## Important Questions

### What is the overall deductible?
- $1,500 per member / $3,000 per family for a participating provider and $3,000 per member / $6,000 per family for a Non-Participating provider.

**Why This Matters:**
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 is covered before you meet your deductible.

**Why This Matters:**
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/](https://www.healthcare.gov/coverage/preventive-care-benefits/).

### Are there other deductibles for specific services?
- Yes. $100 deductible for participating provider and $150 deductible for non-participating provider prescription drug coverage.

**Why This Matters:**
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?
- $4,500 per member / $9,000 per family for a participating provider and $9,000 per member / $18,000 per family for a Non-Participating provider.

**Why This Matters:**
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.

**Why This Matters:**
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 [https://www.bswhealthplan.com/Pages/Provider.aspx](https://www.bswhealthplan.com/Pages/Provider.aspx) or call 844-633-5325 for a list of network providers.

**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.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
</table>
| 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, deductible does not apply  
Pediatric: $30 copayment per visit, deductible does not apply | Adult: $30 copayment per visit, deductible does not apply  
Pediatric: $30 copayment per visit, deductible does not apply | None |
|  | Specialist visit | $50 copayment per visit, deductible does not apply | $60 copayment per visit, deductible does not apply |  |
|  | Preventive care/screening/immunization | No charge | 40% after deductible  
No charge for child immunizations through the 6th birthday. | 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) | No charge | 40% after deductible | None |
|  | Imaging (CT/PET scans, MRIs) | 20% of charges after deductible | 40% after deductible | Failure to obtain preauthorization of benefits, other than emergency care, will result in a penalty of the lesser of $500 or 50%. |
| If you need drugs to treat your illness or condition | Generic drugs (Tier 1) | $3 copayment per prescription after deductible | $3 copayment per prescription after deductible | If a brand name drug is dispensed when a generic is available, 50% coinsurance applies.  
Non-formulary: 50% of charges after deductible. |
|  | Preferred brand drugs (Tier 2) | 50% of charges after deductible | 50% of charges after deductible |  |
|  | Non-preferred brand drugs | 50% of charges after deductible | 50% of charges after deductible |  |

Important Questions | Answers | Why This Matters: |
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Do you need a referral to see a specialist?</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>BSWHealthPlan.com/Gro up/Pages/Pharmacy</strong></td>
<td>(Tier 3)</td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>Specialty drugs (and oral anticancer medications) (Tier 4)</td>
<td></td>
<td>Tier 1: 10% of charges after deductible</td>
<td>Tier 1: 40% of charges after deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tier 2: 20% of charges after deductible</td>
<td>Tier 2: 40% of charges after deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tier 3: 30% of charges after deductible</td>
<td>Tier 3: 40% of charges after deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Non-formulary: 50% of charges after deductible</td>
<td>Non-formulary: 50% of charges after deductible</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% of charges after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% of charges after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$250 copayment and 20% of charges after deductible per emergency visit</td>
<td>$250 copayment and 20% of charges after deductible per emergency visit</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% of charges after deductible</td>
<td>20% of charges after deductible</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$75 copayment per visit, deductible does not apply</td>
<td>$75 copayment 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>20% of charges after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% of charges after deductible</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Adult: 50% of charges after deductible</td>
<td>Adult: 50% of charges after deductible</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>50% of charges after deductible</td>
<td>50% of charges after deductible</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>$50 copayment per visit, deductible does not apply</td>
<td>$60 copayment per visit,</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
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<td>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).</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>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.</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Failure to obtain preauthorization of benefits, other than emergency care, will result in a penalty of the lesser of $500 or 50%.</td>
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<tr>
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<td></td>
<td>Limited to 20 visits per year. Failure to obtain preauthorization of benefits, other than emergency care, will result in a penalty of the lesser of $500 or 50%.</td>
</tr>
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<td></td>
<td></td>
<td>Limited to 20 visits per year. Failure to obtain preauthorization of benefits, other than emergency care, will result in a penalty of the lesser of $500 or 50%.</td>
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<td></td>
<td></td>
<td></td>
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</tr>
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<td></td>
<td></td>
<td></td>
<td>$1,000 maximum annual benefit. Failure to obtain preauthorization of benefits, other than emergency care, will result in a penalty of the lesser of $500 or 50%.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Failure to obtain preauthorization of benefits, other than emergency care, will result in a penalty of the lesser of $500 or 50%.</td>
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</tr>
<tr>
<td>---------------------------------------------</td>
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<td>-------------------------------------------------------</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>$50 copayment per visit, deductible does not apply</td>
<td>Limited to one eye exam per plan year.</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>Not covered</td>
<td>None</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>
<tbody>
<tr>
<td>- Acupuncture</td>
</tr>
<tr>
<td>- Bariatric surgery</td>
</tr>
<tr>
<td>- Chiropractic care</td>
</tr>
<tr>
<td>- Cosmetic surgery</td>
</tr>
<tr>
<td>- Dental care (Adult and Child)</td>
</tr>
<tr>
<td>- Infertility Treatment</td>
</tr>
<tr>
<td>- Long-term care</td>
</tr>
<tr>
<td>- Non-emergency care when traveling outside the U.S.</td>
</tr>
<tr>
<td>- Routine eye care (Adult)</td>
</tr>
<tr>
<td>- Routine foot care</td>
</tr>
<tr>
<td>- Weight loss programs</td>
</tr>
<tr>
<td>- Hearing aids (Limited to one device per ear every 3 years)</td>
</tr>
<tr>
<td>- Private-duty nursing (when medically necessary)</td>
</tr>
</tbody>
</table>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Hearing aids (Limited to one device per ear every 3 years)
- Private-duty nursing (when medically necessary)

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? No.

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? No.

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 $1,500
- Specialist copayment $50
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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:
- Deductibles $1,500
- Copayments $900
- Coinsurance $1,800
- What isn't covered
  - Limits or exclusions $60
The total Peg would pay is $4,300

### Managing Joe's Type 2 Diabetes
- (a year of routine in-network care of a well-controlled condition)
- The plan's overall deductible $1,500
- Specialist copayment $50
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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:
- Deductibles $900
- Copayments $500
- Coinsurance $1,900
- What isn't covered
  - Limits or exclusions $20
The total Joe would pay is $3,400

### Mia's Simple Fracture
- (in-network emergency room visit and follow up care)
- The plan's overall deductible $1,500
- Specialist copayment $50
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

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:
- Deductibles $700
- Copayments $1,000
- Coinsurance $200
- 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.
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.

BSWHP_Nondiscrimination_Notice_12/2021
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: 如果您说繁體中文, 可以免費獲得語言援助服務。請致電 1-844-633-5325 (TTY: 711)。

Korean:

Arabic:
يرجى الإشارة إلى أن إذا كنت تتحدث اللغة العربية، فأن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل برقم 1-844-633-5325 (TTY: 711).

Urdu:

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:
فراهم می باشند. (711) هاگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما 1-844-633-5325 (TTY: 711) می باشند.

German:

Gujarati:
સુચના: તમે ગુજરાતી બોલતા હોવો તો તમારે મુલાકાતમાં ભાષા સહાય સંસ્થાની સેવાઓ ઉપલબ્ધ છે। 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:
陂ເພດ: ປໍ ມາ ອາ ທາ ມາ ຜ້າ ຍາສະຫວັດ ທາ, ທາບໍ ປໍ ທາ ເທີສະ ທາ ແລ້ວ, ທີ່ ທາ ທາ ການຈັດ, ຖິດສິນ ແລ້ວ, ນມ ນ້າມ ແລ້ວ ທາ ຫຍ, ຟາ ທາ ການເຂົ້າໄປ ທາ ທາ ນມ ແລ້ວ ທາ ໄທີ 1-844-633-5325 (TTY: 711).