Coverage Period: 01/01/2022 – 12/31/2022 Coverage for: Member/Family | Plan Type: HMO

The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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 <u>BSWHealthPlan.com</u>. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms, see the Glossary. You can view the Glossary at <u>healthcare.gov/sbc-glossary</u> or call 844-633-5325 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$2,500 per member / \$5,000 per family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. Preventive care and ACA preventive drugs are covered before you meet your deductible.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive</u> <u>services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	\$6,000 per member / \$12,000 per family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> 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 <u>network provider</u> ?	Yes. See <u>BSWHealthPlan.com</u> or call 844-633-5325 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.

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Important Questions	Answers	Why This Matters:
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No	You can see the specialist you choose without a referral.

All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.

	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important
Common Medical Event		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	Information
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 <u>plan</u> year. \$10 <u>copayment</u> per visit for subsequent visits in that <u>plan</u> year, <u>deductible</u> does not apply Pediatric: No charge per visit, <u>deductible</u> does not apply	Not covered	None
	Specialist visit	\$20 <u>copayment</u> per visit, <u>deductible</u> does not apply	Not covered	
	Preventive care/screening/ immunization	No charge, <u>deductible</u> does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	Diagnostic test (X-ray, blood work)	No charge, <u>deductible</u> does not apply	Not covered	None

	Services You May	What You Will Pay		Limitations, Exceptions, & Other Important
Common Medical Event	Need	Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	Information
	Imaging (CT/PET scans, MRIs)	20% of charges	Not covered	Services requiring <u>preauthorization</u> that are not <u>preauthorized</u> will be denied. Refer to <u>BSWHealthPlan.com</u> or call 844-633-5325.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at bswhealthplan.com/Page s/pharmacy.aspx.	ACA preventive drugs	No charge, <u>deductible</u> does not apply	Not covered	
	Tier 1: Preferred generic drugs	\$15 <u>copayment</u> per prescription, <u>deductible</u> 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 & 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 copayment of \$25 per prescription per 30-day supply.
	Tier 2: Preferred brand name drugs	\$60 <u>copayment</u> per prescription, <u>deductible</u> does not apply	Not covered	
	Tier 3: Non-preferred generic drugs and non-preferred brand name drugs	\$120 <u>copayment</u> per prescription, <u>deductible</u> does not apply	Not covered	
	Specialty drugs	Tier 1: \$200 copayment per prescription, deductible does not apply Tier 2: \$300 copayment per prescription, deductible does not apply Tier 3: 15% coinsurance, deductible does not apply	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% after <u>deductible</u>	Not covered	Services requiring <u>preauthorization</u> that are not <u>preauthorized</u> will be denied. Refer to <u>BSWHealthPlan.com</u> or call 844-633-5325.

	Services You May	What You Will Pay		Limitations, Exceptions, & Other Important
Common Medical Event	Need	Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	Information
	Physician/surgeon fees	20% after <u>deductible</u>	Not covered	
	Emergency room care	\$500 <u>copayment</u> per visit, plus 20% of charges	\$500 <u>copayment</u> per visit, plus 20% of charges	Emergency room <u>copayment</u> waived if episode results in <u>hospitalization</u> for the same condition within 24 hours.
If you need immediate medical attention	Emergency medical transportation	\$500 <u>copayment</u> per service, plus 20% of charges	\$500 <u>copayment</u> per service, plus 20% of charges	None
	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	TOTO
If you have a hospital	Facility fee (e.g., hospital room)	20% after <u>deductible</u>	Not covered	Services requiring <u>preauthorization</u> that are not <u>preauthorized</u> will be denied. Refer to
stay	Physician/surgeon fees	20% after <u>deductible</u>	Not covered	BSWHealthPlan.com or call 844-633-5325.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Adult: \$10 copayment per visit, deductible does not apply Pediatric: No charge per visit, deductible does not apply	Not covered	Services requiring <u>preauthorization</u> that are not <u>preauthorized</u> will be denied. Refer to <u>BSWHealthPlan.com</u> or call 844-633-5325.
ususc 30111003	Inpatient services	20% after <u>deductible</u>	Not covered	

	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important
Common Medical Event		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	Information
If you are pregnant	Office visits	\$10 <u>copayment</u> per visit, <u>deductible</u> does not apply	Not covered	Cost sharing does not apply for preventive services. 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).
	Childbirth/delivery professional services	20% 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	20% after <u>deductible</u>	Not covered	
If you need help recovering or have other special health needs	Home health care	20% 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 <u>BSWHealthPlan.com</u> or call 844-633-5325.
	Rehabilitation services	\$15 <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,
	Habilitation services	\$15 <u>copayment</u> per visit, <u>deductible</u> does not apply	Not covered	occupational therapy, and speech therapy. 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 BSWHealthPlan.com or call 844-633-5325.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	Information
	Skilled nursing care	20% 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 <u>BSWHealthPlan.com</u> or call 844-633-5325.
	Durable medical equipment	20% after <u>deductible</u>	Not covered	Services requiring <u>preauthorization</u> that are not <u>preauthorized</u> will be denied. Refer to <u>BSWHealthPlan.com</u> or call 844-633-5325.
	Hospice services	No charge	Not covered	
	Children's eye exam	Not covered	Not covered	None
If your child needs dental or eye care	Children's glasses	Not covered	Not covered	None
	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 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 for members through the age of 18)
- Private duty nursing when <u>medically</u> <u>necessary</u> and <u>preauthorized</u> (Limitations apply when used under <u>Home Health Care</u>)

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 Care Plan at 844-633-5325 or BSWHealthPlan.com; 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 <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information on how to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact: Baylor Scott & White Care Plan at 844-633-5325 or <u>BSWHealthPlan.com</u>; Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or <u>www.dol.gov/ebsa/healthreform</u>; Texas Department of Insurance at 1-800-578-4677 or <u>tdi.texas.gov.</u>

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 <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost-sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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 <u>plan's</u> overall <u>deductible</u>	\$2,500
■ Specialist copayment	\$20
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

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)

\$12,700
\$2,500
\$10
\$1,800
\$60
\$4,370

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$2,500
■ Specialist copayment	\$20
■ Hospital (facility) coinsurance	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

<u>Primary care physician</u> office visits (including disease education)

Diagnostic tests (blood work)

Prescription drugs

<u>Durable medical equipment</u> (glucose meter)

Total Example Cost	\$5,600			
In this example, Joe would pay:				
Cost Sharing				
<u>Deductibles</u>	\$800			
Copayments	\$600			
Coinsurance	\$0			
What isn't covered				
Limits or exclusions	\$20			
The total Joe would pay is	\$1,420			

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$2,500
■ Specialist copayment	\$20
■ Hospital (facility) coinsurance	20%
■ Other <u>coinsurance</u>	20%

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)

Diagnostic test (X-ray)

<u>Durable medical equipment</u> (crutches)

Rehabilitation services (physical therapy)

Total Example Cost	\$2,800
In this example, Mia would pay:	
Cost Sharing	
<u>Deductibles</u>	\$1,100
Copayments	\$800
Coinsurance	\$0
What isn't covered	
Limits or exclusions	
The total Mia would pay is	\$1,900

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 Care 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 Care Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

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

If you believe that Baylor Scott & White Care 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 Care Plan, Compliance Officer 1206 West Campus Drive, Suite 151 Temple, Texas 76502

Compliance HelpLine; 1-888-484-6977 or https://app.mycompliancereport.com/report?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.

Language Assistance/ Asistencia de idiomas



English:

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

Spanish:

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

Korean:

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-633-5325 (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 1-5325-633-844 (رقم

Urdu:

کریں .(TTY: 711) 5325-633-844 خبردار: 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 1-844-633-5325 (TTY: 711).

French:

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-844-633-5325 (ATS : 711).

Hindi:

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध है। 1-844-633-5325 (TTY: 711) पर कॉल करें।

Persian:

فراهم می باشد. با (TTY: 711) 5325-633-844-1 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: 1-844-633-5325 (TTY: 711).

Gujarati:

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-844-633-5325 (TTY: 711).

Russian:

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-633-5325 (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。1-844-633-5325 (TTY:711) まで、お電話にてご連絡ください。

Laotian:

ົປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-844-633-5325 (TTY:711).