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 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.
Are there services covered before you meet your deductible?	Yes. Preventive care, office visits, diagnostic X-ray, diagnostic lab, advanced imaging, emergency room, ambulance, maternity care, prescription and 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 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?	$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.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges, out-of-network expenses, services for which you failed to obtain required preauthorization, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See BSWHealthPlan.com/BSWH or call 844-843-3229 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what

Important Questions	Answers	Why This Matters:
		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
		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	$30 copayment per visit, 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
	Imaging (CT/PET scans, MRIs)	$100 copayment per visit for PET, CT, CAT $150 copayment per visit for MRI, MRA Deductible does not apply	Not covered	Preauthorization is required. If you don't get preauthorization, benefits will be denied. Refer to BSWHealthPlan.com/BSWH or call 844-843-3229.

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)	
	Affordable Care Act (ACA) preventive drugs	No charge, deductible does not apply	Not covered	ACA Preventive Drugs based on Health Care Reform regulations. 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. You have access to Baylor Scott & White Pharmacies and Contracted Pharmacies, such as CVS, Kroger, Walgreens, Wal-Mart and more. 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. Fertility drugs are covered at BSW and contracted pharmacies at 20% coinsurance with a maximum $400 copayment and a $7,500 lifetime maximum pharmacy benefit. Some drugs require preauthorization, including drugs not on the plan's formulary and compounds costing greater than $100.
	Chronic and preventive drugs	BSW Pharmacy: $10 copayment per prescription per 30-day supply (retail) $20 copayment per prescription per 90-day supply (maintenance), deductible does not apply Contracted Pharmacy: $20 copayment per prescription per 30-day supply (retail), deductible does not apply	Not covered	
	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), deductible does not apply	Not covered	
	Tier 2: Preferred brand name drugs	BSW Pharmacy: $35 copayment per prescription per 30-day supply	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)	
		(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), deductible does not apply		Failure to obtain preauthorization will result in a denial of benefits.
	Tier 3: Non-preferred generic drugs and non-preferred brand name drugs	BSW Pharmacy: lesser of $50 copayment or 50% coinsurance per prescription per 30-day supply (retail), lesser of $100 copayment or 50% coinsurance per prescription per 90-day supply (maintenance), deductible does not apply Contracted Pharmacy: Lesser of $75 copayment or 50% coinsurance per prescription per 30-day supply after $100 individual deductible	Not covered	
	Tier 4: Specialty drugs	BSW Pharmacy: 20% coinsurance per prescription per 30-day supply up to $200 maximum, deductible does not apply Contracted Pharmacy: not covered	Not covered	Available through Baylor Scott & White pharmacy only. 30-day supply only. Specialty drugs may require preauthorization. Failure to obtain preauthorization will result in a denial of benefits. 20% coinsurance up to $200 maximum for specialty drugs covered under medical.

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Not covered	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	10% coinsurance	Not covered	
If you need immediate medical attention	Emergency room care	$300 copayment plus 10% coinsurance, deductible does not apply	$300 copayment plus 10% coinsurance, deductible does not apply	Emergency room copayment and coinsurance waived if episode results in hospitalization for the same condition within 24 hours. 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	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% coinsurance	Not covered	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	10% coinsurance	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copayment per visit, deductible does not apply 10% coinsurance for other outpatient services	Not covered	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	10% coinsurance	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)	
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 copayment if newborn is added to coverage, deductible does not apply	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. Copayment applies to facility 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. 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	$400 copayment, deductible does not apply	Not covered	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	10% coinsurance	Not covered	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.

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)	
	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 treatment of 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.
	Habilitation services	$30 copayment per visit, deductible does not apply	Not covered	
	Skilled nursing care	10% coinsurance	Not covered	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	10% coinsurance	Not covered	Preauthorization is required for specified durable medical equipment. If you don't get preauthorization, benefits will be denied. Refer to BSWHealthPlan.com/BSWH or call 844-843-3229.
	Hospice services	10% coinsurance	Not covered	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	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 (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** **$750**
- **Specialist *copayment*** **$50**
- **Hospital (facility)** copayment **$400**
- **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	$0
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$460**

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	$700
Copayments	$1,200
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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

Nondiscrimination Notice

Baylor Scott & White Health Plan

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.

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.

Language Assistance/ Asistencia de idiomas

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

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

Vietnamese:
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-633-5325 (TTY: 711).

Chinese:
注意：如果 使用繁體中文, 可以免費獲得語言援助服務。請致電 1-844-633-5325 (TTY：711)。

Korean:
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-633-5325 (TTY: 711) 번으로 전화해 주십시오.

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

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

Tagalog:
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-633-5325 (TTY: 711).

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

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

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

German:
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-844-633-5325 (TTY: 711).

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

Russian:
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-633-5325 (телетайп: 711).

Japanese:
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-844-633-5325 (TTY:711) まで、お電話にてご連絡ください。

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