



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 844-633-5325 or visit us at <https://www.bswhealthplan.com/Group/Pages/Default.aspx - small>. 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](https://www.healthcare.gov/sbc-glossary) or call 844-633-5325 to request a copy.

| Important Questions                                                                   | Answers                                                                                                                                                                                           | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|---------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall <a href="#">deductible</a>?</b>                                | \$4,500 per member / \$9,000 per family                                                                                                                                                           | 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> .                                                                                                                                                                                                            |
| <b>Are there services covered before you meet your <a href="#">deductible</a>?</b>    | Yes. <a href="#">Preventive care</a> and certain preventive drugs are covered before you meet your <a href="#">deductible</a> .                                                                   | This <a href="#">plan</a> covers some items and services even if you haven't 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">HealthCare.gov/coverage/preventive-care-benefits</a> .                                                                                     |
| <b>Are there other <a href="#">deductibles</a> for specific services?</b>             | No                                                                                                                                                                                                | You don't have to meet <a href="#">deductibles</a> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b> | \$6,900 per member / \$13,800 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> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.                                                                                                                                                                                                                                                                                                                                                             |
| <b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>               | <a href="#">Premiums</a> and health care this <a href="#">plan</a> doesn't cover.                                                                                                                 | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Will you pay less if you use a <a href="#">network provider</a>?</b>               | Yes. See <a href="https://www.bswhealthplan.com/Pages/Provider.aspx">https://www.bswhealthplan.com/Pages/Provider.aspx</a> or call 844-633-5325 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. |
| <b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>    | No                                                                                                                                                                                                | You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |

 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 <a href="#">Provider</a><br>(You will pay the least)                                                                                                                                                                                                                      | Out-of-Network <a href="#">Provider</a><br>(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       | Adult: No charge for the first non-preventive sick visit in the calendar year. \$10 <a href="#">copayment</a> per visit for subsequent visits in that calendar year, <a href="#">deductible</a> does not apply<br>Pediatric: No charge, <a href="#">deductible</a> does not apply | Not covered                                                        | None                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                                                                                                                                                                                       | <a href="#">Specialist</a> visit                       | \$40 <a href="#">copayment</a> per visit, <a href="#">deductible</a> does not apply                                                                                                                                                                                               | 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.                                                                                                                                                                                                                                                  |
| If you have a test                                                                                                                                                                                                                    | <a href="#">Diagnostic test</a> (X-ray, blood work)    | 10% <a href="#">copayment</a> after <a href="#">deductible</a>                                                                                                                                                                                                                    | Not covered                                                        | None                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                                                                                                                                                                                       | Imaging (CT/PET scans, MRIs)                           | 10% <a href="#">copayment</a> after <a href="#">deductible</a>                                                                                                                                                                                                                    | Not covered                                                        | Services requiring <a href="#">preauthorization</a> that are not <a href="#">preauthorized</a> will be denied. Refer to <a href="#">BSWHealthPlan.com</a> or call 844-633-5325.                                                                                                                                                                                                                                                            |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="https://www.bswhealthplan.com/pharmacy">https://www.bswhealthplan.com/pharmacy</a> | Affordable Care Act (ACA) preventive drugs             | No charge, <a href="#">deductible</a> does not apply                                                                                                                                                                                                                              | Not covered                                                        | <a href="#">Copayments</a> are per 30-day supply. Maintenance drugs are allowed up to a 90-day supply for three (3) <a href="#">copayments</a> if obtained through a 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. <a href="#">Specialty drugs</a> limited to a 30-day supply. <a href="#">High Deductible Health</a> |
|                                                                                                                                                                                                                                       | Generic drugs (Tier 1)                                 | \$3 <a href="#">copayment</a> per prescription, <a href="#">deductible</a> does not apply                                                                                                                                                                                         | Not covered                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|                                                                                                                                                                                                                                       | Preferred brand drugs (Tier 2)                         | \$50 <a href="#">copayment</a> per prescription, <a href="#">deductible</a> does not apply                                                                                                                                                                                        | Not covered                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|                                                                                                                                                                                                                                       | Non-preferred brand drugs                              | \$125 <a href="#">copayment</a> per                                                                                                                                                                                                                                               | Not covered                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                            |

| Common Medical Event                                                      | Services You May Need                                                         | What You Will Pay                                                                                                                                                                                                         |                                                                   | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                          |
|---------------------------------------------------------------------------|-------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                                                               | Network <u>Provider</u><br>(You will pay the least)                                                                                                                                                                       | Out-of-Network <u>Provider</u><br>(You will pay the most)         |                                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                           | (Tier 3)                                                                      | prescription, <u>deductible</u> does not apply                                                                                                                                                                            |                                                                   | <a href="#">Plan</a> (HDHP) chronic preventive medications are not subject to <u>deductible</u> . <a href="#">Formulary</a> insulin prescriptions have a maximum <u>copayment</u> of \$25 per prescription per 30-day supply. Certain preventive drugs are covered at no charge and are not subject to the <u>deductible</u> . Tiers 2 - 4 may include brand and generic drugs. |
|                                                                           | <a href="#">Specialty drugs</a> (and oral anticancer medications)<br>(Tier 4) | \$250 <u>copayment</u> per prescription, <u>deductible</u> does not apply                                                                                                                                                 | Not covered                                                       |                                                                                                                                                                                                                                                                                                                                                                                 |
| If you have outpatient surgery                                            | Facility fee (e.g., ambulatory surgery center)                                | 10% <u>copayment</u> after <u>deductible</u>                                                                                                                                                                              | Not covered                                                       | Services requiring <a href="#">preauthorization</a> that are not <a href="#">preauthorized</a> will be denied. Refer to <a href="#">BSWHealthPlan.com</a> or call 844-633-5325.                                                                                                                                                                                                 |
|                                                                           | Physician/surgeon fees                                                        | 10% <u>copayment</u> after <u>deductible</u>                                                                                                                                                                              | Not covered                                                       |                                                                                                                                                                                                                                                                                                                                                                                 |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>                                           | \$500 <u>copayment</u> per visit after <u>deductible</u>                                                                                                                                                                  | \$500 <u>copayment</u> per visit after <u>deductible</u>          | Emergency room <u>copayment</u> waived if episode results in <a href="#">hospitalization</a> for the same condition within 24 hours.                                                                                                                                                                                                                                            |
|                                                                           | <a href="#">Emergency medical transportation</a>                              | \$500 <u>copayment</u> per service after <u>deductible</u>                                                                                                                                                                | \$500 <u>copayment</u> per service after <u>deductible</u>        | None                                                                                                                                                                                                                                                                                                                                                                            |
|                                                                           | <a href="#">Urgent care</a>                                                   | \$50 <u>copayment</u> per visit, <u>deductible</u> does not apply                                                                                                                                                         | \$50 <u>copayment</u> per visit, <u>deductible</u> does not apply | None                                                                                                                                                                                                                                                                                                                                                                            |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)                                            | 10% <u>copayment</u> after <u>deductible</u>                                                                                                                                                                              | Not covered                                                       | Services requiring <a href="#">preauthorization</a> that are not <a href="#">preauthorized</a> will be denied. Refer to <a href="#">BSWHealthPlan.com</a> or call 844-633-5325.                                                                                                                                                                                                 |
|                                                                           | Physician/surgeon fees                                                        | 10% <u>copayment</u> after <u>deductible</u>                                                                                                                                                                              | Not covered                                                       |                                                                                                                                                                                                                                                                                                                                                                                 |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                                                           | Adult: \$10 <u>copayment</u> per office visit, <u>deductible</u> does not apply. 10% <u>copayment</u> after <u>deductible</u> for all other outpatient services<br>Pediatric: No charge, <u>deductible</u> does not apply | Not covered                                                       | Services requiring <a href="#">preauthorization</a> that are not <a href="#">preauthorized</a> will be denied. Refer to <a href="#">BSWHealthPlan.com</a> or call 844-633-5325.                                                                                                                                                                                                 |
|                                                                           | Inpatient services                                                            | 10% <u>copayment</u> after                                                                                                                                                                                                | Not covered                                                       |                                                                                                                                                                                                                                                                                                                                                                                 |

| Common Medical Event                                           | Services You May Need                     | What You Will Pay                                                 |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|----------------------------------------------------------------|-------------------------------------------|-------------------------------------------------------------------|----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                |                                           | Network Provider<br>(You will pay the least)                      | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                                                                |                                           | <u>deductible</u>                                                 |                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| If you are pregnant                                            | Office visits                             | \$10 <u>copayment</u> per visit, <u>deductible</u> does not apply | 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 | 10% <u>copayment</u> after <u>deductible</u>                      | Not covered                                        | 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 facility services     | 10% <u>copayment</u> after <u>deductible</u>                      | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| If you need help recovering or have other special health needs | <a href="#">Home health care</a>          | 10% <u>copayment</u> after <u>deductible</u>                      | Not covered                                        | Limited to 60 visits per calendar year. Services requiring <a href="#">preauthorization</a> that are not <a href="#">preauthorized</a> will be denied. Refer to <a href="#">BSWHealthPlan.com</a> or call 844-633-5325.                                                                                                                                                                                                                                                                                                                                             |
|                                                                | <a href="#">Rehabilitation services</a>   | \$15 <u>copayment</u> per visit, <u>deductible</u> does not apply | Not covered                                        | Limited to 35 visits for <a href="#">rehabilitation services</a> and 35 visits for <a href="#">habilitation services</a> per calendar year. The limit is combined for physical therapy, occupational therapy, speech therapy, and chiropractic care. Limits do not apply for therapies for children with developmental delays, autism spectrum disorder and mental health services. Services requiring <a href="#">preauthorization</a> that are not <a href="#">preauthorized</a> will be denied. Refer to <a href="#">BSWHealthPlan.com</a> or call 844-633-5325. |
|                                                                | <a href="#">Habilitation services</a>     | \$15 <u>copayment</u> per visit, <u>deductible</u> does not apply | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                                                                | <a href="#">Skilled nursing care</a>      | 10% <u>copayment</u> after <u>deductible</u>                      | Not covered                                        | Limited to 25 days per calendar year. Services requiring <a href="#">preauthorization</a> that are not <a href="#">preauthorized</a> will be denied. Refer to <a href="#">BSWHealthPlan.com</a> or call 844-633-5325.                                                                                                                                                                                                                                                                                                                                               |
|                                                                | <a href="#">Durable medical equipment</a> | 10% <u>copayment</u> after <u>deductible</u>                      | Not covered                                        | Services requiring <a href="#">preauthorization</a> that are not <a href="#">preauthorized</a> will be denied. Refer to <a href="#">BSWHealthPlan.com</a> or call 844-633-5325.                                                                                                                                                                                                                                                                                                                                                                                     |

| Common Medical Event                   | Services You May Need            | What You Will Pay                                                |                                                           | Limitations, Exceptions, & Other Important Information                                                                                                                                                 |
|----------------------------------------|----------------------------------|------------------------------------------------------------------|-----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                        |                                  | Network <u>Provider</u><br>(You will pay the least)              | Out-of-Network <u>Provider</u><br>(You will pay the most) |                                                                                                                                                                                                        |
|                                        | <a href="#">Hospice services</a> | 10% <u>copayment</u> after <u>deductible</u>                     | Not covered                                               | Services requiring <a href="#">preauthorization</a> that are not <a href="#">preauthorized</a> will be denied. Refer to <a href="http://BSWHealthPlan.com">BSWHealthPlan.com</a> or call 844-633-5325. |
| If your child needs dental or eye care | Children's eye exam              | \$40 <u>copayment</u> per exam, <u>deductible</u> does not apply | Not covered                                               | Limited to one eye exam per calendar year.                                                                                                                                                             |
|                                        | Children's glasses               | \$40 <u>copayment</u> per pair, <u>deductible</u> does not apply | Not covered                                               | Limited to one pair of glasses per calendar 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
- Infertility Treatment
- Routine foot care
- Bariatric surgery
- Long-term care
- Weight loss programs
- Cosmetic surgery
- Non-emergency care when traveling outside the U.S.
- Dental care (Adult and Child)

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Chiropractic care (Included in [Rehabilitation Services](#) and [Habilitation Services](#))
- Private-duty nursing (when [medically necessary](#) and [preauthorized](#). Limitations apply when used under [Home Health Care](#))
- Hearing aids (Limited to one device per ear every 3 years)
- Routine eye care (Adult and Child) (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 Baylor Scott & White Health Plan at 844-633-5325 or [BSWHealthPlan.com](#); Department of Labor's Employee Benefits Security Administration at 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 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: Baylor Scott & White Health Plan at 844-633-5325 or [BSWHealthPlan.com](#); Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or [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 844-633-5325.

*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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$4,500 |
| ■ <a href="#">Specialist copayment</a>                          | \$40    |
| ■ Hospital (facility) <a href="#">copayment</a>                 | 10%     |
| ■ Other <a href="#">coinsurance</a>                             | 10%     |

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>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$4,500        |
| <a href="#">Copayments</a>        | \$0            |
| <a href="#">Coinsurance</a>       | \$800          |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$5,360</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> | \$4,500 |
| ■ <a href="#">Specialist copayment</a>                          | \$40    |
| ■ Hospital (facility) <a href="#">copayment</a>                 | 10%     |
| ■ Other <a href="#">coinsurance</a>                             | 10%     |

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>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$900          |
| <a href="#">Copayments</a>        | \$600          |
| <a href="#">Coinsurance</a>       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,520</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> | \$4,500 |
| ■ <a href="#">Specialist copayment</a>                          | \$40    |
| ■ Hospital (facility) <a href="#">copayment</a>                 | 10%     |
| ■ Other <a href="#">coinsurance</a>                             | 10%     |

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>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$2,100        |
| <a href="#">Copayments</a>        | \$100          |
| <a href="#">Coinsurance</a>       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,200</b> |

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

# Aviso de No Discriminación



ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-633-5325 (TTY: 711).

Baylor 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. Baylor Scott & White Health Plan no excluye a las personas ni las trata de forma diferente debido a su origen étnico, color, nacionalidad, edad, discapacidad o sexo.

Baylor Scott & White Health Plan:

- Proporciona asistencia y servicios gratuitos a las personas con discapacidades para que se comuniquen de manera eficaz con nosotros, como los siguientes:
  - Información escrita en otros formatos (letra grande y formatos electrónicos accesibles)
- Proporciona servicios lingüísticos gratuitos a personas cuya lengua materna no es el inglés, como los siguientes:
  - Intérpretes capacitados
  - Información escrita en otros idiomas

Si necesita estos servicios, comuníquese con el Oficial de Cumplimiento de Baylor Scott & White Health Plan al 1-214-820-8888 o envíe un correo electrónico a [HPCompliance@BSWHealth.org](mailto:HPCompliance@BSWHealth.org).

Si cree que Baylor Scott & White Health Plan no ha brindado estos servicios o ha sido discriminado de otra manera por motivos de raza, color, nacionalidad, edad, discapacidad o sexo, puede presentar una queja formal con:

Baylor Scott & White Health Plan, Compliance Officer  
1206 West Campus Drive, Suite 151  
Temple, Texas 76502

Línea de ayuda de cumplimiento; 1-888-484-6977 o <https://app.mycompliancereport.com/report?cid=swhp>

Puede presentar una queja en persona o por correo, en línea o por correo electrónico. Si necesita ayuda para presentar un reclamo, el Oficial de Cumplimiento está disponible para ayudarlo.

También puede presentar un reclamo de derechos civiles ante la Office for Civil Rights (Oficina de Derechos Civiles) del Department of Health and Human Services (Departamento de Salud y Servicios Humanos) de EE. UU. de manera electrónica a través de Office for Civil Rights Complaint Portal, disponible en <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, o bien, por correo postal a la siguiente dirección o por teléfono a los números que figuran a continuación:

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)

Puede obtener los formularios de reclamo en el sitio web <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 1-844-633-5325 (TTY: 711).

**Spanish:**

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-633-5325 (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 1-844-633-5325 (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 1-844-633-5325 (TTY: 711)。

**Korean:**

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-633-5325 (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 1-844-633-5325 (رقم 711)

**Urdu:**

کریں (711 TTY: 1-844-633-5325 خبردار: 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 1-844-633-5325 (TTY: 711).

**French:**

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-844-633-5325 (ATS : 711).

**Hindi:**

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-844-633-5325 (TTY: 711) पर कॉल करें।

**Persian:**

فراهم می باشد. با 1-844-633-5325 (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: 1-844-633-5325 (TTY: 711).

**Gujarati:**

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-844-633-5325 (TTY: 711).

**Russian:**

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-633-5325 (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。1-844-633-5325 (TTY: 711) まで、お電話にてご連絡ください。

**Laotian:**

ໂປດຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-844-633-5325 (TTY: 711).