**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 BSWHealthPlan.com. 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 | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | $500 per member / $1,000 per family for a participating provider and $1,000 per member / $2,000 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 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 https://www.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?** | $3,500 per member / $7,000 per family for a participating provider and $7,000 per member / $14,000 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. |
| **Will you pay less if you use a network provider?** | Yes. See https://www.bswhealthplan.com/Pages/Provider.aspx or call 844-633-5325 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 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** | No | You can see the specialist you choose without a referral. |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **see a specialist?** | | |

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 | Adult: $25 copayment per visit<br>Pediatric: $25 copayment per visit | 50% after deductible | None |
| | Specialist visit | $25 copayment per visit | 50% after deductible | |
| | Preventive care/screening/ immunization | No charge | 50% after deductible<br>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) | 20% after deductible | 50% after deductible | None |

| 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) | |
| | Imaging (CT/PET scans, MRIs) | $25 | 50% 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** More information about **prescription drug coverage** is available at BSWHealthPlan.com/Group/Pages/Pharmacy | Affordable Care Act (ACA) preventive drugs | No charge | 50% after deductible | Copayments are per 34-day supply. Two copayments apply for a 90-day supply if a maintenance drug is obtained through a Baylor Scott & White pharmacy OR when using the mail order prescription service. Specific preventative medications will be covered with no cost to the member. Non-formulary drugs: 50% of charges; out-of-network: 50% after deductible.<br><br>Non-formulary specialty drugs: 50% after deductible. |
| | Preferred generic drugs | $10 copayment per prescription, deductible does not apply | 50% after deductible | |
| | Preferred brand drugs | $30 copayment per prescription, deductible does not apply | 50% after deductible | |
| | Non-preferred generic drugs and non-preferred brand drugs | $50 copayment per prescription, deductible does not apply | 50% after deductible | |
| | Specialty drugs and oral anticancer medications | Tier 1: 10% after deductible<br>Tier 2: 20% after deductible<br>Tier 3: 30% after deductible | 50% after deductible | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% after deductible | 50% after deductible | Failure to obtain preauthorization of benefits, other than emergency care, will result in a penalty of the lesser of $500 or 50%. |
| | Physician/surgeon fees | 20% after deductible | 50% after deductible | |
| **If you need immediate medical attention** | Emergency room care | 20% after deductible | 20% after deductible | Emergency room copayment waived if episode results in hospitalization for the same condition within 24 hours. |

| 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) | |
| | Emergency medical transportation | 20% after deductible | 20% after deductible | None |
| | Urgent care | 20% after deductible | 20% after deductible | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% after deductible | 50% after deductible | Failure to obtain preauthorization of benefits, other than emergency care, will result in a penalty of the lesser of $500 or 50%. |
| | Physician/surgeon fees | 20% after deductible | 50% after deductible | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | Not covered | Not covered | None |
| | Inpatient services | Not covered | Not covered | None |
| **If you are pregnant** | Office visits | Not covered | Not covered | None |

| 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) | |
| | Childbirth/delivery professional services | Not covered | Not covered | None |
| | Childbirth/delivery facility services | Not covered | Not covered | |
| **If you need help recovering or have other special health needs** | Home health care | 20% after deductible | 50% after deductible | Failure to obtain preauthorization of benefits, other than emergency care, will result in a penalty of the lesser of $500 or 50%. |
| | Rehabilitation services | 20% after deductible | 50% after deductible | Failure to obtain preauthorization of benefits, other than emergency care, will result in a penalty of the lesser of $500 or 50%. |
| | Habilitation services | 20% after deductible | 50% after deductible | |
| | Skilled nursing care | 20% after deductible | 50% after deductible | Failure to obtain preauthorization of benefits, other than emergency care, will result in a penalty of the lesser of $500 or 50%. |
| | Durable medical equipment | 20% after deductible | 50% after deductible | Failure to obtain preauthorization of benefits, other than emergency care, will result in a penalty of the lesser of $500 or 50%. |
| | Hospice services | 20% after deductible | 50% after deductible | None |
| **If your child needs dental or eye care** | Children's eye exam | 20% after deductible | 50% after deductible | Limited to one eye exam per plan year. |

| 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) | |
| | 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.)**

- Acupuncture
- Bariatric surgery
- Chiropractic care
- 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)
- 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.)**

- 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

**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; Texas Department of Insurance at 800-578-4677 or tdi.texas.gov, Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or www.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 www.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 www.dol.gov/ebsa/healthreform; Texas Department of Insurance at 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:**

Spanish (Español): Para obtener asistencia en Español, llame al 844-633-5325.

*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** **$500**
- **Specialist copayment** **Not covered**
- **Hospital (facility)** **Not covered**
- **Other coinsurance** **Not covered**

**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 | N/A |
| Copayments | N/A |
| Coinsurance | N/A |
| *What isn't covered* | |
| Limits or exclusions | N/A |
| **The total Peg would pay is** | **$12,700** |

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

- **The plan's overall deductible** **$500**
- **Specialist copayment** **$25**
- **Hospital (facility)** **20% after deductible**
- **Other coinsurance** **20% after deductible**

**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 | $500 |
| Copayments | $1,000 |
| Coinsurance | $300 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,820** |

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

- **The plan's overall deductible** **$500**
- **Specialist copayment** **$25**
- **Hospital (facility)** **20% after deductible**
- **Other coinsurance** **20% after deductible**

**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 | $500 |
| Copayments | $100 |
| Coinsurance | $300 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$900** |

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