



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:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|---------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | \$3,600 per member / \$7,200 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> .                                                                                                                                                                                                            |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | 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> .                                                                                     |
| Are there other <a href="#">deductibles</a> for specific services?              | No                                                                                                                                                                                                | You don't have to meet <a href="#">deductibles</a> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | \$11,900 per member / \$23,800 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.                                                                                                                                                                                                                                                                                                                                                             |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <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> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| Will you pay less if you use a <a href="#">network provider</a> ?               | 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. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | 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. \$60 <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                        | \$90 <a href="#">copayment</a> per visit, <a href="#">deductible</a> does not apply                                                                                                                                                                                               | Not covered                                                        |                                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                                                                                                                                                                                       | <a href="#">Preventive care/screening/</a> immunization | 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)     | 30% <a href="#">copayment</a> after <a href="#">deductible</a>                                                                                                                                                                                                                    | Not covered                                                        | None                                                                                                                                                                                                                                                                                                                                                                               |
|                                                                                                                                                                                                                                       | Imaging (CT/PET scans, MRIs)                            | 30% <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 |
|                                                                                                                                                                                                                                       | Generic drugs (Tier 1)                                  | \$6 <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>                                                                                                                                                                                                       | 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)                           |                                                                                                                                                                                                                                                                                                                  |
|                                                                           |                                                                            | does not apply                                                                                                                                                                                                                                                         |                                                                                     | a 30-day supply. <a href="#">Formulary</a> insulin prescriptions have a maximum <a href="#">copayment</a> of \$25 per prescription per 30-day supply. Certain preventive drugs are covered at no charge and are not subject to the <a href="#">deductible</a> . Tiers 2 - 4 may include brand and generic drugs. |
|                                                                           | Non-preferred brand drugs (Tier 3)                                         | \$125 <a href="#">copayment</a> per prescription, <a href="#">deductible</a> does not apply                                                                                                                                                                            | Not covered                                                                         |                                                                                                                                                                                                                                                                                                                  |
|                                                                           | <a href="#">Specialty drugs</a> (and oral anticancer medications) (Tier 4) | \$250 <a href="#">copayment</a> per prescription, <a href="#">deductible</a> does not apply                                                                                                                                                                            | Not covered                                                                         |                                                                                                                                                                                                                                                                                                                  |
| If you have outpatient surgery                                            | Facility fee (e.g., ambulatory surgery center)                             | 30% <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.                                                                                                                                  |
|                                                                           | Physician/surgeon fees                                                     | 30% <a href="#">copayment</a> after <a href="#">deductible</a>                                                                                                                                                                                                         | Not covered                                                                         |                                                                                                                                                                                                                                                                                                                  |
| If you need immediate medical attention                                   | <a href="#">Emergency room care</a>                                        | \$500 <a href="#">copayment</a> per visit after <a href="#">deductible</a>                                                                                                                                                                                             | \$500 <a href="#">copayment</a> per visit after <a href="#">deductible</a>          | Emergency room <a href="#">copayment</a> waived if episode results in <a href="#">hospitalization</a> for the same condition within 24 hours.                                                                                                                                                                    |
|                                                                           | <a href="#">Emergency medical transportation</a>                           | \$500 <a href="#">copayment</a> per service after <a href="#">deductible</a>                                                                                                                                                                                           | \$500 <a href="#">copayment</a> per service after <a href="#">deductible</a>        | None                                                                                                                                                                                                                                                                                                             |
|                                                                           | <a href="#">Urgent care</a>                                                | \$50 <a href="#">copayment</a> per visit, <a href="#">deductible</a> does not apply                                                                                                                                                                                    | \$50 <a href="#">copayment</a> per visit, <a href="#">deductible</a> does not apply | None                                                                                                                                                                                                                                                                                                             |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)                                         | 30% <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.                                                                                                                                  |
|                                                                           | Physician/surgeon fees                                                     | 30% <a href="#">copayment</a> after <a href="#">deductible</a>                                                                                                                                                                                                         | Not covered                                                                         |                                                                                                                                                                                                                                                                                                                  |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                                                        | Adult: \$60 <a href="#">copayment</a> per office visit, <a href="#">deductible</a> does not apply. 30% <a href="#">copayment</a> after <a href="#">deductible</a> for all other outpatient services<br>Pediatric: No charge, <a href="#">deductible</a> 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.                                                                                                                                  |

| 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) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                                                                | Inpatient services                        | 30% <u>copayment</u> after <u>deductible</u>                      | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| If you are pregnant                                            | Office visits                             | \$60 <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 | 30% <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     | 30% <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>          | 30% <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>   | \$60 <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>     | \$60 <u>copayment</u> per visit, <u>deductible</u> does not apply | Not covered                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                                                                | <a href="#">Skilled nursing care</a>      | 30% <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> | 30% <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                                                                                                                                                                                                                                                                                                                                                                                                                                             |

| 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="http://BSWHealthPlan.com">BSWHealthPlan.com</a> or call 844-633-5325.                                                                                                       |
|                                               | <a href="#">Hospice services</a> | 30% <u>copayment</u> after <u>deductible</u>                     | Not covered                                               | Services requiring <u>preauthorization</u> that are not <u>preauthorized</u> will be denied. Refer to <a href="http://BSWHealthPlan.com">BSWHealthPlan.com</a> or call 844-633-5325. |
| <b>If your child needs dental or eye care</b> | Children's eye exam              | \$10 <u>copayment</u> per exam, <u>deductible</u> does not apply | Not covered                                               | Limited to one eye exam per calendar year.                                                                                                                                           |
|                                               | Children's glasses               | \$10 <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
- 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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$3,600 |
| ■ <a href="#">Specialist copayment</a>                          | \$90    |
| ■ Hospital (facility) <a href="#">copayment</a>                 | 30%     |
| ■ Other <a href="#">coinsurance</a>                             | 30%     |

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$3,600        |
| <a href="#">Copayments</a>        | \$10           |
| <a href="#">Coinsurance</a>       | \$2,300        |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$5,970</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> | \$3,600 |
| ■ <a href="#">Specialist copayment</a>                          | \$90    |
| ■ Hospital (facility) <a href="#">copayment</a>                 | 30%     |
| ■ Other <a href="#">coinsurance</a>                             | 30%     |

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)  
[Diagnostic tests](#) (*blood work*)  
[Prescription drugs](#)  
[Durable medical equipment](#) (*glucose meter*)

|                           |                |
|---------------------------|----------------|
| <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>        | \$1,000        |
| <a href="#">Coinsurance</a>       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,920</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> | \$3,600 |
| ■ <a href="#">Specialist copayment</a>                          | \$90    |
| ■ Hospital (facility) <a href="#">copayment</a>                 | 30%     |
| ■ Other <a href="#">coinsurance</a>                             | 30%     |

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*X-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$2,000        |
| <a href="#">Copayments</a>        | \$500          |
| <a href="#">Coinsurance</a>       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,500</b> |

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

# Nondiscrimination Notice



ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-844-633-5325 (TTY: 711).

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

Baylor Scott & White Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Written information in other formats (large print and accessible electronic formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Baylor Scott & White Health Plan Compliance Officer at 1-214-820-8888 or send an email to [HPCompliance@BSWHealth.org](mailto:HPCompliance@BSWHealth.org).

If you believe that Baylor Scott & White Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

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

Compliance HelpLine; 1-888-484-6977 or <https://app.mycompliancereport.com/report?cid=swhp>

You can file a grievance in person or by mail, online, or email. If you need help filing a grievance, the Compliance Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at <https://www.hhs.gov/civil-rights/filing-a-complaint/index.html>.



## Multi-Language Interpreter Services

**English:** We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-855-572-7238. Someone who speaks English/Language can help you. This is a free service.

**Spanish:** Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-855-572-7238. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

**Chinese Mandarin:** 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-855-572-7238。我们的中文工作人员很乐意帮助您。这是一项免费服务。

**Chinese Cantonese:** 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-855-572-7238。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

**Tagalog:** Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-855-572-7238. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

**French:** Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-855-572-7238. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

**Vietnamese:** Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi 1-855-572-7238 sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí.

**German:** Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelpflichtplan. Unsere Dolmetscher erreichen Sie unter 1-855-572-7238. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

**Korean:** 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-855-572-7238 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

**Russian:** Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-855-572-7238. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

**Arabic:** إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-855-572-7238. بمساعدتك. هذه خدمة مجانية. سيقوم شخص ما يتحدث العربية.

**Hindi:** हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-855-572-7238 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

**Italian:** È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-855-572-7238. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

**Portugués:** Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-855-572-7238. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

**French Creole:** Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-855-572-7238. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

**Polish:** Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-855-572-7238. Ta usługa jest bezpłatna.

**Japanese:** 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、1-855-572-7238 にお電話ください。日本語を話す人 者が支援いたします。これは無料のサービスです。