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#large. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at HealthCare.gov/sbc-glossary or call 844-633-5325 to request a copy.

### Important Questions

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>$5,000 per member / $10,000 per family</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Yes. Preventive care and Affordable Care Act (ACA) preventive drugs are covered before you meet your deductible.</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>No</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>$7,000 per member / $14,000 per family</td>
<td>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.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Premiums and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out–of–pocket limit.</td>
</tr>
<tr>
<td><strong>Will you pay less if you use a network provider?</strong></td>
<td>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 network providers.</td>
<td>This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td><strong>Do you need a referral to see a specialist?</strong></td>
<td>No</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider's office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>Participating Provider (You will pay the least): Adult: No charge for the first non-preventive sick visit in the plan year. $25 copayment per visit for subsequent visits in that plan year, deductible does not apply Pediatric: No charge per visit, deductible does not apply</td>
<td>Non-participating Provider (You will pay the most) Not covered</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$50 copayment per visit, deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge, deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (X-ray, blood work)</td>
<td>No charge, deductible does not apply</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>50% coinsurance, deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Affordable Care Act (ACA) preventive drugs</td>
<td>No charge, deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td>More information about prescription drug coverage is available at BSWHealthPlan.com/Grou</td>
<td>Tier 1: Preferred generic drugs</td>
<td>$8 copayment per prescription</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Tier 2: Preferred</td>
<td>$45 copayment per</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

Copayments are per 30-day supply. Maintenance drugs are allowed up to a 90-day supply for 2.5 copayments if obtained through a participating pharmacy. Mail Order: Available for a 1- to 90-day supply. Non-maintenance drugs obtained through mail order are limited to a 30-day supply maximum. Specialty drugs.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
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</tr>
</thead>
<tbody>
<tr>
<td>p/Pages/Pharmacy.</td>
<td>brand name drugs</td>
<td>prescription</td>
<td>limited to a 30-day supply. Formulary insulin prescriptions have a maximum copayment of $25 per prescription per 30-day supply. If a brand name drug is requested when a generic equivalent is available, the member is responsible for the non-preferred copayment plus the difference in cost of the brand name drug and generic equivalent drug.</td>
</tr>
<tr>
<td></td>
<td>Tier 3: Non-preferred generic drugs and non-preferred brand name drugs</td>
<td>$85 copayment per prescription</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>Tier 1: $200 copayment per prescription Tier 2: $300 copayment per prescription Tier 3: $400 copayment per prescription</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>50% coinsurance after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>50% coinsurance after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$500 copayment per visit, plus 50% coinsurance, deductible does not apply</td>
<td>Emergency room copayment waived if episode results in hospitalization for the same condition within 24 hours.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>$500 copayment per service, plus 50% coinsurance, deductible does not apply</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$50 copayment per visit, deductible does not apply</td>
<td></td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>50% coinsurance after deductible</td>
<td>Services requiring preauthorization that are not preauthorized will be denied. Refer to BSWHealthPlan.com or call 844-633-5325.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>50% coinsurance after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
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</tr>
<tr>
<td>----------------------------------------------------------------</td>
<td>-----------------------</td>
<td>-------------------</td>
<td>---------------------------------------------------------</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Adult: $25 copayment per visit, 50% coinsurance after deductible for all other outpatient services Pediatric: No charge per visit, deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>50% coinsurance after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>$25 copayment per visit, deductible does not apply</td>
<td>Not covered</td>
</tr>
<tr>
<td>Childbirth/delivery professional services</td>
<td>50% coinsurance after deductible</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Childbirth/delivery facility services</td>
<td>50% coinsurance after deductible</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>50% coinsurance after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>$25 copayment per visit, deductible does not apply</td>
<td>Not covered</td>
<td>Limited to 35 visits for rehabilitation services and 35 visits for habilitation services per plan year. The limit is combined for physical therapy, occupational therapy, and speech therapy. Limits do not apply for therapies for children with developmental delays, autism</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>$25 copayment per visit, deductible does not apply</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
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<td>----------------------</td>
<td>-----------------------</td>
<td>-------------------</td>
<td>-----------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Participating Provider (You will pay the least)</td>
<td>Non-participating Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>50% coinsurance after deductible</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>50% coinsurance after deductible</td>
<td>Not covered</td>
<td>Services requiring preauthorization that are not preauthorized will be denied. Refer to BSWHealthPlan.com or call 844-633-5325.</td>
</tr>
<tr>
<td>Hospice services</td>
<td>No charge, deductible does not apply</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>
Excluded Services & Other Covered Services:

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</th>
</tr>
</thead>
</table>
| • 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 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.)

<table>
<thead>
<tr>
<th>Services</th>
</tr>
</thead>
</table>
| • Chiropractic care (Limited to 35 visits per plan year)  
• Hearing aids (Limited to one device per ear every 3 years for members through the age of 18)  
• Private duty nursing (when medically necessary and preauthorized. Limitations apply when used under Home Health Care) |

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 Care 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 Care 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 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:

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: $5,000
- Specialist copayment: $50
- Hospital (facility) copayment: 50%
- Other coinsurance: 50%

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: $5,000
  - Copayments: $10
  - Coinsurance: $2,000

What isn’t covered: Limits or exclusions $60

The total Peg would pay is: $7,060

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

- The plan’s overall deductible: $5,000
- Specialist copayment: $50
- Hospital (facility) copayment: 50%
- Other coinsurance: 50%

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: $800
  - Copayments: $700
  - Coinsurance: $0

What isn’t covered: Limits or exclusions $20

The total Joe would pay is: $1,520

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

- The plan’s overall deductible: $5,000
- Specialist copayment: $50
- Hospital (facility) copayment: 50%
- Other coinsurance: 50%

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: $1,100
  - Copayments: $900
  - Coinsurance: $0

What isn’t covered: Limits or exclusions $0

The total Mia would pay is: $2,000

The plan would be responsible for the other costs of these EXAMPLE covered services.
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 Care 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 Care Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Baylor Scott & White Care 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 Care Plan Compliance Officer at 1-214-820-8888 or send an email to HPCompliance@BSWHealth.org.

If you believe that Baylor Scott & White Care 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 Care 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.
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:

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:

Arabic:
)رﻗﻢ 844-633-5325-1.ﻣﻠﺤﻮظﺔ: إذا كنت تتحدث إنجليزية اللغة، فإن خدمات المساعدة اللغوية توفر لك بالمجان. اتصل برقم 1-844-633-5325 (رقم 711).

Urdu:
克斯ین (711) 5325-633-844-1 خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی خدمات مفت مہ میں دستیاب ہیں۔

Tagalog:

French:

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

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

German:

Gujarati:
સુચના: ત્રણ નામે ગુજરાતી બોલતા હોય, તો નાખીયું ભાષા સાધારણ સેબ્યા તમારા માટે ઉપલબ્ધ છે. ટૂંનો કોલ 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: