



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://ers.swhp.org/forms-guides> , 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](http://www.cciio.cms.gov).

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$0 per individual	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> and primary care services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you have not yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
Are there other <a href="#">deductibles</a> for specific services?	\$50 Pharmacy <a href="#">deductible</a>	You do not 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> ?	\$6,650 per individual / \$13,300 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> , the overall family <a href="#">out-of-pocket limit</a> must be met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Copayments</a> on certain services, <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> does not 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="http://www.swhp.org">www.swhp.org</a> or call 1-800-321-7947 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> .

\* For more information about limitations and exceptions, see the plan or policy document at <http://www.ers.swhp.org>

 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$25 <a href="#">copay</a> per visit	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.
	<a href="#">Specialist</a> visit	\$40 <a href="#">copay</a> per visit	Not Covered	
	<a href="#">Preventive care/screening/immunization</a>	No Charge	Not Covered	
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	20% <a href="#">coinsurance</a>	Not Covered	None
	Imaging (CT/PET scans, MRIs)	\$100 <a href="#">copay</a> plus 20% <a href="#">coinsurance</a>	Not Covered	Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://ers.swhp.org/pharmacy-information">http://ers.swhp.org/pharmacy-information</a>	Preferred generic drugs	\$10 <a href="#">copay</a> per 30 day supply \$30 <a href="#">copay</a> per 90 day supply / maintenance	Not Covered	Copays are per 30-day supply. 3 copays 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.
	Preferred brand drugs	\$35 <a href="#">copay</a> per 30 day supply \$105 <a href="#">copay</a> per 90 day supply / maintenance	Not Covered	
	Non-preferred generic drugs and non-preferred Brand drugs	\$60 <a href="#">copay</a> per 30 day supply \$180 <a href="#">copay</a> per 90 day supply / maintenance	Not Covered	
	<a href="#">Specialty drugs</a>	If purchased through a pharmacy, specialty drugs are covered as preferred brand drugs or non-preferred brand drugs as	Not Covered	Some specialty drugs may require prior authorization. 30-day supply only.

\* For more information about limitations and exceptions, see the plan or policy document at <http://www.ers.swhp.org>

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)	
		listed above. Otherwise, covered as a medical benefit		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$100 <u>copay</u> , plus 20% <u>coinsurance</u>	Not Covered	Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
	Physician/surgeon fees	20% <u>coinsurance</u>	Not Covered	
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$150 <u>copay</u> , plus 20% <u>coinsurance</u>	\$150 <u>copay</u> , plus 20% <u>coinsurance</u>	If admitted, copay is applied to inpatient hospital copay.
	<a href="#">Emergency medical transportation</a>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<a href="#">Urgent care</a>	\$50 <u>copay</u> , plus 20% <u>coinsurance</u>	\$50 <u>copay</u> , plus 20% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$150 per day <u>copay</u> , plus 20% <u>coinsurance</u>	Not Covered	\$750 <u>copay</u> max per admission. \$2,250 <u>copay</u> max per plan year per person. Prior authorization may be required. Failure to obtain prior authorization may increase your cost.  For prior authorization requirements and penalties see <a href="http://www.ers.swhp.org">http://www.ers.swhp.org</a> . Failure to obtain Prior Authorization will result in the lesser 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.
	Physician/surgeon fees	20% <u>coinsurance</u>	Not Covered	

\* For more information about limitations and exceptions, see the plan or policy document at <http://www.ers.swhp.org>

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 need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <u>copay</u> per visit	Not Covered	Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
	Inpatient services	\$150 per day <u>copay</u> , plus 20% <u>coinsurance</u>	Not Covered	\$750 <u>copay</u> max per admission. \$2,250 <u>copay</u> max per plan year per person. Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
If you are pregnant	Office visits	\$40 <u>copay</u> per visit	Not Covered	No charge for prenatal visits; postnatal visits are covered at the <u>specialist copay</u> .  Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply.
	Childbirth/delivery professional services	\$25 <u>copay</u> per visit	Not Covered	No charge for prenatal visits; postnatal visits are covered at the specialist copay.  Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply.
	Childbirth/delivery facility services	\$150 per day <u>copay</u> , plus 20% <u>coinsurance</u>	Not Covered	\$750 <u>copay</u> max per admission. \$2,250 <u>copay</u> max per plan year per person. Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <u>coinsurance</u>	Not Covered	Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
	<a href="#">Rehabilitation services</a>	20% without office visit, \$40 plus 20% <u>coinsurance</u> with office visit	Not Covered	Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
	<a href="#">Habilitation services</a>	20% <u>coinsurance</u>	Not Covered	None

\* For more information about limitations and exceptions, see the plan or policy document at <http://www.ers.swhp.org>

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)	
	<a href="#">Skilled nursing care</a>	20% <u>coinsurance</u>	Not Covered	Max of 60 days per plan year per person. Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
	<a href="#">Durable medical equipment</a>	20% <u>coinsurance</u>	Not Covered	Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
	<a href="#">Hospice services</a>	20% <u>coinsurance</u>	Not Covered	Prior authorization may be required. Failure to obtain prior authorization may increase your cost.
If your child needs dental or eye care	Children's eye exam	\$40 <u>copay</u>	Not Covered	One exam limit per 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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
• Acupuncture	• Dental check-up	• Non-emergency care when traveling outside U.S.
• Artificial insemination	• Glasses	• Personal comfort items
• Bariatric surgery	• Infertility treatment	• Routine foot care
• Cosmetic surgery	• Long-term care	• Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>• Hearing Aids</li> <li>• Chiropractic Care (Manipulative Therapy)</li> <li>• Private duty nursing</li> </ul>		

**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 call 1-866-444-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 call 1-800-578-4677. Other coverage

\* For more information about limitations and exceptions, see the plan or policy document at <http://www.ers.swhp.org>

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](http://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.*-----

\* For more information about limitations and exceptions, see the plan or policy document at <http://www.ers.swhp.org>

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](#) \$0
- [Specialist copayment](#) \$40
- Hospital (facility) [coinsurance](#) \$150 + 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)

<b>Total Example Cost</b>	<b>\$12,840</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$490
Coinsurance	\$2,480
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,030</b>

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$40
- Hospital (facility) [coinsurance](#) \$150 + 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)

<b>Total Example Cost</b>	<b>\$7,460</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1,050
Coinsurance	\$370
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$1,480</b>

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$40
- Hospital (facility) [coinsurance](#) \$150 + 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)

<b>Total Example Cost</b>	<b>\$2,010</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$510
Coinsurance	\$330
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$840</b>

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

& 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:**

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-321-7947-1 (رقم هاتف الصم والبكم: 800-735-2989-1). يلتزم Scott & White Health Plan بقوانين الحقوق المدنية الفدرالية المعمول بها ولا يميز على أساس العرق أو اللون أو الأصل الوطني أو السن أو الإعاقة أو الجنس.



**Urdu:**

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں (TTY: 1-800-735-2989) 1-800-321-7947 Scott & White Health Plan قابلِ اطلاق وفاقی شہری حقوق کے قوانین کی تعمیل کرتا ہے اور یہ کہ نسل، رنگ، قومیت، عمر، معذوری یا جنس کی بنیاد پر امتیاز نہیں کرتا۔

**Tagalog:**

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-3217947 (TTY: 1-800-735-2989). Sumusunod ang Scott & White Health Plan sa mga naaangkop na Pederal na batas sa karapatang sibil at hindi nandiskrimina 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: 1-800-7352989). 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: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-321-7947 (TTY: 1-800-735-2989) पर कॉल करें। Scott & White Health Plan लागू होने योग्य संघीय नागरिक अधिकार कानून का पालन करता है और जाति, रंग, राष्ट्रीय मूल, आयु, विकलांगता, या लिंग के आधार पर भेदभाव नहीं करता है।

**Persian:**

مندی فدرال مربوطه تبعیت می کند و فراهم می باشد. با (TTY: 1-800-735-2989) 1-800-321-7947 تماس بگیرید. توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما قابل نمی شود. هیچگونه تبعیضی بر اساس نژاد، رنگ پوست، اصلیت ملیتی، سن، ناتوانی یا جنسیت افراد Scott & White Health Plan از قوانین حقوق

**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:**

સાવધાન: જો તમે ઇંગલિશ બોલતા હો, ભાષા સહાય સેવાઓ, નિ:શુલ્ક, તમારા માટે ઉપલબ્ધ છે. 1-800-321-7947 પર કોલ કરો (TTY: 1-800-735-2989). સ્કોટ એન્ડ વ્હાઇટ હેલ્થ પ્લાન લાગુ ફેડરલ નાગરિક અધિકાર કાયદાઓનું પાલન કરે છે અને જાતિ, રંગ, રાષ્ટ્રીય મૂળ, ઉંમર, અપંગતા, અથવા જાતિના આધારે ભેદભાવ નથી કરતા.

**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 ທ່ານເວົ້າພາສາ ລາວ, ການບໍ່ ຈິ ການຊ່ວຍເຫຼືອ ອຳນາດພາສາ, ໂດຍບໍ່ ເສັ ງຄ່າ, ແມ່ນ ມີ ພ້ອມໃຫ້ທ່ານ. ໂທ 1-800-321-7947 (TTY: 1-800-735-2989). Scott & White Health Plan ປະຕິ ບັດຕາມກົດໝາຍວ່າ ດ້ວຍສິ ດທິ ພົນລະເມັ ອງຂອງຮັບບານກາງທີ່ ບັງຄັບໃຊ້ ແລະບໍ່ ຈໍາແນກໂດຍອີ ງໃສ່ ພື້ນຖານດ້ານເຊື້ອຊາດ, ີສຜິ ວ, ຊາດກໍາເນີ ດ, ອາຍຸ, ຄວາມພິ ການ, ຫຼື ເພດ.