




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 [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](#) or call 844-633-5325 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|--|---|
| What is the overall deductible? | \$0 per member / \$0 per family for a participating provider and \$4,275 per member / \$8,550 per family for a non-participating provider . | 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? | \$8,550 per member / \$17,100 per family for a participating provider and \$25,650 per member / \$51,300 per family for a non-participating provider . | 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 , balance billing charges, 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. |

| Important Questions | Answers | Why This Matters: |
|--|---------|--|
| 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: \$40 copayment per visit Pediatric: No charge | 50% after deductible | None |
| | Specialist visit | \$70 copayment per visit | 50% after deductible | |
| | Preventive care/screening/immunization | No charge, deductible does not apply | 50% after deductible No charge for child immunizations through the 6th birthday. | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. |
| If you have a test | Diagnostic test (X-ray, blood work) | \$250 copayment per visit for X-rays, \$100 copayment per visit for Labs | 50% after deductible | None |
| | Imaging (CT/PET scans, MRIs) | \$250 copayment per visit | 50% after deductible | Failure to obtain preauthorization of benefits, other than emergency care, will result in a penalty of the lesser of \$500 or 50%. |
| If you need drugs to treat your illness or condition | ACA preventive drugs | \$0 copayment | 50% after deductible | 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 |
| | Tier 1: Generic drugs | \$15 copayment per prescription | 50% after deductible | |

| 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) | |
| More information about prescription drug coverage is available at https://swhp.org/en-us/members/manage-your-plan/pharmacy-information | Tier 2: Preferred brand drugs | \$55 <u>copayment</u> per prescription | 50% after <u>deductible</u> | & 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 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. |
| | Tier 3: Non-preferred drugs | \$150 <u>copayment</u> per prescription | 50% after <u>deductible</u> | |
| | Tier 4: Specialty drugs and oral anticancer medications | \$500 <u>copayment</u> per prescription | 50% after <u>deductible</u> | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | \$500 <u>copayment</u> per visit | 50% after <u>deductible</u> | Failure to obtain preauthorization of benefits, other than emergency care, will result in a penalty of the lesser of \$500 or 50%. |
| | Physician/surgeon fees | \$250 <u>copayment</u> per visit | 50% after <u>deductible</u> | |
| If you need immediate medical attention | Emergency room care | \$750 <u>copayment</u> per visit | \$750 <u>copayment</u> per visit | Emergency room <u>copayment</u> waived if episode results in hospitalization for the same condition within 24 hours. |
| | Emergency medical transportation | \$750 <u>copayment</u> per service | \$750 <u>copayment</u> per service | None |
| | Urgent care | \$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) | 50% after <u>deductible</u> | Failure to obtain preauthorization of benefits, other than emergency care, will result in a penalty of the lesser of \$500 or 50%. |
| | Physician/surgeon fees | \$1,000 <u>copayment</u> per day (not to exceed \$5,000) | 50% after <u>deductible</u> | |

| 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 need mental health, behavioral health, or substance abuse services | Outpatient services | Adult: \$40 <u>copayment</u> per office visit, \$500 <u>copayment</u> per visit for all other outpatient services. Pediatric: No charge | 50% after <u>deductible</u> | Failure to obtain <u>preauthorization</u> of partial hospitalization benefits, other than emergency care, will result in a penalty of the lesser of \$500 or 50%. |
| | Inpatient services | \$1,000 <u>copayment</u> per day (not to exceed \$5,000) | 50% after <u>deductible</u> | Failure to obtain <u>preauthorization</u> of residential treatment benefits, other than emergency care, will result in a penalty of the lesser of \$500 or 50%. |
| If you are pregnant | Office visits | \$40 <u>copayment</u> per visit | 50% after <u>deductible</u> | <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) | 50% 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. |
| | Childbirth/delivery facility services | \$1,000 <u>copayment</u> per day (not to exceed \$5,000) | 50% after <u>deductible</u> | |
| If you need help recovering or have other special health needs | <u>Home health care</u> | 10% of charges | 50% after <u>deductible</u> | Limited to 60 visits per <u>plan</u> year. Failure to obtain <u>preauthorization</u> of benefits, other than emergency care, will result in a penalty of the lesser of \$500 or 50%. |
| | <u>Rehabilitation services</u> | \$40 <u>copayment</u> per visit | 50% after <u>deductible</u> | Limited to 35 visits for <u>rehabilitation services</u> and |

| 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) | |
| | Habilitation services | \$40 <u>copayment</u> per visit | 50% after <u>deductible</u> | 35 visits for habilitation services per plan year. Limit is combined for physical therapy, occupational therapy, speech therapy, and, and chiropractic care. Limits do not apply for therapies for children with developmental delays, autism spectrum disorder and mental health services. Failure to obtain preauthorization of benefits, other than emergency care, will result in a penalty of the lesser of \$500 or 50%. |
| | Skilled nursing care | \$500 <u>copayment/day</u> | 50% after <u>deductible</u> | Limited to 25 days per plan year. Failure to obtain preauthorization of benefits, other than emergency care, will result in a penalty of the lesser of \$500 or 50%. |
| | Durable medical equipment | 10% of charges | 50% after <u>deductible</u> | Failure to obtain preauthorization of benefits, other than emergency care, will result in a penalty of the lesser of \$500 or 50%. |
| | Hospice services | 10% of charges | 50% after <u>deductible</u> | |
| If your child needs dental or eye care | Children's eye exam | \$70 <u>copayment</u> per visit | 50% after <u>deductible</u> | Limited to one eye exam per plan year. |
| | Children's glasses | \$70 <u>copayment</u> per pair | 50% after <u>deductible</u> | Limited to one pair of glasses per plan year. |
| | Children's dental check-up | 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](#).)

- 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 Insurance Company at 844-633-5325 or [swbp.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: Baylor Scott & White Insurance Company at 844-633-5325 or [swbp.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 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 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 | \$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*)

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

In this example, Peg would pay:

| | |
|-----------------------------------|----------------|
| <i>Cost Sharing</i> | |
| Deductibles | \$0 |
| Copayments | \$2,000 |
| Coinsurance | \$400 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$2,460 |

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*)

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

In this example, Joe would pay:

| | |
|-----------------------------------|----------------|
| <i>Cost Sharing</i> | |
| Deductibles | \$0 |
| Copayments | \$1,400 |
| Coinsurance | \$80 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$1,500 |

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*)

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

In this example, Mia would pay:

| | |
|-----------------------------------|----------------|
| <i>Cost Sharing</i> | |
| Deductibles | \$0 |
| Copayments | \$1,800 |
| Coinsurance | \$70 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,870 |

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).

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Baylor Scott & White Insurance Company:

- 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 Insurance Company Compliance Officer at 1-214-820-8888 or send an email to SWHPComplianceDepartment@BSWHealth.org

If you believe that Baylor Scott & White Insurance Company 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 Insurance Company, 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).

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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 Insurance Company 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.