



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 800-321-7947 or visit us at swhp.org/plandocs. 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 800-321-7947 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall deductible ? | \$6,000 per member / \$12,000 per 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 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 ? | \$7,500 per member / \$15,000 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 , 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 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 swhp.org or call 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 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | | 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: No charge for the first non-preventive sick visit in the plan year. \$35 copayment per visit for subsequent visits in that plan year, deductible does not apply Pediatric: No charge per visit, deductible does not apply (Age 0 through 18) | Not covered | None |
| | Specialist visit | \$70 copayment per visit, deductible does not apply | Not covered | |
| | Preventive care/screening/immunization | No charge, deductible does not apply. | Not covered | |
| If you have a test | Diagnostic test (X-ray, blood work) | No charge; deductible does not apply | Not covered | None |
| | Imaging (CT/PET scans, MRIs) | 30% of charges; deductible does not apply | Not covered | Services requiring preauthorization that are not preauthorized will be denied. Refer to swhp.org or call 800-321-7947. |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://swhp.org/en-us/members/manage- | ACA preventive drugs | No charge, deductible does not apply | Not covered | Copayments are per 30-day supply. Maintenance drugs are allowed up to a 90-day supply for 2.5 copayments if obtained through a Baylor Scott and White Pharmacy or participating pharmacy. 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 specialty |
| | Tier 1: Preferred generic drugs | \$20 copayment per prescription, deductible does not apply | Not covered | |
| | Tier 2: Preferred brand name drugs | \$65 copayment per prescription, deductible does not apply | Not covered | |

* For more information about limitations and exceptions, see the [plan](#) or policy document at [swhp.org](#).

| 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) | |
| your-plan/pharmacy-information . | Tier 3: Non-preferred generic drugs and non-preferred brand name drugs | \$120 <u>copayment</u> per prescription, <u>deductible</u> does not apply | Not covered | drugs may require preauthorization . 30-day supply only. |
| | Specialty drugs Tier 1 | 20% after <u>deductible</u> | Not covered | |
| | Specialty drugs Tier 2 | 20% after <u>deductible</u> | Not covered | |
| | Specialty drugs Tier 3 | 30% after <u>deductible</u> | Not covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 30% after <u>deductible</u> | Not covered | Services requiring preauthorization that are not preauthorized will be denied. Refer to swhp.org or call 800-321-7947. |
| | Physician/surgeon fees | 30% after <u>deductible</u> | Not covered | |
| If you need immediate medical attention | Emergency room care | \$500 <u>copayment</u> per visit, plus 30% of charges; <u>deductible</u> does not apply | \$500 <u>copayment</u> per visit, plus 30% of charges; <u>deductible</u> does not apply | Emergency room <u>copayment</u> waived if episode results in hospitalization for the same condition within 24 hours. None |
| | Emergency medical transportation | \$500 <u>copayment</u> per service, plus 30% of charges; <u>deductible</u> does not apply | \$500 <u>copayment</u> per service, plus 30% of charges; <u>deductible</u> does not apply | |
| | Urgent care | \$50 <u>copayment</u> per visit, <u>deductible</u> does not apply | \$50 <u>copayment</u> per visit, <u>deductible</u> does not apply | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 30% after <u>deductible</u> | Not covered | Services requiring preauthorization that are not preauthorized will be denied. Refer to swhp.org or call 800-321-7947. |
| | Physician/surgeon fees | 30% after <u>deductible</u> | Not covered | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | \$35 <u>copayment</u> per visit, <u>deductible</u> does not apply | Not covered | Services requiring preauthorization that are not preauthorized will be denied. Refer to swhp.org or call 800-321-7947. |
| | Inpatient services | 30% after <u>deductible</u> | Not covered | |

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| 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 are pregnant | Office visits | \$35 <u>copayment</u> per visit, <u>deductible</u> does not apply | Not covered | <u>Cost sharing</u> does not apply for <u>preventive care</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Inpatient care for the mother and newborn child in a health care facility is covered for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarean section. |
| | Childbirth/delivery professional services | 30% after <u>deductible</u> | Not covered | |
| | Childbirth/delivery facility services | 30% after <u>deductible</u> | Not covered | |
| If you need help recovering or have other special health needs | <u>Home health care</u> | 30% after <u>deductible</u> | Not covered | Limited to 60 visits per <u>plan</u> year. Services requiring <u>preauthorization</u> that are not <u>preauthorized</u> will be denied. Refer to swhp.org or call 800-321-7947. |
| | <u>Rehabilitation services</u> | \$35 <u>copayment</u> per visit, <u>deductible</u> does not apply | Not covered | Limited to 35 visits for <u>rehabilitation services</u> and 35 visits for <u>habilitation services</u> per <u>plan</u> year. Limit is combined for physical therapy, occupational therapy, and speech therapy. Limits may not apply for therapies for children with developmental delays, autism spectrum disorder and mental health services. Services requiring <u>preauthorization</u> that are not <u>preauthorized</u> will be denied. Refer to swhp.org or call 800-321-7947. |
| | <u>Habilitation services</u> | \$35 <u>copayment</u> per visit, <u>deductible</u> does not apply | Not covered | Limited to 25 days per <u>plan</u> year. Services requiring <u>preauthorization</u> that are not <u>preauthorized</u> will be denied. Refer to swhp.org or call 800-321-7947. |
| | <u>Skilled nursing care</u> | 30% after <u>deductible</u> | Not covered | Limited to 25 days per <u>plan</u> year. Services requiring <u>preauthorization</u> that are not <u>preauthorized</u> will be denied. Refer to swhp.org or call 800-321-7947. |
| | <u>Durable medical equipment</u> | 30% after <u>deductible</u> | Not covered | Services requiring <u>preauthorization</u> that are not <u>preauthorized</u> will be denied. Refer to swhp.org or call 800-321-7947. |
| | <u>Hospice services</u> | No charge; <u>deductible</u> does not apply | Not covered | Services requiring <u>preauthorization</u> that are not <u>preauthorized</u> will be denied. Refer to swhp.org or call 800-321-7947. |

* For more information about limitations and exceptions, see the [plan](#) or policy document at swhp.org.

| 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 your child needs dental or eye care | Children's eye exam | Not covered | Not covered | None |
| | 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
- 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 and Child)
- 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.)

- Chiropractic care (Limited to 35 visits per [plan](#) year)
- Hearing aids (Limited to one device per ear every 3 years and limited to members through the age of 18.)
- Private duty nursing (Limited to 60 visits per [plan](#) year 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 Scott & White Care Plans at 800-321-7947 or [swhp.org](#); 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: Scott & White Care Plans at 800-321-7947 or [swhp.org](#); Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](#); Texas Department of Insurance at 1-800-578-4677 or [tdi.texas.gov](#).

Does this plan provide Minimum Essential Coverage? Yes

[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? 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 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](#) \$6,000
- [Specialist copayment](#) \$70
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

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 | \$6,000 |
| Copayments | \$0 |
| Coinsurance | \$1,500 |
| What isn't covered | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$7,560 |

Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$6,000
- [Specialist copayment](#) \$70
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

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 | \$800 |
| Copayments | \$700 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$1,520 |

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$6,000
- [Specialist copayment](#) \$70
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

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 | \$1,100 |
| Copayments | \$1,000 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$2,100 |

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.