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, visit http://swhp.org/plandocs, or call 1-800-321-7947. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary at www.cciio.cms.gov.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**Network Provider:** $750 individual / $1,500 family; Non-Network Provider: $1,500 individual / $3,000 family.	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 primary care services are covered before you meet your **deductible**.	This **plan** covers some items and services even if you have not 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 do not have to meet **deductibles** for specific services.
What is the out-of-pocket limit for this plan?	**Network Provider**: $3,750 per individual / $7,500 per family; Non-Network Provider: $11,250 per individual / $22,500 per family	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**, the overall family **out-of-pocket limit** must be met.
What is not included in the out-of-pocket limit?	**Copayments** on certain services, **premiums, balance-billing** charges, and health care this **plan** does not 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 www.swhp.org or call 1-800-321-7947 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
		Network Provider (You will pay the least)	Out-of-Network 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	$25 copay per visit	50% after deductible	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.
	Specialist visit	$50 copay per visit	50% after deductible	
	Preventive care/screening/ immunization	No Charge	50% after deductible	
If you have a test	Diagnostic test (x-ray, blood work)	20% after deductible	50% after deductible	None
	Imaging (CT/PET scans, MRIs)	20% after deductible	50% after deductible	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at http://swhp.org/en-us/members/manage-your-plan/pharmacy-information.	Preferred generic drugs	$5 copay	$5 copay	Copays are per 30-day supply. Generic and brand preferred and non-preferred copayments will be two times the applicable amount 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% after deductible
	Preferred brand drugs	$50 copay	$50 copay	
	Non-preferred generic drugs and non-preferred Brand drugs and all other Drugs	50% copay	50% copay	
	Preferred Specialty drugs	50% copay	50% copay	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% after deductible	50% after deductible	None
	Physician/surgeon fees	20% after deductible	50% after deductible	
If you need immediate medical attention	Emergency room care	$250 + 20% copay	$250 + 20% copay	None
	Emergency medical transportation	20% after deductible	20% after deductible	
	Urgent care	$25 copay	$25 copay	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% after deductible	50% after deductible	For prior authorization requirements and penalties see http://www.swhp.org/ind-fam/tools-resources. Failure to obtain Prior Authorization will result in the lesser
	Physician/surgeon fees	20% after deductible	50% after deductible	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				of $500 or 50% reduction in benefits, or denial in the case of Health Care Services, other than Emergency Care, provided by an In-Network Provider.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay per visit	50% after deductible	None
	Inpatient services	20% after deductible	50% after deductible	None
If you are pregnant	Office visits	$50 copay per visit	50% after deductible	No charge for prenatal visits; postnatal visits are covered at the specialist copay. Depending on the type of services, a **copayment**, **coinsurance**, or **deductible** may apply.
	Childbirth/delivery professional services	20% after deductible	50% after deductible	
	Childbirth/delivery facility services	20% after deductible	50% after deductible	None
If you need help recovering or have other special health needs	Home health care	20% after deductible	50% after deductible	60 visit limit per year
	Rehabilitation services	$50 copay per visit	50% after deductible	35 visit limit per year
	Habilitation services	$50 copay per visit	50% after deductible	35 visit limit per year
	Skilled nursing care	20% after deductible	50% after deductible	25 visit limit per year
	Durable medical equipment	20% after deductible	50% after deductible	None
	Hospice services	20% after deductible	50% after deductible	None
If your child needs dental or eye care	Children's eye exam	$50 copay per visit	50% after deductible	One exam limit per year.
	Children's glasses	$50 copay per visit	50% after deductible	$300 / one pair limit per 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	• Dental care (Child and Adult)	• Private-duty nursing
• Bariatric surgery	• Infertility treatment	• Routine foot care
• Chiropractic care	• Long-term care	• Weight loss programs
• Cosmetic surgery	• Non-emergency care when traveling outside U.S.	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
• Hearing Aids (limited to the cost of one hearing aid per hearing impaired ear every 36 months)	• Routine eye care (Adult), limited to one per 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: Scott and White Health Plan, visit http://www.swhp.org , or call 1-800-321-7947; Department of Labor Employee Benefits Security Administration, visit http://www.dol.gov/ebsa/healthreform , or call1-866-444-EBSA (3272); Department of Health and Human Services, Center for Consumer Information, visit http://www.cciio.com.gov, or call 1-877-267-2323 x61565; Texas Department of Insurance, visit http://www.tdi.texas.gov, or call1-800-578-4677. 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 1-800-318-2596.

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 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: Scott and White Health Plan, visit http://www.swhp.org , or call 1-800-321-7947; Department of Labor Employee Benefits Security Administration, visit http://www.dol.gov/ebsa/healthreform , or call 1-866-444-EBSA (3272); Texas Department of Insurance, visit http://www.tdi.texas.gov , or call 1-800-252-3439.

Does this plan provide Minimum Essential Coverage? **Yes**
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-800-321-7947.

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	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:

Sample Care Costs
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	**$12,731**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$750
Copayments	$495
Coinsurance	$1,851
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,156**

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	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:

Sample Care Costs
Primary care physician office visits (including disease education)
Diagnostic tests (blood work)
Prescription drugs
Durable medical equipment (glucose meter)

Total Example Cost	**$7,389**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$676
Copayments	$1,660
Coinsurance	$169
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2,560**

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

The plan's overall deductible	$750
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:

Sample Care Costs
Emergency room care (including medical supplies)
Diagnostic test (x-ray)
Durable medical equipment (crutches)
Rehabilitation services (physical therapy)

Total Example Cost	**$1,925**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$859
Copayments	$787
Coinsurance	$111
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,757**

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

English:
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-321-7947 (TTY: 1-800-735-2989). 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.

Spanish:
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-321-7947 (TTY: 1-800-735-2989). Scott & White Health Plan cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

Vietnamese:
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800 321-7947 (TTY: 1-800-735-2989). Scott & White Health Plan 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.

Chinese:
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-321-7947 (TTY：1-800-735-2989）。Scott & White Health Plan 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。

Korean:
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-321-7947 (TTY: 1-800-735-2989) 번으로 전화해 주십시오. Scott & White Health Plan 은(는) 관련 연방 공민권법을 준수하며 인종, 피부색, 출신 국가, 연령, 장애 또는 성별을 이유로 차별하지 않습니다.

Arabic:
ةظوحلم: اذإ تنك تثدحتت ركذا اللغة، نإف تامدخ ةدعاسملا ةيوغللا رفاوتتك لكلناجملابـ. لصتا مقربـ 1-800-321-7947 (مقر فـتاه مصلا مكبلاو: 1-800-735-2989).
مزتلي Scott & White Health Plan نيناوقبـ قوقحلا ةيندملا لومعملا اهبـ لاو زيميـ ىلعـ سساسأ قرعلا وأ نولل وأ لصلأا يـنطولا وأ سلنا وأ ةقاعلإا وأ سنجلا.

Urdu:

رادربخ: رگا پ آ ودرا ےتلوب ہیں، وت پ آ وک نابز یک ددم یک تامدخ تفم ںیم بایتسد ںیہ۔ اکل
1-800-321-7947 (TTY: 1-800-735-2989). ںیرک
Scott & White Health Plan باق لِ قلاطا یقافو یرہش قوقح ےک نیناوق یک لیمعت اترک ےہ
روا ہی ہک نسل، گـنر ، قومیت، عمر، ی روذعم ای سنج یک داینب رپ زایتما ںیہن ۔اترک

Tagalog:

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-321-7947 (TTY: 1-800-735-2989). Sumusunod ang Scott & White Health Plan sa mga naaangkop na Pederal na batas sa karapatang sibil at hindi nandidiskrimina batay sa lahi, kulay, bansang pinagmulan, edad, kapansanan o kasarian.

French:

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-321-7947 (ATS: 1-800-735-2989). Scott & White Health Plan respecte les lois fédérales en vigueur relatives aux droits civiques et ne pratique aucune discrimination basée sur la race, la couleur de peau, l'origine nationale, l'âge, le sexe ou un handicap.

Hindi:

ध्यान दें: यिद आप िहंदी बोलते हैं तो आपके िलए मुफ्त में भाषा सहायता सेवाएंउपलब्ध हैं। 1-800-321-7947 (TTY: 1-800-735-2989) पर कॉल करें। Scott & White Health Plan लागू होनेयोग्य संघीय नागरक अिधकार क़ानून का पालन करता हैऔर जाित, रंग, राष्ट्रीय मूल, आयु, िवकलांगता, या िलंग के आधार पर भेदभाव नहीं करता है।

Persian:

یندم لاردف ہطوبرم تیعبت یمدنک و مهارف یمدشاب. اب 1-800-321-7947 (TTY: 1-800-735-2989) سامتدیریگب. **ہجوت:** رگا ہبناب زی یسراف وگتفگ یمکنید، تلایهست ینابز ت روصب ناگیار ی ار ب امش
لیاق یمدنود ش. ہنوگچیه یضیعبت ربس اسانژاد، گـنر پوست، تیلصاملیتی، سن، یناوتان ایت یسنجدارفا Scott & White Health Plan زانیناوق قوقح

German:

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-321-7947 (TTY: 1-800-735-2989). Scott & White Health Plan erfüllt geltenden bundesstaatliche Menschenrechtsgesetze und lehnt jegliche Diskriminierung aufgrund von Rasse, Hautfarbe, Herkunft, Alter, Behinderung oder Geschlecht ab.

Gujarati:
~ુચના: જો તમે ~ુજરાતી બોલતા હો, તો િન:~ુલ્ક ભાષા સહાય સેવાઓ તમારા માટ~ ઉપલબ્ધ છે. કૉલ કરો
1-800-321-7947 (TTY: 1-800-735-2989). Scott & White Health Plan લા~ુ પડતા સમવાયી નાગ~રક અિધકાર કાયદા સાથે ~ુસંગત છે અને ~િત, રંગ,રાષ્ટ્ર~ય ~ૂળ, ~મર, અશક્તતા અથવા ~લ~ગના આધાર~ ભેદભાવ રાખવામાં આવતો નથી.

Russian:
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-321-7947 (телетайп: 1-800-735-2989). Scott & White Health Plan соблюдает применимое федеральное законодательство в области гражданских прав и не допускает дискриминации по признакам расы, цвета кожи, национальной принадлежности, возраста, инвалидности или пола.

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。1-800-321-7947
(TTY:1-800-735-2989)まで、お電話にてご連絡ください。Scott & White Health Plan は適用される連邦公民権法を遵守し、人種、肌の色
、出身国、年齢、障害または性別に基づく差別をいたしません。

Laotian:
ໂປດຊາບ: ຖ້າວ່າ ທ່ ານເວົ້າພາສາ ລາວ, ການບໍ ລິ ການຊ່ ວຍເຫຼືອ ຣ ດ້ານພາສາ, ໂດຍບ່ ເສັ ງຄ່ າ, ແມ່ ນມີ ພ້ ອມໃຫ້ ທ່ ານ. ໂທຣ 1-800-321-7947 (TTY: 1-800-735-2989). Scott & White Health Plan ປະຕິ ບັ ດຕາມກົ ດໝາຍວ່ າດ້ ວຍສິ ດທິ ພົ ນລະເມື ອງຂອງຣັ ຖບານກາງທີ່ ບັ ງຄັ ບໃຊ້ ແລະບ່ ຈໍ າແນກໂດຍອີ ງໃສ່ ພື້ ນຖານດ້ ານເຊື້ ອຊາ ດ, ສີ ຜິ ວ, ຊາ ດກໍ າເນີ ດ, ອາ ຍຸ , ຄວາມພິ ການ, ຫຼື ເພ ດ.