




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 do not have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	Network Provider : \$6,550 per individual / \$13,100 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	\$20 copay per visit; first visit covered at \$0 copay	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	\$50 copay 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)	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	\$5 copay per 30 day supply	Copays are per 30-day supply. Two 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 deductible	30% after deductible	If a brand name drug is dispensed when a generic is available, 50% coinsurance applies.
	Non-preferred generic drugs and non-preferred Brand drugs and all other Drugs	50% after deductible	50% after deductible	Non-formulary: Greater of \$50 or 50%. Maintenance Quantity Not Available.
	Preferred Specialty drugs	20% after deductible	20% after deductible	Some drugs may require prior authorization.
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	\$150 copay , plus 20% after deductible	\$150 copay , plus 20% after deductible	\$150 copay waived if admitted
	Emergency medical transportation	\$40 copay , plus 20% after deductible	\$40 copay , plus 20% after deductible	\$40 copay waived if transported

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)	
	Urgent care	\$55 <u>copay</u>	\$55 <u>copay</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$150 per day <u>copay</u> *, plus 20% after <u>deductible</u>	Not Covered	*\$750 maximum <u>copayment</u> 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 <u>deductible</u>	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 <u>copay</u> per visit	Not Covered	None
	Inpatient services	\$150 per day <u>copay</u> *, plus 20% after <u>deductible</u>	Not Covered	*\$750 maximum <u>copayment</u> per admission, then 20% applies. Requires referral and pre-authorization
If you are pregnant	Office visits	\$50 <u>copay</u> per visit	Not Covered	No charge for prenatal visits; postnatal visits are covered at the <u>specialist copay</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply.
	Childbirth/delivery professional services	\$150 per day <u>copay</u> *, plus 20% after <u>deductible</u>	Not Covered	*\$750 maximum <u>copayment</u> per admission, then 20% applies. Requires referral and pre-authorization
	Childbirth/delivery facility services	\$150 per day <u>copay</u> *, plus 20% after <u>deductible</u>	Not Covered	*\$750 maximum <u>copayment</u> per admission, then 20% applies. Requires referral and pre-authorization
If you need help recovering or have	Home health care	\$50 <u>copay</u> per visit	Not Covered	None
	Rehabilitation services	\$50 <u>copay</u> per visit	Not Covered	None
	Habilitation services	\$50 <u>copay</u> per visit	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	Skilled nursing care	\$150 per day <u>copay</u> *, plus 20% after <u>deductible</u>	Not Covered	*\$750 maximum <u>copayment</u> per admission, then 20% applies. Requires referral and pre-authorization
	Durable medical equipment	20% after <u>deductible</u>	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 <u>copay</u> .
	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	• Dental care (Child and Adult)	• Non-emergency care when traveling outside U.S.
• Bariatric surgery	• Hearing aids	• Private-duty nursing
• Chiropractic care	• Infertility treatment	• Routine foot care
• Cosmetic surgery	• Long-term care	• Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Manipulative Therapy (35 visit limit per calendar year, 5 visit limit per month)		
• Routine eye care (Adult)		

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 call 1-866-444-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 call 1-800-578-4677. 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](#) \$50
- 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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$60
Coinsurance	\$930
<i>What isn't covered</i>	
Limits or exclusions	\$150
The total Peg would pay is	\$2,140

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](#) \$50
- 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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$300
Coinsurance	\$210
<i>What isn't covered</i>	
Limits or exclusions	\$80
The total Joe would pay is	\$1,590

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

- The [plan's](#) overall [deductible](#) \$1,000
- [Specialist](#) [copayment](#) \$50
- 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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,000
Copayments	\$0
Coinsurance	\$6
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,006

**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 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 ذاكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-321-7947 (رقم هاتف الصم أوليكم: 1-800-735-2989). يلتزم Scott & White Health Plan بفوائين الحقوق المدنية الفدرالية المعمول بها ولا يميز على أساس العرق وأ اللون وأ الأصل الوطني وأ السن وأ الإعاقة وأ الجنس.

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

Urdu:

خبرراد: اگر پآ ودرآ بولتے ہیں، تو پآ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں (TTY: 1-800-735-2989) 1-800-321-7947 Scott & White Health Plan قابلِ طلاق وفاقى یرہش حقوق کے قوانین کی تعمیل کرتا ہے روا یہ کہ نسل، رنگ، قومیت، عمر، معذروى یا جنس کی بنیاد پر امتیاز نہیں اترک

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 nandiskrimina 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:

ध्यान दें: यदि आप िहंदी बोलते हैं तो आपके िलए मुफ्त में भाषा सहायता सेवाएंउपलब्ध हैं। 1-800-321-7947 (TTY: 1-800-735-2989) पर कॉल करें। Scott & White Health Plan लागू होनेयोग्य संघीय नागरक अधिकार कानून का पालन करता हैऔर जाित, रंग, राष्ट्रीय मूल, आयु, िवकलांगता, या िलंग के आधार पर भेदभाव नहीं करता है।

Persian:

مربطوه تبعیت می کند و فههار می باشد. با(1-800-321-7947 (TTY: 1-800-735-2989) تماس بگیرید. توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بستر واریگان باری شما قایل نمی شود. هیچگونه تبعیضی بر اساس داذ، رنگ پوست، اصلیت ملیتی، سن، ناتاوانی یا جنسیت اقدار Scott & White Health Plan ز اقاوانین حقوق مدنی فلارد

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.

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

Gujarati:

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-321-7947 (TTY: 1-800-735-2989). Scott & White Health Plan લાંબુ પડતા સમવાયી નાગરિક અધિકાર કાયદા સાથે સુસંગત છે અને સ્ત્રી, રંગ, રાષ્ટ્રીય સ્ત્રી, સ્ત્રી, અશક્તતા અથવા નિ:શુલ્ક આધારિત ભેદભાવ રાખવામાં આવતી નથી.

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: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-800-321-7947 (TTY: 1-800-735-2989). Scott & White Health Plan ປະຕິບັດຕາມກົດໝາຍວ່າດ້ວຍສິດທິພົນລະເມືອງຂອງຮູບພາບກາງທີ່ບັງຄັບໃຊ້ ແລະບໍ່ຈຳແນກໂດຍອີງໃສ່ພື້ນຖານດ້ານເຊື້ອຊາດ, ີສີ, ວ, ຊາດກຳເນີດ, ອາຍຸ, ຄວາມພິການ, ຫຼື ເພດ.

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.