




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 : \$2,000 individual / \$6,000 family; Non-Network Provider: \$4,000 individual / \$8,000 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 : \$7,150 per individual / \$14,300 per family; Non-Network Provider: \$21,450 per individual / \$42,900 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	\$40 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	\$75 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)	30% after deductible	50% after deductible	None
	Imaging (CT/PET scans, MRIs)	\$250 copay	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	<p>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.</p> <p>Specific preventative medications will be covered with no cost to the member.</p> <p>Non-formulary drugs: 50% after deductible</p>
	Preferred brand drugs	\$50 copay	\$50 copay	
	Non-preferred generic drugs and non-preferred Brand drugs and all other Drugs	\$100 copay	\$100 copay	
	Preferred Specialty drugs	\$150 copay	\$150 copay	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% after deductible	50% after deductible	None
	Physician/surgeon fees	30% after deductible	50% after deductible	
If you need immediate medical attention	Emergency room care	\$500 + 30% after deductible	\$500 + 30% after deductible	None
	Emergency medical transportation	30% after deductible	30% after deductible	
	Urgent care	\$75 copay	\$75 copay	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 copay per stay + 30% 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	\$250 copay per stay + 30% after deductible	50% after deductible	

* For more information about limitations and exceptions, see the plan or policy document at <http://www.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)	
				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	\$40 <u>copay</u> per visit	50% after <u>deductible</u>	None
	Inpatient services	\$250 <u>copay</u> per stay + 30% after <u>deductible</u>	50% after <u>deductible</u>	None
If you are pregnant	Office visits	\$75 <u>copay</u> per visit	50% after <u>deductible</u>	No charge for prenatal visits; postnatal visits are covered at the specialist <u>copay</u> .
	Childbirth/delivery professional services	\$250 <u>copay</u> per stay + 30% after <u>deductible</u>	50% after <u>deductible</u>	Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply.
	Childbirth/delivery facility services	\$250 <u>copay</u> per stay + 30% after <u>deductible</u>	50% after <u>deductible</u>	None
If you need help recovering or have other special health needs	Home health care	30% after <u>deductible</u>	50% after <u>deductible</u>	60 visit limit per year
	Rehabilitation services	\$75 <u>copay</u> per visit	50% after <u>deductible</u>	35 visit limit per year
	Habilitation services	\$75 <u>copay</u> per visit	50% after <u>deductible</u>	35 visit limit per year
	Skilled nursing care	\$250 <u>copay</u> per stay + 30% after <u>deductible</u>	50% after <u>deductible</u>	25 visit limit per year
	Durable medical equipment	30% after <u>deductible</u>	50% after <u>deductible</u>	None
	Hospice services	30% after <u>deductible</u>	50% after <u>deductible</u>	None
If your child needs dental or eye care	Children's eye exam	\$75 <u>copay</u> per visit	50% after <u>deductible</u>	One exam limit per year.
	Children's glasses	\$75 <u>copay</u> per visit	50% after <u>deductible</u>	\$300 / one pair limit per year.
	Children's dental check-up	Not Covered	Not Covered	None

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

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 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 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	\$2,000
■ Specialist copayment	\$75
■ Hospital (facility) coinsurance	\$250 + 30%
■ Other coinsurance	30%

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,000
Copayments	\$1,030
Coinsurance	\$2,402
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$5,492

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$2,000
■ Specialist copayment	\$75
■ Hospital (facility) coinsurance	\$250 + 30%
■ Other coinsurance	30%

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$134
Copayments	\$1,445
Coinsurance	\$254
<i>What isn't covered</i>	
Limits or exclusions	\$55
The total Joe would pay is	\$1,888

Mia's Simple Fracture

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

■ The plan's overall deductible	\$2,000
■ Specialist copayment	\$75
■ Hospital (facility) coinsurance	\$250 + 30%
■ Other coinsurance	30%

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$964
Copayments	\$787
Coinsurance	\$174
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,925

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:

تظوظلم: اذا تىك تىحتت ركذا اللغة، نافتامدخ ءءعاسملا تىوغللا رفاوتت كلكل انجملاب. لصنا مقر ب 1-800-321-7947 (مقر فتاه وصللا مكبلو: 1-800-735-2989). لىمزت Scott & White Health Plan نىناوقب قوقحلا تىندملا تىلار دفا لومعملا اهبلاو زىمى لءس اسأ قرعلا وانوللا ول لصلأا نطوللا وانسلا وانقاعلا وانسجلا.

Urdu:

رادربخ: رگا پ آ ودر اے تلوب بیں، و تپ آ وک نابز کی ک تادمخ ت فم نیم بایتسد نیب۔ لاک
نیرک (TTY: 1-800-735-2989) 1-800-321-7947
Scott & White Health Plan باق ل ق لاطا قی قافو یر پشد قوقد کے ک نیناوقہ کی ک لیمعتا ترک ہے
روا ہ یہ ک نسل، گنر، قومیت، عمر، یہ روزعم ایس نج کی ک داینڈ رپ زایتما نیبند 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 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: 1-800-735-2989). 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: 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:

ی ندم لاردف بطور متبعیت ی مدنک و مهارف ی مدشباب (TTY: 1-800-735-2989) 1-800-321-7947 س امتدیر یگیب مجوت: رگا مین ابز ی سراقوگتفگی مکنید، تالایهستی نابز ت روصین اگیار ی اربامش
لیاق ی مندوشب منوگچیه ی ضیعت ریس اساسانژاد، گنر پوست، تیلصاملیتی، سن، ی ناوتادایت سیسندارفا Scott & White Health Plan زانیناوقه و قد

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:

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-321-7947 (TTY: 1-800-735-2989). Scott & White Health Plan લાંુ પડતા સમવાયી નાગરક સિધકાર કાયદા સાથે સુસંગત છે અને િત, રંગ, રાજ્ય-યૂ, મર, અશક્તતા અથવા લગના આધારે 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 ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສຍຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-800-321-7947 (TTY: 1-800-735-2989). Scott & White Health Plan ປະຕິບັດຕາມກົດໝາຍວ່າດ້ວຍສິດທິພົນລະເມືອງຂອງຮັບບັນທຶກທີ່ບັງຄັບໃຊ້ ແລະບໍ່ຈຳແນກໂດຍອີງໃສ່ພື້ນຖານດ້ານເຊື້ອຊາດ, ິສຜິວ, ຊາດກຳເນີດ, ອາຍຸ, ຄວາມພິການ, ຫຼື ເພດ.