



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](http://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](http://HealthCare.gov/sbc-glossary) or call 844-843-3229 to request a copy.

Important Questions	Answers	Why This Matters:												
What is the overall <a href="#">deductible</a> ?	<table border="1"> <tr> <td>INN</td> <td>Tier 1</td> <td>Tier 2</td> <td>Tier 3</td> </tr> <tr> <td>EE</td> <td>\$1,750</td> <td>\$3,500</td> <td>\$7,000</td> </tr> <tr> <td>EF</td> <td>\$3,500</td> <td>\$7,000</td> <td>\$14,000</td> </tr> </table>	INN	Tier 1	Tier 2	Tier 3	EE	\$1,750	\$3,500	\$7,000	EF	\$3,500	\$7,000	\$14,000	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , the overall family deductible must be met before the plan begins to pay.
INN	Tier 1	Tier 2	Tier 3											
EE	\$1,750	\$3,500	\$7,000											
EF	\$3,500	\$7,000	\$14,000											
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> and ACA preventive drugs are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="http://HealthCare.gov/coverage/preventive-care-benefits">HealthCare.gov/coverage/preventive-care-benefits</a> .												
Are there other <a href="#">deductibles</a> for specific services?	No	You don't have to meet <a href="#">deductibles</a> for specific services.												
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<table border="1"> <tr> <td>INN</td> <td>Tier 1</td> <td>Tier 2</td> <td>Tier 3</td> </tr> <tr> <td>EE</td> <td>\$4,500</td> <td>\$7,000</td> <td>Unlimited</td> </tr> <tr> <td>EF</td> <td>\$9,000</td> <td>\$14,000</td> <td>Unlimited</td> </tr> </table>	INN	Tier 1	Tier 2	Tier 3	EE	\$4,500	\$7,000	Unlimited	EF	\$9,000	\$14,000	Unlimited	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
INN	Tier 1	Tier 2	Tier 3											
EE	\$4,500	\$7,000	Unlimited											
EF	\$9,000	\$14,000	Unlimited											
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums, balance billing charge, Tier 3 - out of network expenses, services for which you failed to obtain required pre-authorization</a> , and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .												
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://BSWHealthPlan.com/BSWH">BSWHealthPlan.com/BSWH</a> or call 844-843-3229 for a list of <a href="#">network providers</a> .	You pay the least if you use a <a href="#">provider</a> in Tier 1. You pay more if you use a <a href="#">provider</a> in Tier 2. You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.												
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .												



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
		Tier 1 Participating Provider (You will pay the least)	Tier 2 Participating Provider (You will pay more)	Tier 3 Non-Participating Provider (You will pay the most)	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	80% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	80% <a href="#">coinsurance</a>	
	<a href="#">Preventive care/screening/immunization</a>	No charge, <a href="#">deductible</a> does not apply	No charge, <a href="#">deductible</a> does not apply	Not covered	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (X-ray, blood work)	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	80% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	80% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , <a href="#">benefits</a> will be denied. Refer to <a href="#">BSWHealthPlan.com/BSWH</a> or call 844-843-3229.
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug</a>	Affordable Care Act (ACA) preventive drugs	No charge, <a href="#">deductible</a> does not apply	No charge, <a href="#">deductible</a> does not apply	Not covered	ACA Preventive Drugs based on Health Care Reform regulations.
	Chronic and preventive drugs	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Not covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Participating Provider (You will pay the least)	Tier 2 Participating Provider (You will pay more)	Tier 3 Non-Participating Provider (You will pay the most)	
<a href="http://joinrightway.com/bswh">coverage</a> is available at <a href="http://joinrightway.com/bswh">joinrightway.com/bswh</a> .	Tier 1: Preferred generic drugs	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Not covered	<p>90-day supply is available if a maintenance drug is obtained through a Baylor Scott &amp; White pharmacy OR when using the mail order prescription service.</p> <p>You have access to Baylor Scott &amp; White Pharmacies and Contracted Pharmacies, such as CVS, Kroger, Walgreens, Wal-Mart and more.</p>
	Tier 2: Preferred brand name drugs	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Not covered	<p>If the member or provider requests a brand name drug when a generic equivalent is available, the member is responsible for the non-preferred <a href="#">copayment</a> 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 <a href="#">deductible</a>, medical <a href="#">deductible</a>, pharmacy <a href="#">deductible</a>, or maximum out-of-pocket for the plan.</p>
	Tier 3: Non-preferred generic drugs and non-preferred brand name drugs	10% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	Not covered	<p>Some drugs require <a href="#">preauthorization</a>, including drugs not on the plan's formulary and compounds costing greater than \$100. Failure to obtain <a href="#">preauthorization</a> will result in a denial of benefits.</p>

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Participating Provider (You will pay the least)	Tier 2 Participating Provider (You will pay more)	Tier 3 Non-Participating Provider (You will pay the most)	
	Tier 4: <a href="#">Specialty drugs</a>	10% <a href="#">coinsurance</a>	Not covered	Not covered	Limited to a 30-day supply available through Baylor Scott & White pharmacies.  Specialty drugs may require preauthorization. Failure to obtain preauthorization will result in a denial of benefits.  <a href="#">Specialty drugs</a> covered under medical: You pay 10% after <a href="#">deductible</a> for Tier 1 and Tier 2 participating <a href="#">providers</a> , and 80% after <a href="#">deductible</a> for Tier 3 non-participating providers.
	Fertility drugs	20% <a href="#">coinsurance</a> with \$400 maximum <a href="#">copayment</a>		Not covered	<a href="#">Limited to 30-day supply.</a>  Fertility drugs are covered at Baylor Scott & White and Contracted Pharmacies. You pay 20% <a href="#">coinsurance</a> with a maximum \$400 <a href="#">copayment</a> . The lifetime maximum pharmacy benefit is \$7,500.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	80% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization, benefits</a> will be denied. Refer to <a href="#">BSWHealthPlan.com/BSWH</a> or call 844-843-3229.
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	80% <a href="#">coinsurance</a>	
If you need immediate medical attention	<a href="#">Emergency room care</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	Non-emergency care in an emergency room is not covered.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Participating Provider (You will pay the least)	Tier 2 Participating Provider (You will pay more)	Tier 3 Non-Participating Provider (You will pay the most)	
	<a href="#">Emergency medical transportation</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	Emergency transportation includes ground and air ambulance.
	<a href="#">Urgent care</a>	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	80% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization, benefits</a> will be denied. Refer to <a href="http://BSWHealthPlan.com/BSWH">BSWHealthPlan.com/BSWH</a> or call 844-843-3229.
	Physician/surgeon fees	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	80% <a href="#">coinsurance</a>	
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	80% <a href="#">coinsurance</a>	Admissions to behavioral health/substance abuse residential, partial hospitalization, and day programs require preauthorization. If you don't get <a href="#">preauthorization, benefits</a> will be denied. Refer to <a href="http://BSWHealthPlan.com/BSWH">BSWHealthPlan.com/BSWH</a> or call 844-843-3229.
	Inpatient services	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	80% <a href="#">coinsurance</a>	
<b>If you are pregnant</b>	Office visits	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	80% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, a <a href="#">copayment</a> , <a href="#">coinsurance</a> , or <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	80% <a href="#">coinsurance</a>	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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Participating Provider (You will pay the least)	Tier 2 Participating Provider (You will pay more)	Tier 3 Non-Participating Provider (You will pay the most)	
					hours following an uncomplicated delivery by caesarean section. Notification is required. If you don't notify, <a href="#">benefits</a> will be denied. Refer to <a href="http://BSWHealthPlan.com/BSWH">BSWHealthPlan.com/BSWH</a> or call 844-843-3229.
	Childbirth/delivery facility services	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	80% <a href="#">coinsurance</a>	Notification is required. If you don't notify, <a href="#">benefits</a> will be denied. Refer to <a href="http://BSWHealthPlan.com/BSWH">BSWHealthPlan.com/BSWH</a> or call 844-843-3229.
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	80% <a href="#">coinsurance</a>	Limited to 120 visits per calendar year. <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , <a href="#">benefits</a> will be denied. Refer to <a href="http://BSWHealthPlan.com/BSWH">BSWHealthPlan.com/BSWH</a> or call 844-843-3229.
	<a href="#">Rehabilitation services</a>	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	80% <a href="#">coinsurance</a>	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.
	<a href="#">Habilitation services</a>	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	80% <a href="#">coinsurance</a>	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.
	<a href="#">Skilled nursing care</a>	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	80% <a href="#">coinsurance</a>	Limited to 120 days per <a href="#">calendar</a> year. <a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization</a> , <a href="#">benefits</a> will be denied. Refer to <a href="http://BSWHealthPlan.com/BSWH">BSWHealthPlan.com/BSWH</a> or call 844-

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Participating Provider (You will pay the least)	Tier 2 Participating Provider (You will pay more)	Tier 3 Non-Participating Provider (You will pay the most)	
					843-3229.
	<a href="#">Durable medical equipment</a>	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	80% <a href="#">coinsurance</a>	<a href="#">Preauthorization</a> is required. If you don't get <a href="#">preauthorization, benefits</a> will be denied. Refer to <a href="#">BSWHealthPlan.com/BSWH</a> or call 844-843-3229.
	<a href="#">Hospice services</a>	10% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	80% <a href="#">coinsurance</a>	Notification is required. If you don't notify, <a href="#">benefits</a> will be denied. Refer to <a href="#">BSWHealthPlan.com/BSWH</a> or call 844-843-3229.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	Not covered	None
	Children's dental check-up	Not covered	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](#).)**

- |                                                                                                               |                                                                                                                                  |                                                                                                                                                     |
|---------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental care (Adult and Child)</li> </ul> | <ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>• Routine eye care (Adult and Child)</li> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul> |
|---------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------|

**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 (Tier 1 and Tier 2 only; 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](https://adminservices.optumhealthfinancial.com), or call 855-409-7029; Department of Labor Employee Benefits Security Administration, visit [dol.gov/ebsa/healthreform](https://dol.gov/ebsa/healthreform), or call 1-866-444-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](https://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](https://BSWHealthPlan.com) or call 1-844-843-3229; Department of Labor Employee Benefits Security Administration, visit [dol.gov/ebsa/healthreform](https://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](#) \$1,750
- [Specialist coinsurance](#) 10%
- 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,750
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,100
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,910</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$1,750
- [Specialist coinsurance](#) 10%
- 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,750
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,170</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$1,750
- [Specialist coinsurance](#) 10%
- 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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,750
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,850</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

# Nondiscrimination Notice



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](mailto: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>.

**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:**

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

**Urdu:**

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

**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 हैं। 1-844-633-5325 (TTY: 711) पर कॉल करें।

**Persian:**

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

**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: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສຍຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-844-633-5325 (TTY:711).