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 bswh.swhp.org. 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?	In-network: $750 Employee Only (EE) / $1,500 Employee & Family (ES, EC, EF) Out-of-network: not covered	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. There is an embedded deductible for coverage tier Employee + Family (which includes Employee + Spouse and Employee + Children).
Are there services covered before you meet your deductible?	Yes. Preventive care, office visits, ACA preventive drugs are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes	$100 individual deductible for Tier 3: Non-preferred generic drugs and non-preferred brand name drugs obtained from contracted pharmacies.
What is the out-of-pocket limit for this plan?	$4,000 Employee Only (EE) / $8,000 Employee & Family (ES, EC, EF)	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. There is an embedded out-of-pocket limit for coverage tier Employee + Family (which includes Employee + Spouse and Employee + Children). Deductible included in out-of-pocket max.
What is not included in the out-of-pocket limit?	Premiums, balance-billing and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See bswh.swhp.org or call 844-843-3229 for a list of network	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
Do you need a referral to see a specialist?	No	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Adult: $30 copayment per visit Pediatric: $30 copayment per visit (Age 0 through 18) Deductible does not apply	Not covered	None
	Specialist visit	$50 copayment per visit, deductible does not apply	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)	X-ray: $75 copayment per visit Labs: 30% coinsurance per visit Deductible does not apply	Not covered	None

* For more information about limitations and exceptions, see the plan or policy document at bswh.swhp.org.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
	Imaging (PET, CT, CAT, MRI, MRA scans)	$100 copayment per visit for PET, CT, CAT $150 copayment per visit for MRI, MRA	Not covered	Services requiring preauthorization that are not preauthorized will be denied. Refer to bswh.swhp.org/tools-and-resources or call 844-843-3229.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://**bswh.swhp.org**/en-us/members/manage-your-plan/pharmacy-information	ACA preventive drugs	No charge, deductible does not apply	Not covered	Copayments are per 30-day supply. 90-day supply is available if a maintenance drug is obtained through a Baylor Scott & White pharmacy OR when using the mail order prescription service. Specific preventative medications will be covered with no cost to the member. The ACA Preventive Drugs are based on Health Care Reform regulations. You have access to Baylor Scott & White Pharmacies and Contracted Pharmacies, such as CVS, Kroger, Walgreens, Wal-Mart and more.
	Tier 1: Preferred generic drugs	BSW Pharmacy: $5 copayment per prescription per 30-day supply (retail) $10 copayment per prescription per 90-day supply (maintenance), deductible does not apply Contracted Pharmacy: $12 copayment per prescription per 30-day supply (retail)	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
	Tier 2: Preferred brand name drugs	BSW Pharmacy: $35 copayment per prescription per 30-day supply (retail) $70 copayment per prescription per 90-day supply (maintenance), deductible does not apply Contracted Pharmacy: $50 copayment per prescription per 30-day supply (retail)	Not covered	
	Tier 3: Non-preferred generic drugs and non-preferred brand name drugs	BSW Pharmacy: lesser of $50 copayment or 50% coinsurance per prescription (retail), lesser of $100 or 50% coinsurance per prescription (maintenance), deductible does not apply Contracted Pharmacy: Lesser of $75 copayment or 50% coinsurance per prescription after $100 individual deductible	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
	Tier 4: Specialty drugs	BSW Pharmacy: 20% coinsurance per prescription per 30-day supply per prescription up to $200 maximum, deductible does not apply Contracted Pharmacy: not covered	Not covered	Available through Baylor Scott & White pharmacy only. Some drugs may require prior authorization. 30-day supply only. 20% coinsurance up to $200 maximum for specialty drugs covered under medical.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% after deductible	Not covered	Services requiring preauthorization that are not preauthorized will be denied. Refer to bswh.swhp.org/tools-and-resources or call 844-843-3229.
	Physician/surgeon fees	10% after deductible	Not covered	
If you need immediate medical attention	Emergency room care	$250 copayment per visit, deductible does not apply	$250 copayment per visit, deductible does not apply	Emergency room copayment waived if episode results in hospitalization for the same condition within 24 hours.
	Emergency medical transportation	$250 copayment per visit, deductible does not apply	$250 copayment per visit, deductible does not apply	Emergency transportation includes ground and air ambulance.
	Urgent care	$75 copayment per visit, deductible does not apply	$75 copayment per visit, deductible does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% after deductible	Not covered	Services requiring preauthorization that are not preauthorized will be denied. Refer to

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
	Physician/surgeon fees	10% after deductible	Not covered	bswh.swhp.org/tools-and-resources or call 844-843-3229.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Adult: $30 copayment per visit Pediatric: $30 copayment per visit (Age 0 through 18) Deductible does not apply	Not covered	Services requiring preauthorization that are not preauthorized will be denied. Refer to bswh.swhp.org/tools-and-resources or call 844-843-3229.
	Inpatient services	10% after deductible	Not covered	
If you are pregnant	Office visits	PCP: $30 copayment per visit Specialist: $50 copayment per visit Deductible does not apply	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 SBC (i.e., ultrasound).
	Childbirth/delivery professional services	0% after applicable copay	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.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
	Childbirth/delivery facility services	$400 copayment Deductible does not apply	Not covered	Copayment applies to Room & Board charges. All other charges (e.g., anesthesia, OBGYN, pathology, etc.) driven by maternity/delivery DRG are covered at 100% including well-baby charges, if newborn is added for coverage. Services that are not preauthorized will be denied.
If you need help recovering or have other special health needs	Home health care	10% after deductible	Not covered	Limited to 120 visits per calendar year. Services requiring preauthorization that are not preauthorized will be denied. Refer to bswh.swhp.org/tools-and-resources or call 844-843-3229.
	Rehabilitation services	$50 copayment per visit, deductible does not apply	Not covered	Combined occupational/physical therapy 60 visits max per calendar year, speech therapy 60 visits max per calendar year. Limits may not apply for therapies for children with developmental delays, autism spectrum disorder and mental health services. Services that are not preauthorized will be denied.
	Habilitation services	$30 copayment per visit, deductible does not apply	Not covered	
	Skilled nursing care	10% after deductible	Not covered	Limited to 120 days per calendar year. Services requiring preauthorization that are not preauthorized will be denied. Refer to bswh.swhp.org/tools-and-resources or call 844-843-3229.
	Durable medical equipment	10% after deductible	Not covered	Services requiring preauthorization that are not preauthorized will be denied. Refer to

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
	Hospice services	10% after deductible	Not covered	bswh.swhp.org/tools-and-resources or call 844-843-3229.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- 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
- 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 866-301-6681; 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 to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Scott and White Health Plan, visit bswh.swhp.org/, 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	$750
Specialist copayment	$50
Hospital (facility) coinsurance	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	$750
Copayments	$600
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,410**

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

The plan's overall deductible	$750
Specialist copayment	$50
Hospital (facility) coinsurance	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	$750
Copayments	$900
Coinsurance	$40
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,710**

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

The plan's overall deductible	$750
Specialist copayment	$50
Hospital (facility) coinsurance	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	$750
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$1,800
The total Mia would pay is	**$3,650**

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