




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 844-843-3229 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	<p><a href="#">In-network</a>: \$350 Employee Only (EE) / \$700 Employee &amp; Family (ES, EC, EF)</p> <p><a href="#">Out-of-network</a>: <a href="#">not covered</a></p>	<p>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>, each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a>.</p>
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	<p>Yes. <a href="#">Preventive care</a>, office visits, diagnostic X-ray, diagnostic lab, advanced imaging, emergency room, ambulance, maternity care, prescription and ACA preventive drugs are covered before you meet your <a href="#">deductible</a>.</p>	<p>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>.</p>
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	<p>No</p>	<p>You don't have to meet <a href="#">deductibles</a> for specific services.</p>
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	<p>\$4,000 Employee Only (EE) / \$8,000 Employee &amp; Family (ES, EC, EF)</p>	<p>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.</p>
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<p><a href="#">Premiums</a>, <a href="#">balance billing charges</a>, <a href="#">out-of-network expenses</a>, <a href="#">services for which you failed to obtain required preauthorization</a>, and health care this <a href="#">plan</a> doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>

Important Questions	Answers	Why This Matters:
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> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . 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
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care <a href="#">provider's office or clinic</a>	Primary care visit to treat an injury or illness	\$25 <a href="#">copayment</a> per visit, <a href="#">deductible</a> does not apply	Not covered	None
	<a href="#">Specialist</a> visit	\$40 <a href="#">copayment</a> per visit, <a href="#">deductible</a> does not apply	Not covered	
	<a href="#">Preventive care/screening/immunization</a>	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)	X-ray: \$75 <a href="#">copayment</a> per visit Labs: 20% <a href="#">coinsurance</a> per visit, <a href="#">deductible</a> does not apply	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)	
	Imaging (CT/PET scans, MRIs)	\$100 <a href="#">copayment</a> per visit for PET, CT, CAT \$150 <a href="#">copayment</a> per visit for MRI, MRA <a href="#">Deductible</a> does not apply	Not covered	<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.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://joinrightway.com/bswh">joinrightway.com/bswh</a> .	Affordable Care Act (ACA) preventive drugs	No charge, <a href="#">deductible</a> does not apply	Not covered	ACA Preventive Drugs based on Health Care Reform regulations.
	Chronic and preventive drugs	<b>BSW Pharmacy:</b> \$10 <a href="#">copayment</a> per prescription per 30-day supply (retail) \$20 <a href="#">copayment</a> per prescription per 90-day supply (maintenance) \$0 diabetic treatment, <a href="#">deductible</a> does not apply <b>Contracted Pharmacy:</b> \$20 <a href="#">copayment</a> per prescription per 30-day supply (retail) \$0 diabetic treatment, <a href="#">deductible</a> does not apply	Not covered	90-day supply is available if a maintenance drug is obtained through a Baylor Scott & White pharmacy OR when using the mail order prescription service.  You have access to Baylor Scott & White Pharmacies and Contracted Pharmacies, such as CVS, Kroger, Walgreens, Wal-Mart and more.  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.
	Tier 1: Preferred generic drugs	<b>BSW Pharmacy:</b> \$5 <a href="#">copayment</a> per prescription per 30-day supply (retail) \$10 <a href="#">copayment</a> per prescription per 90-day supply (maintenance), <a href="#">deductible</a> does not apply <b>Contracted Pharmacy:</b> \$12 <a href="#">copayment</a> per	Not covered	Some drugs require <a href="#">preauthorization</a> , including drugs not on the plan's formulary and compounds costing greater than \$100.

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)	
		prescription per 30-day supply (retail), <a href="#">deductible</a> does not apply		Failure to obtain <a href="#">preauthorization</a> will result in a denial of benefits.
	Tier 2: Preferred brand name drugs	<u>BSW Pharmacy:</u> \$25 <a href="#">copayment</a> per prescription per 30-day supply (retail) \$50 <a href="#">copayment</a> per prescription per 90-day supply (maintenance), <a href="#">deductible</a> does not apply <u>Contracted Pharmacy:</u> \$50 <a href="#">copayment</a> per prescription per 30-day supply (retail), <a href="#">deductible</a> does not apply	Not covered	
	Tier 3: Non-preferred generic drugs and non-preferred brand name drugs	<u>BSW Pharmacy:</u> lesser of \$50 <a href="#">copayment</a> or 50% <a href="#">coinsurance</a> per prescription per 30-day supply (retail), lesser of \$100 or 50% <a href="#">coinsurance</a> per prescription per 90-day supply (maintenance), <a href="#">deductible</a> does not apply <u>Contracted Pharmacy:</u> Lesser of \$75 <a href="#">copayment</a> or 50% <a href="#">coinsurance</a> per prescription per 30-day supply, <a href="#">deductible</a> does not apply	Not covered	

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)	
	Tier 4: <a href="#">Specialty drugs</a>	BSW Pharmacy: \$100 <a href="#">copayment</a> per 30-day supply per prescription, <a href="#">deductible</a> does not apply <u>Contracted Pharmacy</u> : not covered	Not covered	Limited to a 30-day supply and only available through Baylor Scott & White pharmacies.  Specialty drugs may require preauthorization. Failure to obtain preauthorization will result in a denial of benefits.  Specialty drugs coverage under medical: You pay \$100 <a href="#">copayment</a> .
	Fertility drugs	20% <a href="#">coinsurance</a> with \$400 maximum <a href="#">copayment</a> , <a href="#">deductible</a> does not apply	Not covered	Limited to 30-day supply.  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.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% <a href="#">coinsurance</a>	Not covered	<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>	Not covered	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$500 <a href="#">copayment</a> , <a href="#">deductible</a> does not apply	\$500 <a href="#">copayment</a> , <a href="#">deductible</a> does not apply	Emergency room <a href="#">copayment</a> waived if episode results in <a href="#">hospitalization</a> for the same condition within 24 hours.  Non-emergency care in an emergency room is not covered.
	<a href="#">Emergency medical transportation</a>	\$250 <a href="#">copayment</a> per visit, <a href="#">deductible</a> does not apply	\$250 <a href="#">copayment</a> per visit, <a href="#">deductible</a> does not apply	Emergency transportation includes ground and air ambulance.

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)	
	<a href="#">Urgent care</a>	\$25 <a href="#">copayment</a> per visit, <a href="#">deductible</a> does not apply	\$25 <a href="#">copayment</a> per visit, <a href="#">deductible</a> does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <a href="#">coinsurance</a>	Not covered	<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>	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <a href="#">copayment</a> per visit, <a href="#">deductible</a> does not apply 10% <a href="#">coinsurance</a> for other outpatient services	Not covered	Admissions to behavioral health/substance abuse residential, partial hospitalization, and day programs require preauthorization. If you don't get <a href="#">preauthorization</a> , benefits will be denied. Refer to <a href="#">BSWHealthPlan.com/BSWH</a> or call 844-843-3229.
	Inpatient services	10% <a href="#">coinsurance</a>	Not covered	
If you are pregnant	Office visits	PCP: \$25 <a href="#">copayment</a> per visit Specialist: \$40 <a href="#">copayment</a> per visit, <a href="#">deductible</a> does not apply	Not covered	<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	0% after applicable <a href="#">copayment</a> if newborn is added to coverage, <a href="#">deductible</a> does not apply	Not covered	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. 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.

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)	
				<a href="#">Copayment</a> applies to facility charges. All other services billed with a maternity/delivery diagnosis code (e.g., anesthesia, OBGYN, pathology, etc.) are covered at 100% including well-baby charges, if newborn is added for coverage. 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	\$400 <a href="#">copayment</a> , <a href="#">deductible</a> does not apply	Not covered	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>	Not covered	Limited to 120 visits per calendar year. Preauthorization 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>	\$40 <a href="#">copayment</a> per visit, <a href="#">deductible</a> does not apply	Not covered	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>	\$25 <a href="#">copayment</a> per visit, <a href="#">deductible</a> does not apply	Not covered	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>	Not covered	Limited to 120 days 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

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)	
				844-843-3229.
	<a href="#">Durable medical equipment</a>	10% <a href="#">coinsurance</a>	Not covered	<a href="#">Preauthorization</a> is required for specified durable medical equipment. 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>	Not covered	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	None
	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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<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 <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>• Acupuncture (20 visit limit per calendar year)</li> <li>• Bariatric surgery (one morbid obesity surgery per lifetime)</li> <li>• Chiropractic care (20 visit limit per calendar year)</li> </ul>	<ul style="list-style-type: none"> <li>• Hearing aids (Limited to one device every 36 months)</li> <li>• Infertility treatment (Limited to \$7,500 medical and \$7,500 pharmacy lifetime max)</li> </ul>	<ul style="list-style-type: none"> <li>• Private-duty nursing (120 visit limit per calendar year)</li> </ul>



**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](#) \$350
- [Specialist copayment](#) \$40
- Hospital (facility) copayment \$400
- 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:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$400
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$460</b>

### Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$350
- [Specialist copayment](#) \$40
- 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:

Cost Sharing	
<a href="#">Deductibles</a>	\$350
<a href="#">Copayments</a>	\$700
<a href="#">Coinsurance</a>	\$70
What isn't covered	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,140</b>

### Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$350
- [Specialist copayment](#) \$40
- 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:

Cost Sharing	
<a href="#">Deductibles</a>	\$350
<a href="#">Copayments</a>	\$500
<a href="#">Coinsurance</a>	\$200
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,050</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).