




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 844-633-5325 or visit us at https://swhp.org/Portals/0/PDFs/plandocs/2022/SWHP_2022_SHIW2M13_MED.pdf. 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 844-633-5325 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$0 at Indian Health Care Provider (IHCP) or with IHCP referral at non-IHCP; or \$4,000 per member / \$8,000 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?	\$8,700 per member / \$17,400 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 844-633-5325 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
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP Participating Provider (You will pay more)	Non-IHCP 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	No charge	Adult: \$30 copayment per visit, deductible does not apply Pediatric: No charge, deductible does not apply	Not covered	Cost sharing waived at non-IHCP with IHCP referral . If an out-of-network provider charges more than the allowed amount , you may have to pay the difference (balance billing).
	Specialist visit	No charge	\$60 copayment per visit, deductible does not apply	Not covered	
	Preventive care/screening/immunization	No charge	No charge	Not covered	
If you have a test	Diagnostic test (X-ray, blood work)	No charge	40% after deductible	Not covered	Cost sharing waived at non-IHCP with IHCP referral . If an out-of-network provider charges more than the allowed amount , you may have to pay the difference (balance billing).
	Imaging (CT/PET scans, MRIs)	No charge	40% after deductible	Not covered	Services requiring preauthorization that are not preauthorized will be denied. Refer to swhp.org or call 844-633-5325. Cost sharing waived at non-IHCP with IHCP referral . If an out-of-network provider charges more than the allowed amount , you may have to pay the difference (balance billing).
If you need drugs to treat your illness or	ACA preventive drugs	No charge	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 three (3) copayments if obtained through a Baylor Scott & White Pharmacy or participating pharmacy. Mail Order: Available for a 1- to 90-day supply. Non-maintenance
	Tier 1: Generic drugs	No charge	\$15 copayment per prescription, deductible does not apply	Not covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP Participating Provider (You will pay more)	Non-IHCP Non-Participating Provider (You will pay the most)	
condition More information about prescription drug coverage is available at https://swhp.org/en-us/member-s/managing-your-plan/pharmacy-information	Tier 2: Preferred brand drugs	No charge	\$55 <u>copayment</u> per prescription after <u>deductible</u>	Not covered	drugs obtained through mail order are limited to a 30-day supply maximum. Some specialty drugs may require preauthorization . 30-day supply only. Formulary insulin prescriptions have a maximum <u>copayment</u> of \$25 per prescription per 30-day supply. Cost sharing waived at non-IHCP with IHCP referral . If an out-of-network provider charges more than the allowed amount , you may have to pay the difference (balance billing).
	Tier 3: Non-preferred drugs	No charge	\$150 <u>copayment</u> per prescription after <u>deductible</u>	Not covered	
	Tier 4: Specialty drugs /oral anticancer medications	No charge	\$500 <u>copayment</u> per prescription after <u>deductible</u>	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	\$600 <u>copayment</u> per visit plus 40% after <u>deductible</u>	Not covered	Services requiring preauthorization that are not preauthorized will be denied. Refer to swhp.org or call 844-633-5325. Cost sharing waived at non-IHCP with IHCP referral . If an out-of-network provider charges more than the allowed amount , you may have to pay the difference (balance billing).
	Physician/surgeon fees	No charge	\$300 <u>copayment</u> per visit plus 40% after <u>deductible</u>	Not covered	
If you need immediate medical attention	Emergency room care	No charge	\$750 <u>copayment</u> per visit plus 40% after <u>deductible</u>	\$750 <u>copayment</u> per visit plus 40% after <u>deductible</u>	Emergency room copayment waived if episode results in hospitalization for the same condition within 24 hours. Cost sharing waived at non-IHCP with IHCP referral . If an out-of-network provider charges more than the allowed amount , you may have to pay the difference (balance billing).

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP Participating Provider (You will pay more)	Non-IHCP Non-Participating Provider (You will pay the most)	
	Emergency medical transportation	No charge	\$750 <u>copayment</u> per service plus 40% after <u>deductible</u>	\$750 <u>copayment</u> per service plus 40% after <u>deductible</u>	Cost sharing waived at non-IHCP with IHCP referral . If an out-of-network provider charges more than the allowed amount , you may have to pay the difference (balance billing).
	Urgent care	No charge	\$60 <u>copayment</u> per visit, <u>deductible</u> does not apply	\$60 <u>copayment</u> per visit, <u>deductible</u> does not apply	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	\$2,000 <u>copayment</u> per stay plus 40% after <u>deductible</u>	Not covered	Services requiring preauthorization that are not preauthorized will be denied. Refer to swhp.org or call 844-633-5325. Cost sharing waived at non-IHCP with IHCP referral . If an out-of-network provider charges more than the allowed amount , you may have to pay the difference (balance billing).
	Physician/surgeon fees	No charge	40% after <u>deductible</u>	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	Adult: \$30 <u>copayment</u> per office visit, <u>deductible</u> does not apply, \$600 <u>copayment</u> plus 40% after <u>deductible</u> for all other outpatient services Pediatric: No charge, <u>deductible</u> does not apply	Not covered	Services requiring preauthorization that are not preauthorized will be denied. Refer to swhp.org or call 844-633-5325. Cost sharing waived at non-IHCP with IHCP referral . If an out-of-network provider charges more than the allowed amount , you may have to pay the difference (balance billing).
	Inpatient services	No charge	\$2,000 <u>copayment</u> per stay plus 40% after <u>deductible</u>	Not covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP Participating Provider (You will pay more)	Non-IHCP Non-Participating Provider (You will pay the most)	
If you are pregnant	Office visits	No charge	\$30 <u>copayment</u> per visit	Not covered	Cost sharing does not apply for preventive care . 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). Cost sharing waived at non-IHCP with IHCP referral . If an out-of-network provider charges more than the allowed amount , you may have to pay the difference (balance billing).
	Childbirth/delivery professional services	No charge	40% 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. Cost sharing waived at non-IHCP with IHCP referral . If an out-of-network provider charges more than the allowed amount , you may have to pay the difference (balance billing).
	Childbirth/delivery facility services	No charge	\$2,000 <u>copayment</u> per stay plus 40% after <u>deductible</u>	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge	40% after <u>deductible</u>	Not covered	Limited to 60 visits per plan year. Services requiring preauthorization that are not preauthorized will be denied. Refer to swhp.org or call 844-633-5325. Cost sharing waived at non-IHCP with IHCP referral . If an out-of-network provider charges more than the allowed amount , you may have to pay the difference (balance billing).
	Rehabilitation services	No charge	\$30 <u>copayment</u> per visit, <u>deductible</u> does not apply	Not covered	Limited to 35 visits for rehabilitation services and 35 visits for habilitation services per plan year. Limit is combined for physical therapy, occupational therapy, speech therapy, and chiropractic

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP Participating Provider (You will pay more)	Non-IHCP Non-Participating Provider (You will pay the most)	
	Habilitation services	No charge	\$30 <u>copayment</u> per visit, <u>deductible</u> does not apply	Not covered	care. Limits do not apply for therapies for children with developmental delays, autism spectrum disorder, and mental health services. Services requiring preauthorization that are not preauthorized will be denied. Refer to swhp.org or call 844-633-5325. Cost sharing waived at non-IHCP with IHCP referral . If an out-of-network provider charges more than the allowed amount , you may have to pay the difference (balance billing).
	Skilled nursing care	No charge	40% after <u>deductible</u>	Not covered	Limited to 25 days per plan year. Services requiring preauthorization that are not preauthorized will be denied. Refer to swhp.org or call 844-633-5325. Cost sharing waived at non-IHCP with IHCP referral . If an out-of-network provider charges more than the allowed amount , you may have to pay the difference (balance billing).
	Durable medical equipment	No charge	40% after <u>deductible</u>	Not covered	Services requiring preauthorization that are not preauthorized will be denied. Refer to swhp.org or call 844-633-5325. Cost sharing waived at non-IHCP with IHCP referral . If an out-of-network provider charges more than the allowed amount , you may have to pay the difference (balance billing).
	Hospice services	No charge	40% after <u>deductible</u>	Not covered	
If your child needs dental or eye care	Children's eye exam	No charge	\$60 <u>copayment</u> per visit, <u>deductible</u> does not apply	Not covered	Limited to one eye exam per plan year. Cost sharing waived at non-IHCP with IHCP referral . If an out-of-network provider charges more than the allowed amount , you may have to pay the difference (balance billing).
	Children's glasses	No charge	\$60 <u>copayment</u> per pair, <u>deductible</u> does not apply	Not covered	Limited to one pair of glasses per plan year. Cost sharing waived at non-IHCP with IHCP referral . If an out-of-network provider charges more than the allowed amount , you may have to pay the difference (balance billing).
	Children's dental check-up	Not covered	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](#).)

- Abortion (except when the life of the mother is endangered)
- 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 when [medically necessary](#) and [preauthorized](#) (Limitations apply when used under [Home Health Care](#))

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: Baylor Scott & White Health [Plan](#) at 844-633-5325 or [swhp.org](#); Texas Department of Insurance at 800-578-4677 or [tdi.texas.gov](#); Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or [dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa](#). 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: Baylor Scott & White Health [Plan](#) at 844-633-5325 or [swhp.org](#); Texas Department of Insurance at 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? Not Applicable

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 844-633-5325.

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](#) No charge
- Hospital (facility) [coinsurance](#) No charge
- Other [coinsurance](#) No charge

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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Peg would pay is	\$0

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](#) No charge
- Hospital (facility) [coinsurance](#) No charge
- Other [coinsurance](#) No charge

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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Joe would pay is	\$0

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) No charge
- Hospital (facility) [coinsurance](#) No charge
- Other [coinsurance](#) No charge

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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$0

Note: These numbers assume the patient received care from an IHCP [provider](#) or with IHCP [referral](#) at a non-IHCP. If you receive care from a non-IHCP [provider](#) without a [referral](#) from an IHCP your costs may be higher.

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

Nondiscrimination Notice

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-844-633-5325 (TTY: 711).

Baylor Scott & 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. Baylor Scott & White Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Baylor Scott & 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 Baylor Scott & White Health Plan Compliance Officer at 1-214-820-8888 or send an email to: SWHPComplianceDepartment@BSWHealth.org.

If you believe that Baylor Scott & 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:

Baylor Scott & White Health Plan, 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 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>.



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ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-633-5325 (TTY: 711).

Baylor Scott & White Health Plan cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-633-5325 (TTY: 711).

Baylor Scott & White Health Plan tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.