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 or call 844-633-5325 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$7,000 per member / $14,000 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 certain 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 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?	$8,600 per member / $17,200 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 https://www.bswhealthplan.com/Pages/Provider.aspx or call 844-633-5325 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Adult: No charge for the first non-preventive sick visit in the calendar year. Then 10% copayment after deductible for subsequent visits in that calendar year Pediatric: No charge, deductible does not apply	Not covered	None
	Specialist visit	10% copayment after deductible	Not covered	
	Preventive care/screening/ immunization	No charge, deductible does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (X-ray, blood work)	10% copayment after deductible	Not covered	None
	Imaging (CT/PET scans, MRIs)	10% copayment after deductible	Not covered	Services requiring preauthorization that are not preauthorized will be denied. Refer to BSWHealthPlan.com or call 844-633-5325.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.bswhealthplan.com/pharmacy	Affordable Care Act (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 three (3) copayments 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. Specialty drugs limited to a 30-day supply. Formulary insulin
	Generic drugs (Tier 1)	$6 copayment per prescription, deductible does not apply	Not covered	
	Preferred brand drugs (Tier 2)	$50 copayment per prescription, deductible does not apply	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)	
	Non-preferred brand drugs (Tier 3)	$125 copayment per prescription, deductible does not apply	Not covered	prescriptions have a maximum copayment of $25 per prescription per 30-day supply. Certain preventive drugs are covered at no charge and are not subject to the deductible. Tiers 2 - 4 may include brand and generic drugs.
	Specialty drugs (and oral anticancer medications) (Tier 4)	$250 copayment per prescription, deductible does not apply	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% copayment after deductible	Not covered	Services requiring preauthorization that are not preauthorized will be denied. Refer to BSWHealthPlan.com or call 844-633-5325.
	Physician/surgeon fees	10% copayment after deductible	Not covered	
If you need immediate medical attention	Emergency room care	10% copayment after deductible	10% copayment after deductible	Emergency room copayment waived if episode results in hospitalization for the same condition within 24 hours.
	Emergency medical transportation	10% copayment after deductible	10% copayment after deductible	None
	Urgent care	$50 copayment per visit, deductible does not apply	$50 copayment per visit, deductible does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% copayment after deductible	Not covered	Services requiring preauthorization that are not preauthorized will be denied. Refer to BSWHealthPlan.com or call 844-633-5325.
	Physician/surgeon fees	10% copayment after deductible	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Adult: 10% copayment after deductible Pediatric: No charge, deductible does not apply	Not covered	Services requiring preauthorization that are not preauthorized will be denied. Refer to BSWHealthPlan.com or call 844-633-5325.
	Inpatient services	10% copayment after deductible	Not covered	
If you are pregnant	Office visits	10% copayment after deductible	Not covered	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the

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)	
				SBC (i.e., ultrasound).
	Childbirth/delivery professional services	10% copayment after deductible	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% copayment after deductible	Not covered	
If you need help recovering or have other special health needs	Home health care	10% copayment after deductible	Not covered	Limited to 60 visits per calendar year. Services requiring preauthorization that are not preauthorized will be denied. Refer to BSWHealthPlan.com or call 844-633-5325.
	Rehabilitation services	10% copayment after deductible	Not covered	Limited to 35 visits for rehabilitation services and 35 visits for habilitation services 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 preauthorization that are not preauthorized will be denied. Refer to BSWHealthPlan.com or call 844-633-5325.
	Habilitation services	10% copayment after deductible	Not covered	
	Skilled nursing care	10% copayment after deductible	Not covered	Limited to 25 days per calendar year. Services requiring preauthorization that are not preauthorized will be denied. Refer to BSWHealthPlan.com or call 844-633-5325.
	Durable medical equipment	10% copayment after deductible	Not covered	Services requiring preauthorization that are not preauthorized will be denied. Refer to BSWHealthPlan.com or call 844-633-5325.
	Hospice services	10% copayment after deductible	Not covered	Services requiring preauthorization that are not preauthorized will be denied. Refer to BSWHealthPlan.com or call 844-633-5325.
If your child needs dental or eye care	Children's eye exam	10% copayment after deductible	Not covered	Limited to one eye exam per calendar year.
	Children's glasses	10% copayment after	Not covered	Limited to one pair of glasses per calendar

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)	
		deductible		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
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult and Child)
- Infertility Treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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 (Included in Rehabilitation Services and Habilitation Services)
- Hearing aids (Limited to one device per ear every 3 years)
- Private-duty nursing (when medically necessary and preauthorized. Limitations apply when used under Home Health Care)
- 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 plan's overall deductible	$7,000
Specialist copayment	10%
Hospital (facility) copayment	10%
Other coinsurance	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)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$7,000
Copayments	$0
Coinsurance	$600
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$7,660

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

The plan's overall deductible	$7,000
Specialist copayment	10%
Hospital (facility) copayment	10%
Other coinsurance	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)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$1,800
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$2,220

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

The plan's overall deductible	$7,000
Specialist copayment	10%
Hospital (facility) copayment	10%
Other coinsurance	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)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,800
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2,810

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.

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.

Language Assistance/ Asistencia de idiomas

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:
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-844-633-5325 (رقم هاتف الصم والبكم: 711.

Urdu:
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال 1-844-633-5325 (TTY: 711). کریں

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 है। 1-844-633-5325 (TTY: 711) पर कॉल करें।

Persian:
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-844-633-5325 (TTY: 711) تماس بگیرید.

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 નિ:શુલ્ક 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: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-844-633-5325 (TTY:711).