




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 BSWHealthPlan.com. 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? | \$3,000 per member / \$6,000 per family for a participating provider and \$6,000 per member / \$12,000 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? | Yes. \$200 deductible for participating provider and \$250 deductible for non- participating provider prescription drug coverage. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| What is the out-of-pocket limit for this plan? | \$6,000 per member / \$12,000 per family for a participating provider and \$12,000 per member / \$24,000 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 . |

| Important Questions | Answers | Why This Matters: |
|--|---|---|
| Will you pay less if you use a network provider ? | Yes. See https://www.bswhealthplan.com/Pages/Provider.aspx 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 |
|--|--|--|--|---|
| | | 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: \$30 copayment per visit, deductible does not apply Pediatric: \$30 copayment per visit, deductible does not apply | Adult: \$30 copayment per visit, deductible does not apply Pediatric: \$30 copayment per visit, deductible does not apply | None |
| | Specialist visit | \$50 copayment per visit, deductible does not apply | \$60 copayment per visit, deductible does not apply | |
| | Preventive care/screening/immunization | No charge | 40% 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) | No charge | 40% after deductible | None |

| 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) | |
| | Imaging (CT/PET scans, MRIs) | 20% of charges after <u>deductible</u> | 40% after <u>deductible</u> | Failure to obtain <u>preauthorization</u> 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 More information about <u>prescription drug coverage</u> is available at BSWHealthPlan.com/Group/Pages/Pharmacy | Affordable Care Act (ACA) preventive drugs | No charge | 40% of charges after <u>deductible</u> | ACA preventive drugs from non- <u>participating provider</u> : 40% of charges after <u>deductible</u> . |
| | Tier 1: Generic drugs | \$5 <u>copayment</u> per prescription after <u>deductible</u> | \$5 <u>copayment</u> per prescription after <u>deductible</u> | If a brand name drug is dispensed when a generic is available, 50% <u>coinsurance</u> applies. Non-formulary: Greater of \$50 <u>copayment</u> or 50% of charges. |
| | Tier 2: Preferred brand drugs | 30% of charges after <u>deductible</u> | 30% of charges after <u>deductible</u> | |
| | Tier 3: Non-preferred drugs | 50% of charges after <u>deductible</u> | 50% of charges after <u>deductible</u> | |
| | <u>Specialty drugs</u> and oral anticancer medications | Tier 1: 10% of charges after <u>deductible</u> Tier 2: 20% of charges after <u>deductible</u> Tier 3: 30% of charges after <u>deductible</u> Non-formulary: 50% of charges after <u>deductible</u> | Tier 1: 40% of charges after <u>deductible</u> Tier 2: 40% of charges after <u>deductible</u> Tier 3: 40% of charges after <u>deductible</u> Non-formulary: 50% of charges after <u>deductible</u> | Prescription <u>deductible</u> applies. |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% of charges after <u>deductible</u> | 40% after <u>deductible</u> | Failure to obtain <u>preauthorization</u> of benefits, other than emergency care, will result in a penalty of the lesser of \$500 or 50%. |
| | Physician/surgeon fees | 20% of charges after <u>deductible</u> | 40% 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 immediate medical attention | Emergency room care | \$250 <u>copayment</u> and 20% of charges after <u>deductible</u> per emergency visit | \$250 <u>copayment</u> and 20% of charges after <u>deductible</u> per emergency visit | Emergency room <u>copayment</u> waived if episode results in <u>hospitalization</u> for the same condition within 24 hours. |
| | Emergency medical transportation | 20% of charges after <u>deductible</u> | 20% of charges after <u>deductible</u> | None |
| | Urgent care | \$75 <u>copayment</u> per visit, <u>deductible</u> does not apply | \$75 <u>copayment</u> per visit, <u>deductible</u> does not apply | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 20% of charges after <u>deductible</u> | 40% after <u>deductible</u> | Failure to obtain <u>preauthorization</u> of benefits, other than emergency care, will result in a penalty of the lesser of \$500 or 50%. |
| | Physician/surgeon fees | 20% of charges after <u>deductible</u> | 40% after <u>deductible</u> | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Adult: 50% of charges after <u>deductible</u> Pediatric: 50% of charges after <u>deductible</u> | Adult: 50% of charges after <u>deductible</u> Pediatric: 50% of charges after <u>deductible</u> | Limited to 20 visits per 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%. |
| | Inpatient services | 50% of charges after <u>deductible</u> | 50% of charges 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 are pregnant | Office visits | \$50 <u>copayment</u> per visit, <u>deductible</u> does not apply | \$60 <u>copayment</u> per visit, <u>deductible</u> does not apply | <u>Cost sharing</u> does not apply for <u>preventive services</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 | 20% of charges after <u>deductible</u> | 40% 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 | 20% of charges after <u>deductible</u> | 40% after <u>deductible</u> | |
| If you need help recovering or have other special health needs | <u>Home health care</u> | \$50 <u>copayment</u> per visit, <u>deductible</u> does not apply | \$60 <u>copayment</u> per visit, <u>deductible</u> does not apply | 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> | \$50 <u>copayment</u> per visit, <u>deductible</u> does not apply | 40% after <u>deductible</u> | Limited to 20 visits per 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>Habilitation services</u> | \$50 <u>copayment</u> per visit, <u>deductible</u> does not apply | 40% after <u>deductible</u> | Limited to 20 visits per 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>Skilled nursing care</u> | 20% of charges after <u>deductible</u> | 40% after <u>deductible</u> | Failure to obtain <u>preauthorization</u> of benefits, other than emergency care, will result in a penalty of the lesser of \$500 or 50%. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|--|
| | | <u>Participating provider</u> (You will pay the least) | <u>Non-Participating provider</u> (You will pay the most) | |
| | Durable medical equipment | 50% of charges after <u>deductible</u> | 50% of charges after <u>deductible</u> | \$1,000 maximum annual benefit. Failure to obtain preauthorization of benefits, other than emergency care, will result in a penalty of the lesser of \$500 or 50%. |
| | Hospice services | No charge | 50% of charges 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%. |
| If your child needs dental or eye care | Children's eye exam | \$50 <u>copayment</u> per visit, <u>deductible</u> does not apply | \$60 <u>copayment</u> per visit, <u>deductible</u> does not apply | Limited to one eye exam per plan year. |
| | 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
- Chiropractic care
- Cosmetic surgery
- Dental care (Adult and Child)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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.)

- Hearing aids (Limited to one device per ear every 3 years)
- Private duty nursing when [medically necessary](#) and [preauthorized](#)
- Routine eye care (Limited to one exam per Member 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 Baylor Scott & White Health 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 [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](#); 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? No

[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? No

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](#) \$3,000
- [Specialist copayment](#) \$50
- 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*)

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

In this example, Peg would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$3,000 |
| Copayments | \$900 |
| Coinsurance | \$1,800 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$5,800 |

Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$3,000
- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 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*)

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

In this example, Joe would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$900 |
| Copayments | \$1,100 |
| Coinsurance | \$900 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$3,000 |

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$3,000
- [Specialist copayment](#) \$50
- Hospital (facility) [coinsurance](#) 20%
- Other [coinsurance](#) 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*)

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

In this example, Mia would pay:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$700 |
| Copayments | \$1,000 |
| Coinsurance | \$200 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,900 |

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 HPCompliance@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?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>.

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 1-844-633-5325 (رقم 844-633-5325-1)

Urdu:

کریں (1-844-633-5325 (TTY: 711) 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 हैं। 1-844-633-5325 (TTY: 711) पर कॉल करें।

Persian:

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

ໂປດຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສຍຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-844-633-5325 (TTY: 711).