



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, call 844-633-5325 or visit us at <https://www.bswhealthplan.com/Group/Pages/Default.aspx#large>. 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](https://www.healthcare.gov/sbc-glossary) or call 844-633-5325 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	\$0 per member / \$0 per family	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible ?	No	This plan does not have a deductible .
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 ?	\$3,000 per member / \$6,000 per family	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 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 see a specialist ?	No	You can see the specialist you choose without a referral .

 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: No charge for the first non-preventive sick visit in the plan year. \$15 copayment per visit for subsequent visits in that plan year. Pediatric: No charge	Not covered	None
	Specialist visit	\$15 copayment per visit	Not covered	
	Preventive care/screening/immunization	No charge	Not covered	
If you have a test	Diagnostic test (X-ray, blood work)	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	\$150 copayment per visit	Not covered	Services requiring preauthorization that are not preauthorized will be denied. Refer to BSWHealthPlan.com or call 844-633-5325.
If you need drugs to treat your illness or condition More information about prescription drug coverage	Affordable Care Act (ACA) preventive drugs	No charge	Not covered	Copayments are per 30-day supply. Maintenance drugs are allowed up to a 90-day supply for 2.5 copayments if obtained through a participating pharmacy . Mail Order: Available for a 1- to 90-day supply. Non-maintenance drugs obtained through mail order are limited to a 30-day supply maximum. Specialty drugs limited to a 30-day supply. Formulary insulin
	Low-cost generic drugs	No charge	Not covered	
	Tier 1: Preferred generic drugs	\$15 copayment per prescription	Not covered	
	Tier 2: Preferred brand name drugs	\$60 copayment per prescription	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
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is available at BSWHealthPlan.com/Group/Pages/Pharmacy	Tier 3: Non-preferred generic drugs and non-preferred brand name drugs	\$120 <u>copayment</u> per prescription	Not covered	prescriptions have a maximum <u>copayment</u> of \$25 per prescription per 30-day supply. If a brand name drug is requested when a generic equivalent is available, the member is responsible for the non-preferred <u>copayment</u> plus the difference in cost of the brand name drug and generic equivalent drug.
	Specialty drugs	Tier 1: \$200 <u>copayment</u> per prescription Tier 2: \$300 <u>copayment</u> per prescription Tier 3: 15% <u>coinsurance</u>	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$250 <u>copayment</u> per visit	Not covered	Services requiring <u>preauthorization</u> that are not <u>preauthorized</u> will be denied. Refer to BSWHealthPlan.com or call 844-633-5325.
	Physician/surgeon fees	Included in facility fee	Not covered	
If you need immediate medical attention	Emergency room care	\$250 <u>copayment</u> per visit	\$250 <u>copayment</u> per visit	Emergency room <u>copayment</u> waived if episode results in <u>hospitalization</u> for the same condition within 24 hours.
	Emergency medical transportation	\$250 <u>copayment</u> per service	\$250 <u>copayment</u> per service	None
	Urgent care	\$50 <u>copayment</u> per visit	\$50 <u>copayment</u> per visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 <u>copayment</u> per day (not to exceed \$1,250)	Not covered	Services requiring <u>preauthorization</u> that are not <u>preauthorized</u> will be denied. Refer to BSWHealthPlan.com or call 844-633-5325.
	Physician/surgeon fees	\$250 <u>copayment</u> per day (not to exceed \$1,250)	Not covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Adult: \$15 <u>copayment</u> per visit Pediatric: No charge	Not covered	Services requiring <u>preauthorization</u> that are not <u>preauthorized</u> will be denied. Refer to BSWHealthPlan.com or call 844-633-5325.
	Inpatient services	\$250 <u>copayment</u> per day (not to exceed \$1,250)	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)	
If you are pregnant	Office visits	\$15 <u>copayment</u> per visit	Not covered	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	\$250 <u>copayment</u> per day (not to exceed \$1,250)	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.
	Childbirth/delivery facility services	\$250 <u>copayment</u> per day (not to exceed \$1,250)	Not covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	\$15 <u>copayment</u> per visit	Not covered	Services requiring <u>preauthorization</u> that are not <u>preauthorized</u> will be denied. Refer to BSWHealthPlan.com or call 844-633-5325.
	<u>Rehabilitation services</u>	\$15 <u>copayment</u> per visit	Not covered	Services requiring <u>preauthorization</u> that are not <u>preauthorized</u> will be denied. Refer to BSWHealthPlan.com or call 844-633-5325.
	<u>Habilitation services</u>	\$15 <u>copayment</u> per visit	Not covered	
	<u>Skilled nursing care</u>	\$250 <u>copayment</u> per day	Not covered	Limited to 25 days per <u>plan</u> year. Services requiring <u>preauthorization</u> that are not <u>preauthorized</u> will be denied. Refer to BSWHealthPlan.com or call 844-633-5325.
	<u>Durable medical equipment</u>	50% <u>coinsurance</u>	Not covered	Services requiring <u>preauthorization</u> that are not <u>preauthorized</u> will be denied. Refer to BSWHealthPlan.com or call 844-633-5325.
	<u>Hospice services</u>	No charge	Not covered	
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 [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- Acupuncture
- Infertility treatment
- Routine eye care (Adult and Child)
- Bariatric surgery
- Long-term care
- Routine foot care
- Cosmetic surgery
- Non-emergency care when traveling outside the U.S.
- Weight loss programs
- Dental care (Adult and Child)

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

- Chiropractic care
- 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 Care 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 Care 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 800-578-4677 or [TDI.texas.gov](#).

Does this [plan](#) provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this [plan](#) meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

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	\$0
■ Specialist copayment	\$15
■ Hospital (facility) copayment	\$250
■ Other coinsurance	\$250

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$300
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$360

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$0
■ Specialist copayment	\$15
■ Hospital (facility) copayment	\$250
■ Other coinsurance	\$250

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$300
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$320

Mia's Simple Fracture

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

■ The plan's overall deductible	\$0
■ Specialist copayment	\$15
■ Hospital (facility) copayment	\$250
■ Other coinsurance	\$250

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$500
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$500

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

Baylor Scott & White Care 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 Care Plan Compliance Officer at 1-214-820-8888 or send an email to HPCompliance@BSWHealth.org.

If you believe that Baylor Scott & White Care 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 Care 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 844-633-5325-1)

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).