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?	$750 per member / $1,500 per family for a participating provider and $1,500 per member / $3,000 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$3,750 per member / $7,500 per family for a participating provider and $7,500 per member / $15,000 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.
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	No	You can see the specialist you choose without a referral.

Important Questions	Answers	Why This Matters:
see a specialist?		

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: $25 copayment per visit Pediatric: $25 copayment per visit	50% after deductible	None
	Specialist visit	$25 copayment per visit	50% after deductible	
	Preventive care/screening/ immunization	No charge	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)	20% after deductible	50% 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)	$25	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 More information about **prescription drug coverage** is available at BSWHealthPlan.com/Group/Pages/Pharmacy	Affordable Care Act (ACA) preventive drugs	No charge	50% after deductible	Copayments are per 34-day supply. Two copayments apply for a 90-day supply if a maintenance drug is obtained through a Baylor Scott & White pharmacy OR when using the mail order prescription service. Specific preventative medications will be covered with no cost to the member. Non-formulary drugs: 50% of charges; out-of-network: 50% after deductible. Non-formulary specialty drugs: 50% after deductible.
	Preferred generic drugs	$10 copayment per prescription, deductible does not apply	50% after deductible	
	Preferred brand drugs	$30 copayment per prescription, deductible does not apply	50% after deductible	
	Non-preferred generic drugs and non-preferred brand drugs	$50 copayment per prescription, deductible does not apply	50% after deductible	
	Specialty drugs and oral anticancer medications	Tier 1: 10% after deductible Tier 2: 20% after deductible Tier 3: 30% after deductible	50% after deductible	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% after deductible	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%.
	Physician/surgeon fees	20% after deductible	50% after deductible	
If you need immediate medical attention	Emergency room care	20% after deductible	20% after deductible	Emergency room copayment waived if episode results in hospitalization for the same condition within 24 hours.

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)	
	Emergency medical transportation	20% after deductible	20% after deductible	None
	Urgent care	$75 copayment per visit	$75 copayment per visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% after deductible	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%.
	Physician/surgeon fees	20% after deductible	50% after deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not covered	Not covered	None
	Inpatient services	Not covered	Not covered	None
If you are pregnant	Office visits	Not covered	Not covered	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)	
	Childbirth/delivery professional services	Not covered	Not covered	None
	Childbirth/delivery facility services	Not covered	Not covered	
If you need help recovering or have other special health needs	Home health care	20% after deductible	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%.
	Rehabilitation services	20% after deductible	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%.
	Habilitation services	20% after deductible	50% after deductible	
	Skilled nursing care	20% after deductible	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%.
	Durable medical equipment	20% after deductible	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%.
	Hospice services	20% after deductible	50% after deductible	None
If your child needs dental or eye care	Children's eye exam	20% after deductible	50% after deductible	Limited to one eye exam per plan year.

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)	
	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 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.)

- Hearing aids (Limited to one device per ear every 3 years for members through the age of 18)
- Private duty nursing when medically necessary and preauthorized

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 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 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 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** **$750**
- **Specialist copayment** **Not covered**
- **Hospital (facility)** **Not covered**
- **Other coinsurance** **Not covered**

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:	
Cost Sharing	
Deductibles	N/A
Copayments	N/A
Coinsurance	N/A
What isn't covered	
Limits or exclusions	N/A
The total Peg would pay is	**$12,700**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$750**
- **Specialist copayment** **$25**
- **Hospital (facility)** **20% after deductible**
- **Other coinsurance** **20% after deductible**

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:	
Cost Sharing	
Deductibles	$750
Copayments	$1,000
Coinsurance	$300
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,070**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$750**
- **Specialist copayment** **$25**
- **Hospital (facility)** **20% after deductible**
- **Other coinsurance** **20% after deductible**

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:	
Cost Sharing	
Deductibles	$750
Copayments	$100
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,150**

The plan would be responsible for the other costs of these EXAMPLE covered services.