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 or call 844-633-5325 to request a copy.

### Important Questions

| **What is the overall deductible?** | **$5,900 per member / $11,800 per family for a participating provider and $11,800 per member / $23,600 per family for a Non-Participating provider.** | **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 and certain 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?** | **No** | **You don’t have to meet deductibles for specific services.** |
| **What is the out-of-pocket limit for this plan?** | **$9,100 per member / $18,200 per family for a participating provider and $27,300 per member / $54,600 per family for a Non-Participating provider.** | **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, 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

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Will you pay less if you use a network provider?</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>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No</td>
</tr>
</tbody>
</table>

### Why This Matters:

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.

### Important Information

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></td>
<td>Primary care visit to treat an injury or illness</td>
<td><strong>Network Provider (You will pay the least)</strong>&lt;br&gt;Adult: No charge for the first non-preventive sick visit in the plan year.&lt;br&gt;$35 copayment per visit for subsequent visits in that plan year, deductible does not apply&lt;br&gt;Pediatric: No charge, deductible does not apply</td>
<td><strong>Out-of-Network Provider (You will pay the most)</strong>&lt;br&gt;50% after deductible</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$70 copayment per visit, deductible does not apply</td>
<td>50% after deductible</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge, deductible does not apply</td>
<td>50% after deductible, no charge for child immunizations through the 6th birthday.</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td><strong>Diagnostic test</strong> (X-ray, blood work)</td>
<td>10% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>-------------------</td>
<td>---------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Network Provider</strong></td>
<td><strong>Out-of-Network Provider</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>(You will pay the least)</em></td>
<td><em>(You will pay the most)</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td>10% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>No charge, deductible does not apply</td>
<td>50% after deductible</td>
</tr>
<tr>
<td></td>
<td>Affordable Care Act (ACA) preventive drugs</td>
<td>$15 co-payment per prescription, deductible does not apply</td>
<td>50% after deductible</td>
</tr>
<tr>
<td></td>
<td>Generic drugs (Tier 1)</td>
<td>$55 co-payment per prescription, deductible does not apply</td>
<td>50% after deductible</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs (Tier 2)</td>
<td>$150 co-payment per prescription, deductible does not apply</td>
<td>50% after deductible</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs (Tier 3)</td>
<td>$500 co-payment per prescription, deductible does not apply</td>
<td>50% after deductible</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs (and oral anticancer medications) (Tier 4)</td>
<td>$750 co-payment per visit after deductible</td>
<td>$750 co-payment per visit after deductible</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>10% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$750 co-payment per visit after deductible</td>
<td>$750 co-payment per visit after deductible</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>$750 co-payment per service after deductible</td>
<td>$750 co-payment per service after deductible</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$70 co-payment per visit, deductible does not apply</td>
<td>$70 co-payment per visit, deductible does not apply</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>10% after deductible</td>
<td>50% after deductible</td>
</tr>
</tbody>
</table>

More information about [prescription drug coverage](#) is available at [https://www.bswhealthplan.com/Pages/Pharmacy.aspx](https://www.bswhealthplan.com/Pages/Pharmacy.aspx).
<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></td>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Adult: $35 copayment per office visit, 10% after deductible for all other outpatient services Pediatric: No charge, deductible does not apply</td>
<td>50% after deductible</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>10% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>$35 copayment per visit, deductible does not apply</td>
<td>50% after deductible</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>10% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>10% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>10% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$35 copayment per visit, deductible does not apply</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>-------------------</td>
<td>------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>copayment per visit, deductible does not apply</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Habilitation services</td>
<td></td>
<td>$35</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td></td>
<td>10% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td></td>
<td>10% after deductible</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Hospice services</td>
<td></td>
<td>10% after deductible</td>
<td>50% after deductible</td>
</tr>
</tbody>
</table>

If your child needs dental or eye care

<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></td>
<td></td>
<td>copayment per visit, deductible does not apply</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Children's eye exam</td>
<td></td>
<td>$70</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Children's glasses</td>
<td></td>
<td>$70</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Children's dental check-up</td>
<td></td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>
### 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.)**

<table>
<thead>
<tr>
<th>Excluded Services</th>
<th>Other Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture</td>
<td>Chiropractic care (Included in Rehabilitation Services and Habilitation Services)</td>
</tr>
<tr>
<td>Bariatric surgery</td>
<td>Hearing aids (Limited to one device per ear every 3 years)</td>
</tr>
<tr>
<td>Cosmetic surgery</td>
<td>Private-duty nursing (when medically necessary and preauthorized. Limitations apply when used under Home Health Care)</td>
</tr>
<tr>
<td>Dental care (Adult and Child)</td>
<td></td>
</tr>
<tr>
<td>Infertility treatment</td>
<td></td>
</tr>
<tr>
<td>Long-term care</td>
<td></td>
</tr>
<tr>
<td>Non-emergency care when traveling outside the U.S.</td>
<td></td>
</tr>
<tr>
<td>Routine eye care (Adult)</td>
<td></td>
</tr>
<tr>
<td>Routine foot care</td>
<td></td>
</tr>
<tr>
<td>Weight loss programs</td>
<td></td>
</tr>
</tbody>
</table>

### 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)
- Private-duty nursing (when medically necessary and preauthorized. Limitations apply when used under Home Health Care)
- Hearing aids (Limited to one device per ear every 3 years)

### 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 Insurance Company 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 Insurance Company 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:

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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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)</th>
<th>Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition)</th>
<th>Mia's Simple Fracture (in-network emergency room visit and follow up care)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The <strong>plan’s</strong> overall deductible $5,900</td>
<td>The <strong>plan’s</strong> overall deductible $5,900</td>
<td>The <strong>plan’s</strong> overall deductible $5,900</td>
</tr>
<tr>
<td>Specialist [cost sharing] $70</td>
<td>Specialist [cost sharing] $70</td>
<td>Specialist [cost sharing] $70</td>
</tr>
<tr>
<td>Hospital (facility) [cost sharing] 10%</td>
<td>Hospital (facility) [cost sharing] 10%</td>
<td>Hospital (facility) [cost sharing] 10%</td>
</tr>
<tr>
<td>Other [cost sharing] 10%</td>
<td>Other [cost sharing] 10%</td>
<td>Other [cost sharing] 10%</td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$5,900</td>
</tr>
<tr>
<td>Copayments</td>
<td>$10</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$700</td>
</tr>
</tbody>
</table>

What isn’t covered

Limits or exclusions $60

The total Peg would pay is $6,670

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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$900</td>
</tr>
<tr>
<td>Copayments</td>
<td>$800</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

What isn’t covered

Limits or exclusions $40

The total Joe would pay is $1,720

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:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$2,100</td>
</tr>
<tr>
<td>Copayments</td>
<td>$400</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

What isn’t covered

Limits or exclusions $20

The total Mia would pay is $2,500

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 Insurance Company 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 Insurance Company does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Baylor Scott & White Insurance Company:

- 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 Insurance Company Compliance Officer at 1-214-820-8888 or send an email to HPCompliance@BSWHealth.org.

If you believe that Baylor Scott & White Insurance Company 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 Insurance Company, 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：如果您使用繁體中文，可以免費獲得語言援助服務。請致電1-844-633-5325（TTY：711）。

Korean:

Arabic:

Urdu:
کریں (711). 1-844-633-5325 (TTY: 711) کے ذریعہ تماس کریں۔

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:
فرامهم می باشد. با (711) 1-844-633-5325 تماس بگیرید. توجه: اگر به زبان فارسی تلفنگو می کنید، تسهیلات زبانی بصورت رایگان برای شما قابل‌توجه است.

German:

Gujarati:
સુચના: જો તમે ગુજરાતી બોલતા હો, તો તમારે મફતે ભાષા સહાય સેવા મળી શકે. 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: