




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://www.bswhealthplan.com/SiteCollectionDocuments/PlanDocs/2023/SOB/SWHP\\_2023\\_SHIW3M28\\_MED.pdf](https://www.bswhealthplan.com/SiteCollectionDocuments/PlanDocs/2023/SOB/SWHP_2023_SHIW3M28_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](https://www.healthcare.gov/sbc-glossary) or call 844-633-5325 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$0 per member / \$0 per family	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	No	This <a href="#">plan</a> does not have a <a href="#">deductible</a> .
Are there other <a href="#">deductibles</a> for specific services?	No	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$1,500 per member / \$3,000 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.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<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> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="https://portal.swhp.org/#/search?networkCode=PREM_HMO_INDV">https://portal.swhp.org/#/search?networkCode=PREM_HMO_INDV</a> or call 844-633-5325 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.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	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</a> office or clinic	Primary care visit to treat an injury or illness	Adult: No charge for the first 2 sick visits, \$5 <a href="#">copayment</a> per visit for subsequent visits in that <a href="#">plan</a> year Pediatric: No charge	Not covered	None
	<a href="#">Specialist</a> visit	\$5 <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 preventive. Ask your <a href="#">provider</a> if the services needed are preventive. 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)	20% of charges	Not covered	None
	Imaging (CT/PET scans, MRIs)	20% of charges	Not covered	Services requiring <a href="#">preauthorization</a> that are not <a href="#">preauthorized</a> will be denied. Refer to <a href="#">BSWHealthPlan.com</a> or call 844-633-5325.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at	Generic drugs (Tier 1)	No charge per prescription	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 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. <a href="#">Specialty drugs</a> limited to a 30-day supply.
	Preferred brand drugs (Tier 2)	\$45 <a href="#">copayment</a> per prescription	Not covered	
	Non-preferred brand drugs (Tier 3)	\$150 <a href="#">copayment</a> per prescription	Not covered	

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)	
<a href="https://www.bswhealthplan.com/individuals-families/Pages/Marketplace">BSWHealthPlan.com/individuals-families/Pages/Marketplace</a>	<a href="#">Specialty drugs</a> (and oral anticancer medications) (Tier 4)	\$500 <u>copayment</u> per prescription	Not covered	<a href="#">Formulary</a> insulin prescriptions have a maximum <u>copayment</u> of \$25 per prescription per 30-day supply. Certain preventive drugs are covered at no charge. Tiers 2 - 4 may include brand and generic drugs.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% of charges	Not covered	Services requiring <a href="#">preauthorization</a> that are not <a href="#">preauthorized</a> will be denied. Refer to <a href="https://www.bswhealthplan.com">BSWHealthPlan.com</a> or call 844-633-5325.
	Physician/surgeon fees	20% of charges	Not covered	
If you need immediate medical attention	<a href="#">Emergency room care</a>	20% of charges	20% of charges	Emergency room <u>copayment</u> waived if episode results in <a href="#">hospitalization</a> for the same condition within 24 hours.
	<a href="#">Emergency medical transportation</a>	20% of charges	20% of charges	None
	<a href="#">Urgent care</a>	\$5 <u>copayment</u> per visit	\$5 <u>copayment</u> per visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% of charges	Not covered	Services requiring <a href="#">preauthorization</a> that are not <a href="#">preauthorized</a> will be denied. Refer to <a href="https://www.bswhealthplan.com">BSWHealthPlan.com</a> or call 844-633-5325.
	Physician/surgeon fees	20% of charges	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Adult: \$5 <u>copayment</u> per office visit; 20% for all other outpatient services Pediatric: No charge per office visit; 20% for all other outpatient services	Not covered	Services requiring <a href="#">preauthorization</a> that are not <a href="#">preauthorized</a> will be denied. Refer to <a href="https://www.bswhealthplan.com">BSWHealthPlan.com</a> or call 844-633-5325.
	Inpatient services	20% of charges	Not covered	

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 are pregnant	Office visits	\$5 <u>copayment</u> per visit	Not covered	<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	20% of charges	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% of charges	Not covered	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% 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="#">BSWHealthPlan.com</a> or call 844-633-5325.
	<a href="#">Rehabilitation services</a>	\$5 <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 chiropractic care. Limits do 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="#">BSWHealthPlan.com</a> or call 844-633-5325.
	<a href="#">Habilitation services</a>	\$5 <u>copayment</u> per visit	Not covered	
	<a href="#">Skilled nursing care</a>	20% of charges	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="#">BSWHealthPlan.com</a> or call 844-633-5325.

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)	
	<a href="#">Durable medical equipment</a>	20% of charges	Not covered	Services requiring <a href="#">preauthorization</a> that are not <a href="#">preauthorized</a> will be denied. Refer to <a href="http://BSWHealthPlan.com">BSWHealthPlan.com</a> or call 844-633-5325.
	<a href="#">Hospice services</a>	20% of charges	Not covered	
If your child needs dental or eye care	Children's eye exam	\$5 <a href="#">copayment</a> per visit	Not covered	Limited to one eye exam per <a href="#">plan</a> year.
	Children's glasses	\$5 <a href="#">copayment</a> 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

## 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) | • Cosmetic surgery              | • Non-emergency care when traveling outside the U.S. |
| • Acupuncture   | • Dental care (Adult and Child) | • Routine eye care (Adult)                           |
| • Bariatric surgery   | • Infertility treatment         | • Routine foot care                                  |
|   | • Long-term 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 <a href="#">Rehabilitation Services</a> and <a href="#">Habilitation Services</a> ) | • Hearing aids (Limited to one device per ear every 3 years) | • Private duty nursing when <a href="#">medically necessary</a> and <a href="#">preauthorized</a> (Limitations apply when used under <a href="#">Home Health Care</a> ) |
|--|--|---|

**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 [BSWHealthPlan.com](#); 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 [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 [BSWHealthPlan.com](#); 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$5
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,500
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,560</b>

### Managing Joe's Type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$5
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	20%

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:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$400
<a href="#">Coinsurance</a>	\$200
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$620</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$5
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	20%

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:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$40
<a href="#">Coinsurance</a>	\$300
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$340</b>

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