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, visit https://trs.swhp.org/, or call 1-800-321-7947. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary at www.cciio.cms.gov.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network Provider: $1,000 individual / $3,000 family	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?	Preventive care and primary care services are covered before you meet your deductible.	This plan covers some items and services even if you have not 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?	Yes. $150 Pharmacy deductible (generics excluded).	You have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network Provider: $7,000 per individual / $14,000 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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Copayments on certain services, premiums, balance-billing charges, and health care this plan does not 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 trs.swhp.org or call 1-800-321-7947 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
		Network Provider (You will pay the least)	Out-of-Network 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	$15 copay per visit; first visit covered at $0 copay. Deductible does not apply	Not Covered	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.
	Specialist visit	$70 copay per visit; deductible does not apply	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)	20% after deductible	Not Covered	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://trs.swhp.org/benefits.	Preferred generic drugs	$5 copay per 30 day supply / retail $12.50 copay per 90-day supply / maintenance. deductible does not apply	$5 copay per 30 day supply / retail $12.50 copay per 90-day supply / maintenance. deductible does not apply	Copays are per 30-day supply. *2.5* copays 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.
	Preferred brand drugs	30% after pharmacy deductible	30% after pharmacy deductible	
	Non-preferred generic drugs and non-preferred brand drugs	50% after pharmacy deductible	50% after pharmacy deductible	
	Specialty drugs	Tier 1: 15% after pharmacy deductible Tier 2: 15% after pharmacy deductible Tier 3: 25% after pharmacy deductible	Tier 1: 15% after pharmacy deductible Tier 2: 15% after pharmacy deductible Tier 3: 25% after pharmacy deductible	Some drugs may require prior authorization. 30-day supply only.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$150 copay, plus 20% after deductible	Not Covered	None
	Physician/surgeon fees	20% after deductible	Not Covered	
If you need immediate medical attention	Emergency room care	$250 copay, plus 20% after deductible	$250 copay, plus 20% after deductible	$250 copay waived if admitted

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Emergency medical transportation	$40 copay, plus 20% after deductible	$40 copay, plus 20% after deductible	$40 copay waived if transported
	Urgent care	$50 copay per visit; deductible does not apply	$50 copay per visit; deductible does not apply	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$150 per day copay*, plus 20% after deductible	Not Covered	*$750 maximum copayment per admission, then 20% applies. For prior authorization requirements and penalties see https://trs.swhp.org/tools-and-resources. Failure to obtain Prior Authorization will result in the lesser of $500 or 50% reduction in benefits, or denial in the case of Health Care Services, other than Emergency Care, provided by an In-Network Provider.
	Physician/surgeon fees	20% after deductible	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$15 copay per visit; deductible does not apply	Not Covered	None
	Inpatient services	$150 per day copay*, plus 20% after deductible	Not Covered	*$750 maximum copayment per admission, then 20% applies. Requires referral and pre-authorization
If you are pregnant	Office visits	$70 copay per visit; deductible does not apply	Not Covered	No charge for prenatal visits; postnatal visits are covered at the specialist copay. Depending on the type of services, a copayment, coinsurance, or deductible may apply.
	Childbirth/delivery professional services	$150 per day copay*, plus 20% after deductible	Not Covered	*$750 maximum copayment per admission, then 20% applies. Requires referral and pre-authorization
	Childbirth/delivery facility services	$150 per day copay*, plus 20% after deductible	Not Covered	*$750 maximum copayment per admission, then 20% applies. Requires referral and pre-authorization
If you need help recovering or have	Home health care	$70 copay per visit; deductible does not apply	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
other special health needs	Rehabilitation services	$70 copay per visit; deductible does not apply	Not Covered	None
	Habilitation services	$70 copay per visit	Not Covered	None
	Skilled nursing care	$150 per day copay*, plus 20% after deductible	Not Covered	*$750 maximum copayment per admission, then 20% applies. Requires referral and pre-authorization
	Durable medical equipment	20% after deductible	Not Covered	None
	Hospice services	No Charge	Not Covered	None
If your child needs dental or eye care	Children's eye exam	No Charge	Not Covered	One exam limit per year. Adult eye exams covered at $0 copay.
	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
- Cosmetic surgery
- Dental care (Child and Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside U.S.
- Private-duty nursing
- 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 per ear every three years for covered members 18 years of age or younger)
- Manipulative therapy (limited to 35 visits per Calendar year)
- Routine eye care (Adult) (limited to annual eye exam conducted by a licensed ophthalmologist or optometrist)

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: Scott and White Health Plan, visit https://trs.swhp.org/ , or call 1-800-321-7947; Department of Labor Employee Benefits Security Administration, visit http://www.dol.gov/ebsa/healthreform , or call1-866-444-EBSA (3272); Department of Health and Human Services, Center for Consumer Information, visit http://www.cciio.com.gov, or call 1-877-267-2323 x61565; Texas Department of Insurance, visit http://www.tdi.texas.gov, or call1-800-578-4677. 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 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 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: Scott and White Health Plan, visit https://trs.swhp.org/ , or call 1-800-321-7947; Department of Labor Employee Benefits Security Administration, visit http://www.dol.gov/ebsa/healthreform , or call 1-866-444-EBSA (3272); Texas Department of Insurance, visit http://www.tdi.texas.gov , or call 1-800-252-3439.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-800-321-7947.

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	$1,000
Specialist copayment	$70
Hospital (facility) coinsurance	$150 + 20%
Other coinsurance	20%

This EXAMPLE event includes services like:

Sample Care Costs
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	$12,731

In this example, Peg would pay:

Cost Sharing	
Deductibles	$100
Copayments	$1,400
Coinsurance	$30
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$1,600

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

The plan's overall deductible	$1,000
Specialist copayment	$70
Hospital (facility) coinsurance	$150 + 20%
Other coinsurance	20%

This EXAMPLE event includes services like:

Sample Care Costs
Primary care physician office visits (including disease education)
Diagnostic tests (blood work)
Prescription drugs
Durable medical equipment (glucose meter)

Total Example Cost	$7,389

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$400
Coinsurance	$1,400
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$2,900

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

The plan's overall deductible	$1,000
Specialist copayment	$70
Hospital (facility) coinsurance	$150 + 20%
Other coinsurance	20%

This EXAMPLE event includes services like:

Sample Care Costs
Emergency room care (including medical supplies)
Diagnostic test (x-ray)
Durable medical equipment (crutches)
Rehabilitation services (physical therapy)

Total Example Cost	$1,925

In this example, Mia would pay:

Cost Sharing	
Deductibles	$80
Copayments	$1,400
Coinsurance	$20
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,500

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

English:

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-321-7947 (TTY: 1-800-735-2989). 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.

Spanish:

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-321-7947 (TTY: 1-800-735-2989). Scott & White Health Plan
Health Plan
& White Health Plan cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

Vietnamese:

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800 321-7947 (TTY: 1-800-735-2989). Scott & White Health Plan tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.

Chinese:

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-321-7947 (TTY：1-800-735-2989）。Scott & White Health Plan 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。

Korean:

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-321-7947 (TTY: 1-800-735-2989) 번으로 전화해 주십시오. Scott & White Health Plan 은(는) 관련 연방 공민권법을 준수하며 인종, 피부색, 출신 국가, 연령, 장애 또는 성별을 이유로 차별하지 않습니다.

Arabic:

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-321-7947 (رقم
هاتف الصم والبكم: 1-800-735-2989).
يلتزم Scott & White Health Plan بقوانين الحقوق المدنية الفدرالية المعمول بها ولا يميز على أساس العرق أو اللون أو
الأصل الوطني أو السن أو الإعاقة أو الجنس.

Urdu:

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-800-321-7947 (TTY: 1-800-735-2989).

Scott & White Health Plan قابل ِ طلاق وفاقی شہری حقوق کے قوانین کی تعمیل کرتا ہے

اور نسل، رنگ ، قومیت، عمر، معذوری یا جنس کی بنیاد پر امتیاز نہیں کرتا۔

Tagalog:

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-3217947 (TTY: 1-800-735-2989). Sumusunod ang Scott & White Health Plan sa mga naaangkop na Pederal na batas sa karapatang sibil at hindi nandidiskrimina batay sa lahi, kulay, bansang pinagmulan, edad, kapansanan o kasarian.

French:

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-321-7947 (ATS: 1-800-7352989). Scott & White Health Plan respecte les lois fédérales en vigueur relatives aux droits civiques et ne pratique aucune discrimination basée sur la race, la couleur de peau, l'origine nationale, l'âge, le sexe ou un handicap.

Hindi:

यान द : ियद आप िहद ी बोलते ह तो आपके िलए मु त म भाषा सहायता सेवाएं उपल ध ह। 1-800-321-7947 (TTY: 1-800-735-2989) पर कॉल कर। Scott & White Health Plan लाग

होनेयो य संघीय नागरक िअधकार क़ानन का पालन करता हऔर जाित, रंग, रा ीय मल, आय, िवकलांग ता, या िलंग के आधार पर भेदभाव नह करता ह।

Persian:

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-735-2989) (TTY: 1-800-321-7947 تماس بگیرید. Scott & White Health Plan از قوانین حقوق مدنی فدرال مربوطه تبعیت می کند و به تبعیض بر اساس نژاد، رنگ پوست، اصلیت ملی، سن، ناتوانی یا جنسیت قائل نمی شود.

German:

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-321-7947 (TTY: 1-800-735-2989). Scott & White Health Plan erfüllt geltenden bundesstaatliche Menschenrechtsgesetze und lehnt jegliche Diskriminierung aufgrund von Rasse, Hautfarbe, Herkunft, Alter, Behinderung oder Geschlecht ab.

Gujarati:

સાવધાન: જો તમે ગુજરાતી બોલતા હો, ભાષા સહાય સેવાઓ, િન:શુલ્ક, તમારા માટે ઉપલબ્ધ છે. 1-800-321-7947 પર કૉલ કરો (TTY: 1-800-735-2989). સ્કોટ એન્ડ વ્હાઇટ હેલ્થ પ્લાન લાગુ ફેડરલ નાગરિક અધિકાર કાયદાઓનું પાલન કરે છે અને જાતિ, રંગ, રાષ્ટ્રીય મૂળ, ઉંમર, અપંગતા, અથવા

ितના આધાર ભેદભાવ નથી કરતા.

Russian:
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-321-7947 (телетайп: 1-800-735-2989). Scott & White Health Plan соблюдает применимое федеральное законодательство в области гражданских прав и не допускает дискриминации по признакам расы, цвета кожи, национальной принадлежности, возраста, инвалидности или пола.

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。1-800-321-7947 (TTY:1-800-735-2989）まで、お電話にてご連絡ください。Scott & White Health Plan は適用される連邦公民権法を遵守し、人種、肌の色、出身国、年齢、障害または性別に基づく差別をいたしません。

Laotian:
ໂປດຊາບ: ຖ້ າວ່ າທ່ ານເ ົ ້ າພາສາ ລາວ, ການ ໍ ບ ິ ລ ຮດ້ ານພາສາ, ໂດຍ ່ ໍ ບເສັ ຽຄ່ າ, ແມ່ ນ ີ ມພ້ ອມໃຫ້ ທ່ ານ. ໂທຣ 1-800-321-7947 (TTY: 1-800-
ການຊ່ ວຍເ ື ຫ
735-2989). Scott & White Health Plan ປະຕິ ບັ ດຕາມກົ ດໝາຍວ່ າດ້ ວຍ ິ ສດ ິ ທພິ ນລະເ ື ມ ຮຽຂຮຽຣັ ຖບານກາງ ິ ່ ທບັ ງຄັ ບໃຊ
ແລະ ່ ໍ ບ ໍ ຈາແເນກໂດຍ ິ ອ ງໃສ ື ພ້ ນຖານດ້ ານເ ື ຊ້ ອຊາດ, ິ ສ ິ ຜ ວ, ຊາດ ໍ ກ າເ ິ ນ ດ, ອາຍຸ , ຄວາມ ິ ພ ການ, ື ຫ ເພດ.