org/tools-and-resources</a> or call 844-843-3229.
	<a href="#">Durable medical equipment</a>	10% after <u>deductible</u>	50% after <u>deductible</u>	70% after <u>deductible</u>	Services requiring <a href="#">preauthorization</a> that are not preauthorized will be denied. Refer to <a href="#">bswh.swhp.org/tools-and-resources</a>
	<a href="#">Hospice services</a>	10% after <u>deductible</u>	50% after <u>deductible</u>	70% after <u>deductible</u>	or call 844-843-3229
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	Not covered	None

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

- Cosmetic surgery
- Dental care (Adult [and Child](#))
- Long-term care
- Non-emergency care when traveling outside 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.)

- Acupuncture (20 visit limit per [calendar](#) year)
- Bariatric surgery (Tier 1 and Tier 2 only)
- Chiropractic care (20 visit limit per [calendar](#) year)
- Hearing aids (1 device every 36 months)
- Infertility treatment (Limited to \$7,500 medical and \$7,500 pharmacy lifetime max)
- Private-duty nursing (120 visit limit per [calendar](#) year)

**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: Optum, [adminservices.optumhealthfinancial.com](#), or call 866-301-6681; Department of Labor Employee Benefits Security Administration, visit [dol.gov/ebsa/healthreform](#), or call 1-866-444-EBSA (3272). 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 [bswh.swhp.org](#), or call 1-844-843-3229; Department of Labor Employee Benefits Security Administration, visit [dol.gov/ebsa/healthreform](#), or call 1-866-444-EBSA (3272).

### 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](#) \$60
- 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:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,000
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$1,000
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](#) \$60
- 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:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,000
<a href="#">Copayments</a>	\$900
<a href="#">Coinsurance</a>	\$0
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,920</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$1,000
- [Specialist copayment](#) \$60
- 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:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,000
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$100
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,300</b>

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