




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 [swhp.org/plandocs](http://swhp.org/plandocs) 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. You can view the Glossary at [healthcare.gov/sbc-glossary](http://healthcare.gov/sbc-glossary) or call 1-800-321-7947 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$0 individual / \$0 family	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your <u>deductible</u> ?	No	This <u>plan</u> does not have a <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$3,000 individual / \$6,000 family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="http://swhp.org">swhp.org</a> or call 1-800-321-7947 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$40 <a href="#">copay</a> /visit	Not covered	None
	<a href="#">Specialist</a> visit	\$40 <a href="#">copay</a> /visit	Not covered	
	<a href="#">Preventive care/screening/immunization</a>	No charge <a href="#">Deductible</a> does not apply.	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.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	No charge	Not covered	Services that are not <a href="#">preauthorized</a> will be denied. Refer to <a href="#">swhp.org</a> or Customer Service at 1-800-321-7947.
	Imaging (CT/PET scans, MRIs)	20% of charges	Not covered	Services that are not <a href="#">preauthorized</a> will be denied.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="#">swhp.org/en-us/members/manage-your-plan/pharmacy-information</a> .	ACA Preventive Drugs	\$0 <a href="#">copay</a> /prescription.	Not covered	<a href="#">Copays</a> are per 30-day supply. Maintenance-eligible drugs are allowed up to a 90-day supply for 2.5 <a href="#">copays</a> if obtained through a Baylor Scott & White Pharmacy or participating 90-day retail or mail order pharmacy provider. Mail Order: Available for a 1 to 90-day supply. Non-maintenance drugs obtained through mail order are limited to a 30-day supply maximum. Some <a href="#">Specialty drugs</a> may require prior authorization. 30-day supply only.
	Tier 1: Preferred Generic Drugs	\$20 <a href="#">copay</a> /prescription.	Not covered	
	Tier 2: Preferred Brand Name Drugs	\$65 <a href="#">copay</a> /prescription.	Not covered	
	Tier 3: Non-Preferred Generic / Brand Name Drugs	\$120 <a href="#">copay</a> /prescription.	Not covered	
	<a href="#">Specialty Drugs</a>	T1: 20%/prescription. T2: 20%/prescription. T3: 30%/prescription.	Not covered	

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% of charges	Not covered	Services that are not <a href="#">preauthorized</a> will be denied. Refer to <a href="#">swhp.org</a> or Customer Service at 1-800-321-7947.
	Physician/surgeon fees	20% of charges	Not covered	
If you need immediate medical attention	<a href="#">Emergency room care</a>	20% of charges	20% of charges	<a href="#">Copay</a> waived if episode results in <a href="#">hospitalization</a> for the same condition within 24 hours.
	<a href="#">Emergency medical transportation</a>	20% of charges	20% of charges	None
	<a href="#">Urgent care</a>	\$75 <a href="#">copay</a> /visit	\$75 <a href="#">copay</a> /visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% of charges	Not covered	Services that are not <a href="#">preauthorized</a> will be denied.
	Physician/surgeon fees	20% of charges	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$40 <a href="#">copay</a> /visit	Not covered	Services that are not <a href="#">preauthorized</a> will be denied. Refer to <a href="#">swhp.org</a> or Customer Service at 1-800-321-7947.
	Inpatient services	20% of charges	Not covered	Services that are not <a href="#">preauthorized</a> will be denied.
If you are pregnant	Office visits	\$40 <a href="#">copay</a> /visit	Not covered	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> , or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% of charges	Not covered	The health plan must be notified of the delivery. If a length of stay for an

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)	
	Childbirth/delivery facility services	20% of charges	Not covered	uncomplicated delivery exceeds 48 hours for vaginal, or 96 hours for caesarean, <a href="#">preauthorization</a> is required. Failure to notify or <a href="#">preauthorize</a> , when required, may result of a denial of the service. Refer to <a href="#">swhp.org</a> or Customer Service at 1-800-321-7947.
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	\$40 <u>copay</u> /visit	Not covered	Services that are not <a href="#">preauthorized</a> will be denied.
	<a href="#">Rehabilitation services</a>	\$40 <u>copay</u> /visit	Not covered	Services that are not <a href="#">preauthorized</a> will be denied.
	<a href="#">Habilitation services</a>	\$40 <u>copay</u> /visit	Not covered	Services that are not <a href="#">preauthorized</a> will be denied.
	<a href="#">Skilled nursing care</a>	20% of charges	Not covered	Services that are not <a href="#">preauthorized</a> will be denied.
	<a href="#">Durable medical equipment</a>	50% of charges	Not covered	Services that are not <a href="#">preauthorized</a> will be denied.
	<a href="#">Hospice services</a>	No Charge	Not covered	Services that are not <a href="#">preauthorized</a> will be denied. Refer to <a href="#">swhp.org</a> or Customer Service at 1-800-321-7947.
<b>If your child needs dental or eye care</b>	Children's eye exam	\$40 <u>copay</u> /visit	Not covered	Limited to one eye exam per <a href="#">plan</a> year.
	Children's glasses	Not covered	Not covered	None

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)	
	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](#).)**

- |  |  |   |
|--|--|---|
| <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Bariatric surgery</li> <li>• Children's glasses</li> <li>• Cosmetic surgery</li> </ul> | <ul style="list-style-type: none"> <li>• Dental care (Adult and Child)</li> <li>• Infertility treatment</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul> |
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**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)**

- Chiropractic care (Limited to 35 visits per [plan](#) year)
- Hearing aids (Limited to one per ear every three years for covered members 18 years of age or younger)
- Routine eye care (Adult) (Limited to an annual eye exam conducted by a licensed ophthalmologist or optometrist)

**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 & White Care Plans, visit [swhp.org](#), or call 1-800-321-7947; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [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 [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 & White Care Plans, visit [swhp.org](#), or call 1-800-321-7947; Texas Department of Insurance, visit [tdi.texas.gov](#) or call 1-800-578-4677; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [dol.gov/ebsa/healthreform](#), Texas Department of Insurance Texas Health Options at 1-800-252-3439 or [texashealthoptions.com](#).

### 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.

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*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

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## 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$40
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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#### In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$800
<a href="#">Coinsurance</a>	\$1,830
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,690</b>

### Managing Joe's type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$40
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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#### In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$1,100
<a href="#">Coinsurance</a>	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$1,260</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$40
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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#### In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$600</b>

# Nondiscrimination Notice

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ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-321-7947 (TTY: 711).

Scott & White Care Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Scott & White Care Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Scott & White Care Plans:

- 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 Scott & White Care Plans Compliance Officer at 1-214-820-8888 or send an email to [SWHPComplianceDepartment@BSWHealth.org](mailto:SWHPComplianceDepartment@BSWHealth.org)

If you believe that Scott & White Care Plans 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:

Scott & White Care Plans, Compliance Officer  
1206 West Campus Drive, Suite 151  
Temple, Texas 76502

Compliance HelpLine; 1-888-484-6977 or <https://app.mycompliancereport.com/report.aspx?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 1-800-321-7947 (TTY: 711).

**Spanish:**

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-321-7947 (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 1-800-321-7947 (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 1-800-321-7947(TTY:711)。

**Korean:**

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-321-7947 (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 1-800-321-7947 (رقم 800-321-7947-1)

**Urdu:**

کریں۔ (1-800-321-7947 (TTY: 711) خیردار: 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 1-800-321-7947 (TTY: 711).

**French:**

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-321-7947 (ATS : 711).

**Hindi:**

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-321-7947 (TTY: 711) पर कॉल करें।

**Persian:**

فراهم می باشد. با 1-800-321-7947 (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: 1-800-321-7947 (TTY: 711).

**Gujarati:**

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-321-7947 (TTY: 711).

**Russian:**

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-321-7947 (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。1-800-321-7947 (TTY:711)まで、お電話にてご連絡ください。

**Laotian:**

ໂປດຊາບ: ຖ້າ ວ່າ ທ່ານ ເວົ້າ ພາສາ ລາວ, ການບໍລິການ ຊ່ວຍເຫຼືອ ດ້ານພາສາ, ໂດຍບໍ່ເສຍຄ່າ, ຈະມີ ພ້ອມໃຫ້ ທ່ານ. ໂທ 1-800-321-7947 (TTY: 711).