



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://HealthCare.gov/sbc-glossary) or call 844-633-5325 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	\$3,000 per member / \$6,000 per family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> and Affordable Care Act (ACA) preventive drugs are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered preventive services at <a href="https://HealthCare.gov/coverage/preventive-care-benefits">HealthCare.gov/coverage/preventive-care-benefits</a> .
Are there other <u>deductibles</u> for specific services?	No	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$6,000 per member / \$12,000 per family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="https://www.bswhealthplan.com/Pages/Provider.aspx">https://www.bswhealthplan.com/Pages/Provider.aspx</a> or call 844-633-5325 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	Adult: No charge for the first non-preventive sick visit in the calendar year. \$25 <u>copayment</u> per visit for subsequent visits in that calendar year, <u>deductible</u> does not apply Pediatric: No charge per visit, <u>deductible</u> does not apply	Not covered	None
	<u>Specialist</u> visit	\$50 <u>copayment</u> per visit, <u>deductible</u> does not apply	Not covered	
	<u>Preventive care/screening/immunization</u>	No charge, <u>deductible</u> does not apply	Not covered	
<b>If you have a test</b>	<u>Diagnostic test</u> (X-ray, blood work)	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	20% <u>copayment</u> , <u>deductible</u> does not apply	Not covered	Services requiring <u>preauthorization</u> that are not <u>preauthorized</u> will be denied. Refer to <a href="http://BSWHealthPlan.com">BSWHealthPlan.com</a> or call 844-633-5325.
<b>If you need drugs to treat your illness or condition</b>  More information about <a href="#">prescription drug</a>	Affordable Care Act (ACA) preventive drugs	No charge, <u>deductible</u> does not apply	Not covered	<u>Copayments</u> are per 30-day supply. Maintenance drugs are allowed up to a 90-day supply for 2.5 <u>copayments</u> if obtained through a Participating pharmacy. Mail Order: Available for a 1- to 90-day supply. Non-maintenance
	Tier 1: Preferred generic drugs	No charge	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)	
<a href="#">coverage</a> is available at <a href="#">BSWHealthPlan.com/Groups/Pages/Pharmacy</a> .	Tier 2: Non-preferred generic drugs	\$10 <u>copayment</u> per prescription	Not covered	drugs obtained through mail order are limited to a 30-day supply maximum. <a href="#">Specialty drugs</a> limited to a 30-day supply. <a href="#">Formulary</a> insulin 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.
	Tier 3: Preferred brand drugs	\$50 <u>copayment</u> per prescription	Not covered	
	Tier 4: Non-preferred brand drugs	\$115 <u>copayment</u> per prescription	Not covered	
	<a href="#">Specialty drugs</a>	Tier 1: \$100 <u>copayment</u> per prescription Tier 2: \$175 <u>copayment</u> per prescription Tier 3: \$350 <u>copayment</u> per prescription	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <u>copayment</u> , after <u>deductible</u>	Not covered	Services requiring <a href="#">preauthorization</a> that are not <a href="#">preauthorized</a> will be denied. Refer to <a href="#">BSWHealthPlan.com</a> or call 844-633-5325.
	Physician/surgeon fees	20% <u>copayment</u> , after <u>deductible</u>	Not covered	
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	\$500 <u>copayment</u> per visit, plus 20% <u>copayment</u> , <u>deductible</u> does not apply	\$500 <u>copayment</u> per visit, plus 20% <u>copayment</u> , <u>deductible</u> does not apply	Emergency room <u>copayment</u> waived if episode results in <a href="#">hospitalization</a> for the same condition within 24 hours.
	<a href="#">Emergency medical transportation</a>	\$500 <u>copayment</u> per service, plus 20% <u>copayment</u> , <u>deductible</u> does not apply	\$500 <u>copayment</u> per service, plus 20% <u>copayment</u> , <u>deductible</u> does not apply	None
	<a href="#">Urgent care</a>	\$50 <u>copayment</u> per visit, <u>deductible</u> does not apply	\$50 <u>copayment</u> per visit, <u>deductible</u> does not apply	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <u>copayment</u> , after <u>deductible</u>	Not covered	Services requiring <a href="#">preauthorization</a> that are not <a href="#">preauthorized</a> will be denied. Refer to <a href="#">BSWHealthPlan.com</a> or call 844-633-5325.

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)	
	Physician/surgeon fees	20% <u>copayment</u> , after <u>deductible</u>	Not covered	<a href="http://BSWHealthPlan.com">BSWHealthPlan.com</a> or call 844-633-5325.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	Adult: \$25 <u>copayment</u> per visit, 20% <u>copayment</u> , after <u>deductible</u> for all other outpatient services Pediatric: No charge per visit, <u>deductible</u> does not apply	Not covered	Services requiring <u>preauthorization</u> that are not <u>preauthorized</u> will be denied. Refer to <a href="http://BSWHealthPlan.com">BSWHealthPlan.com</a> or call 844-633-5325.
	Inpatient services	20% <u>copayment</u> , after <u>deductible</u>	Not covered	
<b>If you are pregnant</b>	Office visits	\$25 <u>copayment</u> per visit, <u>deductible</u> does not apply	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	20% <u>copayment</u> , after <u>deductible</u>	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	20% <u>copayment</u> , after <u>deductible</u>	Not covered	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	20% <u>copayment</u> , after <u>deductible</u>	Not covered	Limited to 60 visits per calendar year. Services requiring <u>preauthorization</u> that are not <u>preauthorized</u> will be denied. Refer to <a href="http://BSWHealthPlan.com">BSWHealthPlan.com</a> or call 844-633-5325.
	<a href="#">Rehabilitation services</a>	\$25 <u>copayment</u> per visit, <u>deductible</u> does not apply	Not covered	Limited to 35 visits for <a href="#">rehabilitation services</a> and 35 visits for <a href="#">habilitation services</a> per

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="#"><u>Habilitation services</u></a>	\$25 <u>copayment</u> per visit, <u>deductible</u> does not apply	Not covered	calendar year. The limit is combined for physical therapy, occupational therapy, and speech therapy. Limits do not apply for therapies for children with developmental delays, autism spectrum disorder and mental health services. Services requiring <u>preauthorization</u> that are not <u>preauthorized</u> will be denied. Refer to <a href="http://BSWHealthPlan.com">BSWHealthPlan.com</a> or call 844-633-5325.
	<a href="#"><u>Skilled nursing care</u></a>	20% <u>copayment</u> , after <u>deductible</u>	Not covered	Limited to 25 days per calendar year. Services requiring <u>preauthorization</u> that are not <u>preauthorized</u> will be denied. Refer to <a href="http://BSWHealthPlan.com">BSWHealthPlan.com</a> or call 844-633-5325.
	<a href="#"><u>Durable medical equipment</u></a>	20% <u>copayment</u> , after <u>deductible</u>	Not covered	Services requiring <u>preauthorization</u> that are not <u>preauthorized</u> will be denied. Refer to <a href="http://BSWHealthPlan.com">BSWHealthPlan.com</a> or call 844-633-5325.
	<a href="#"><u>Hospice services</u></a>	No charge, <u>deductible</u> does not apply	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.)

- |  |   |   |
|--|---|---|
| <ul style="list-style-type: none"><li>• Acupuncture</li><li>• Bariatric surgery</li><li>• Cosmetic surgery</li><li>• Dental care (Adult and Child)</li></ul> | <ul style="list-style-type: none"><li>• Infertility treatment</li><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.)

- |  |  |  |
|--|--|--|
| <ul style="list-style-type: none"><li>• Chiropractic care (Limited to 35 visits per calendar year)</li></ul> | <ul style="list-style-type: none"><li>• Hearing aids (Limited to one device per ear every 3 years for members through the age of 18)</li></ul> | <ul style="list-style-type: none"><li>• Private duty nursing (when <u>medically necessary</u> and <u>preauthorized</u>. Limitations apply when used under <u>Home Health Care</u>)</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 Baylor Scott & White Care Plan at 844-633-5325 or [BSWHealthPlan.com](http://BSWHealthPlan.com); Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or [DOL.gov/ebsa/healthreform](http://DOL.gov/ebsa/healthreform). Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](http://HealthInsuranceMarketplace.gov). For more information about the [Marketplace](http://Marketplace.gov), visit [HealthCare.gov](http://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](http://BSWHealthPlan.com); Department of Labor's Employee Benefits Security Administration at 866-444-EBSA (3272) or [DOL.gov/ebsa/healthreform](http://DOL.gov/ebsa/healthreform); Texas Department of Insurance at 800-578-4677 or [TDI.texas.gov](http://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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,000
■ <a href="#">Specialist copayment</a>	\$50
■ Hospital (facility) <a href="#">copayment</a>	20%
■ Other <a href="#">coinsurance</a>	20%

**This EXAMPLE event includes services like:**  
[Specialist](#) office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

**Total Example Cost** **\$12,700**

**In this example, Peg would pay:**

Cost Sharing	
<a href="#">Deductibles</a>	\$3,000
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,900

*What isn't covered*

Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,960</b>

### Managing Joe's Type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,000
■ <a href="#">Specialist copayment</a>	\$50
■ Hospital (facility) <a href="#">copayment</a>	20%
■ Other <a href="#">coinsurance</a>	20%

**This EXAMPLE event includes services like:**  
[Primary care physician](#) office visits (*including disease education*)  
[Diagnostic tests](#) (*blood work*)  
[Prescription drugs](#)  
[Durable medical equipment](#) (*glucose meter*)

**Total Example Cost** **\$5,600**

**In this example, Joe would pay:**

Cost Sharing	
<a href="#">Deductibles</a>	\$900
<a href="#">Copayments</a>	\$700
<a href="#">Coinsurance</a>	\$0

*What isn't covered*

Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,620</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,000
■ <a href="#">Specialist copayment</a>	\$50
■ Hospital (facility) <a href="#">copayment</a>	20%
■ Other <a href="#">coinsurance</a>	20%

**This EXAMPLE event includes services like:**  
[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*X-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

**Total Example Cost** **\$2,800**

**In this example, Mia would pay:**

Cost Sharing	
<a href="#">Deductibles</a>	\$2,100
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$0

*What isn't covered*

Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,400</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 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](mailto: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>.

