**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 844-843-3229 or visit us at BSWHealthPlan.com/BSWH. 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 844-843-3229 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | INN Tier 1 Tier 2 Tier 3<br>EE $2,000 $3,000 $10,000<br>EF $4,000 $6,000 $20,000 | 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. Medical expenses will only apply to the applicable network tier deductible and therefore do not cross accumulate. |
| **Are there services covered before you meet your deductible?** | Yes. Preventive care, Tier 1 and Tier 2 office and emergency room visits, ambulance, maternity care, ACA preventive, and prescription 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?** | Yes. $100 for non-preferred generic drugs and non-preferred brand name drugs obtained from Contracted Pharmacies. There are no other specific deductibles. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| **What is the out-of-pocket limit for this plan?** | INN Tier 1 Tier 2 Tier 3<br>EE $5,000 $7,000 Unlimited<br>EF $10,000 $14,000 Unlimited | 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. Medical expenses will only apply to the applicable network tier out-of-pocket maximum and do not cross accumulate. Total Tier 1 and Tier 2 aggregate out-of-pocket expenses will not exceed the overall Affordable Care Act (ACA) maximum. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance billing charges, Tier 3, out-of-network expenses, services for which you failed to obtain required | Even though you pay these expenses, they don't count toward the out–of–pocket limit. |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| | preauthorization, and health care this plan doesn't cover. | |
| **Will you pay less if you use a network provider?** | Yes. See BSWHealthPlan.com/BSWH or call 844-843-3229 for a list of network providers. | You pay the least if you use a provider in Tier 1. You pay more if you use a provider in Tier 2. 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 |
|---|---|---|---|---|---|
| | | Tier 1 Participating Provider (You will pay the least) | Tier 2 Participating Provider (You will pay more) | Tier 3 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 | $45 copayment per visit, deductible does not apply | $70 copayment per visit, deductible does not apply | 80% coinsurance | None |
| | Specialist visit | $60 copayment per visit, deductible does not apply | $100 copayment per visit, deductible does not apply | 80% coinsurance | |
| | Preventive care/screening/ immunization | No charge, deductible does not apply | 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) | 20% coinsurance | 50% coinsurance | 80% coinsurance | None |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Tier 1 Participating Provider (You will pay the least) | Tier 2 Participating Provider (You will pay more) | Tier 3 Non-Participating Provider (You will pay the most) | |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 50% coinsurance | 80% coinsurance | Preauthorization is required. If you don't get preauthorization, benefits will be denied. Refer to BSWHealthPlan.com/BSWH or call 844-843-3229. |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at **RightwayHealthcare.com/BSWH**. | Affordable Care Act (ACA) preventive drugs | No charge, deductible does not apply | No charge, deductible does not apply | Not Covered | ACA Preventive Drugs based on Health Care Reform regulations. |
| | Chronic and preventive drugs | $10 copayment per prescription per 30-day supply (retail) $20 copayment per prescription per 90-day supply (maintenance), deductible does not apply | $20 copayment per prescription per 30-day supply (retail), deductible does not apply | Not Covered | You have access to contracted pharmacies such as CVS, Kroger, Walgreens, Wal-Mart and more. The max day supply through a contracted pharmacy is 30 days. Only the Baylor Scott & White Pharmacy mail-order can fill a 90-day supply. |
| | Tier 1: Preferred generic drugs | $7 copayment per prescription per 30-day supply (retail) $14 copayment per prescription per 90-day supply (maintenance), deductible does not apply | $14 copayment per prescription per 30-day supply (retail), deductible does not apply | Not Covered | If the member or provider requests a brand name drug when a generic equivalent is available, the member is responsible for the non-preferred copayment plus the difference in the cost of the brand name drug and the generic equivalent drug. The difference in cost does not apply to any combined deductible, medical deductible, pharmacy deductible, or maximum out-of-pocket for the plan. |
| | Tier 2: Preferred brand name drugs | $40 copayment per prescription per 30-day supply (retail) $80 copayment per | $60 copayment per prescription per 30-day supply (retail), deductible does not | Not Covered | |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Tier 1 Participating Provider (You will pay the least) | Tier 2 Participating Provider (You will pay more) | Tier 3 Non-Participating Provider (You will pay the most) | |
| | | prescription per 90-day supply (maintenance), deductible does not apply | apply | | Some drugs require preauthorization, including drugs not on the plan's formulary and compounds costing greater than $100. Failure to obtain preauthorization will result in a denial of benefits. |
| | Tier 3: Non-preferred generic drugs and non-preferred brand name drugs | Lesser of $60 copayment or 50% coinsurance per prescription per 30-day supply (retail) Lesser of $120 copayment or 50% coinsurance per prescription per 90-day supply (maintenance), deductible does not apply | Lesser of $75 copayment or 50% coinsurance per prescription per 30-day supply (retail) after $100 individual deductible | Not Covered | |
| | Tier 4: Specialty drugs | 20% coinsurance per prescription up to $200 maximum copayment (retail), deductible does not apply | Not covered | Not covered | Limited to a 30-day supply and only available through Baylor Scott & White pharmacies.<br><br>Specialty drugs require preauthorization. Failure to obtain preauthorization will result in a denial of benefits.<br><br>Specialty drugs covered under medical: You pay 20% coinsurance up to $200 maximum for Tier 1 and Tier 2 participating providers and 80% after deductible for Tier 3 non-participating providers.<br><br>Amounts paid by a copay assistance |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Tier 1 Participating Provider (You will pay the least) | Tier 2 Participating Provider (You will pay more) | Tier 3 Non-Participating Provider (You will pay the most) | |
| | | | | | program for specialty drugs do not count toward the deductible or out-of-pocket limit. Certain specialty drugs are considered non-essential health benefits and amounts paid for such drugs do not count toward the out-of-pocket limit. |
| | Fertility drugs | 20% coinsurance with $400 maximum copayment, deductible does not apply | | Not covered | Limited to 30-day supply.<br><br>Fertility drugs are covered at Baylor Scott & White and Contracted Pharmacies. You pay 20% coinsurance with a maximum of $400 copayment. The lifetime maximum pharmacy benefit is $7,500. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 50% coinsurance | 80% coinsurance | Preauthorization is required. If you don't get preauthorization, benefits will be denied. Refer to BSWHealthPlan.com/BSWH or call 844-843-3229. |
| | Physician/surgeon fees | 20% coinsurance | 50% coinsurance | 80% coinsurance | |
| **If you need immediate medical attention** | Emergency room care | $500 copayment plus 20% coinsurance per visit, deductible does not apply | $500 copayment plus 20% coinsurance per visit, deductible does not apply | $500 copayment plus 20% coinsurance per visit, deductible does not apply | Emergency room copayment and coinsurance waived if episode results in hospitalization for the same condition within 24 hours.<br><br>Non-emergency care in an emergency room is not covered. |
| | Emergency medical transportation | $250 copayment per visit, deductible does not apply | $250 copayment per visit, deductible does not apply | $250 copayment per visit, deductible does | Emergency transportation includes ground and air ambulance. |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Tier 1 Participating Provider (You will pay the least) | Tier 2 Participating Provider (You will pay more) | Tier 3 Non-Participating Provider (You will pay the most) | |
| | | | | not apply | |
| | Urgent care | $45 copayment per visit, deductible does not apply | $100 copayment per visit, deductible does not apply | $100 copayment per visit, deductible does not apply | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 50% coinsurance | 80% coinsurance | Preauthorization is required. If you don't get preauthorization, benefits will be denied. Refer to BSWHealthPlan.com/BSWH or call 844-843-3229. |
| | Physician/surgeon fees | 20% coinsurance | 50% coinsurance | 80% coinsurance | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $45 copayment per visit, deductible does not apply<br>20% coinsurance for other outpatient services | $70 copayment per visit, deductible does not apply<br>50% coinsurance for other outpatient services | 80% coinsurance | Admissions to behavioral health/substance abuse residential, partial hospitalization, and day programs require preauthorization. If you don't get preauthorization, benefits will be denied. Refer to BSWHealthPlan.com/BSWH or call 844-843-3229. |
| | Inpatient services | 20% coinsurance | 50% coinsurance | 80% coinsurance | |
| **If you are pregnant** | Office visits | PCP: $45 copayment per visit<br>Specialist: $60 copayment per visit, deductible does not apply | PCP: $70 copayment per visit<br>Specialist: $100 copayment per visit, deductible does not apply | 80% coinsurance | 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 SBC (i.e., ultrasound). |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Tier 1 Participating Provider (You will pay the least) | Tier 2 Participating Provider (You will pay more) | Tier 3 Non-Participating Provider (You will pay the most) | |
| | Childbirth/delivery professional services | 0% after applicable copayment if newborn is added to coverage, deductible does not apply | 50% coinsurance | 80% coinsurance | 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. Copayment applies to facility charges. All other services billed with a maternity / delivery diagnosis code (e.g., anesthesia, OBGYN, pathology, etc.) are covered at 100% including well-baby charges, if newborn is added for coverage. Notification is required. If you don't notify, benefits will be denied. Refer to BSWHealthPlan.com/BSWH or call 844-843-3229. |
| | Childbirth/delivery facility services | $1,200 copayment, deductible does not apply | 50% coinsurance | 80% coinsurance | Notification is required. If you don't notify, benefits will be denied. Refer to BSWHealthPlan.com/BSWH or call 844-843-3229. |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 50% coinsurance | 80% coinsurance | Limited to 120 visits per calendar year. Preauthorization is required. If you don't get preauthorization, benefits will be denied. Refer to BSWHealthPlan.com/BSWH or call 844-843-3229. |
| | Rehabilitation services | 20% coinsurance | 50% coinsurance | 80% coinsurance | Combined occupational/physical therapy 60 visits max per calendar year. Speech therapy 60 visits max per calendar year. Limits may not apply for treatment of |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Tier 1 Participating Provider (You will pay the least) | Tier 2 Participating Provider (You will pay more) | Tier 3 Non-Participating Provider (You will pay the most) | |
| | Habilitation services | $45 copayment per visit, deductible does not apply | $70 copayment per visit, deductible does not apply | 80% coinsurance | autism spectrum disorder. Excludes educational training, services designed to develop physical function, and vocational rehabilitation. Therapy services must be rendered in accordance with a physician's written plan. |
| | Skilled nursing care | 20% coinsurance | 50% coinsurance | 80% coinsurance | Limited to 120 days per calendar year. Preauthorization is required. If you don't get preauthorization, benefits will be denied. Refer to BSWHealthPlan.com/BSWH or call 844-843-3229. |
| | Durable medical equipment | 20% coinsurance | 50% coinsurance | 80% coinsurance | Preauthorization is required. If you don't get preauthorization, benefits will be denied. Refer to BSWHealthPlan.com/BSWH or call 844-843-3229. |
| | Hospice services | 20% coinsurance | 50% coinsurance | 80% coinsurance | Notification is required. If you don't notify, benefits will be denied. Refer to BSWHealthPlan.com/BSWH or call 844-843-3229. |
| **If your child needs dental or eye care** | Children's eye exam | Not covered | Not covered | Not covered | None |
| | Children's glasses | Not covered | Not covered | Not covered | None |
| | Children's dental check-up | Not covered | 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.)**

- Cosmetic surgery
- Dental care (Adult and Child)
- 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.)**

- Acupuncture (20 visit limit per calendar year)
- Bariatric surgery (Tier 1 and Tier 2 only; one morbid obesity surgery per lifetime)
- Chiropractic care (20 visit limit per calendar year)
- Hearing aids (Limited to one device every 36 months)
- Infertility treatment (Limited to $7,500 medical and $7,500 pharmacy lifetime max)
- Private-duty nursing (120 visit limit per calendar year)

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Optum, adminservices.optumhealthfinancial.com, or call 855-409-7029; Department of Labor Employee Benefits Security Administration, visit dol.gov/ebsa/healthreform, or call1-866-444-EBSA (3272). Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit HealthCare.gov or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information 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, visit BSWHealthPlan.com or call 1-844-843-3229; Department of Labor Employee Benefits Security Administration, visit dol.gov/ebsa/healthreform, or call 1-866-444-EBSA (3272).

**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 844-843-3229.

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

## About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

| | |
|---|---|
| The plan's overall deductible | $2,000 |
| Specialist copayment | $60 |
| Hospital (facility) copayment | $1,200 |
| Other coinsurance | 20% |

**This EXAMPLE event includes services like:**
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

| **Total Example Cost** | **$12,700** |
|---|---|
| **In this example, Peg would pay:** | |
| *Cost Sharing* | |
| Deductibles | $2,000 |
| Copayments | $70 |
| Coinsurance | $1,700 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$3,830** |

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

| | |
|---|---|
| The plan's overall deductible | $2,000 |
| Specialist copayment | $60 |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 20% |

**This EXAMPLE event includes services like:**
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

| **Total Example Cost** | **$5,600** |
|---|---|
| **In this example, Joe would pay:** | |
| *Cost Sharing* | |
| Deductibles | $900 |
| Copayments | $1,300 |
| 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 | $2,000 |
| Specialist copayment | $60 |
| Hospital (facility) coinsurance | 20% |
| Other coinsurance | 20% |

**This EXAMPLE event includes services like:**
Emergency room care *(including medical supplies)*
Diagnostic test *(X-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

| **Total Example Cost** | **$2,800** |
|---|---|
| **In this example, Mia would pay:** | |
| *Cost Sharing* | |
| Deductibles | $2,000 |
| Copayments | $700 |
| Coinsurance | $20 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,720** |

The plan would be responsible for the other costs of these EXAMPLE covered services.