



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 <a href="#">deductible</a> ?                                | \$7,500 per member / \$15,000 per family                                                                                                                                                          | 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> .                                                                                                                                                                                                            |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. <a href="#">Preventive care</a> and Affordable Care Act (ACA) preventive drugs are covered before you meet your <a href="#">deductible</a> .                                                 | 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="https://www.healthcare.gov/coverage/preventive-care-benefits">HealthCare.gov/coverage/preventive-care-benefits</a> .                                                                                     |
| Are there other <a href="#">deductibles</a> for specific services?              | No                                                                                                                                                                                                | You don't have to meet <a href="#">deductibles</a> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | \$9,200 per member / \$18,400 per family                                                                                                                                                          | 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.                                                                                                                                                                                                                                                                                                                                                             |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | <a href="#">Premiums</a> and health care this <a href="#">plan</a> doesn't cover.                                                                                                                 | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
| Will you pay less if you use a <a href="#">network provider</a> ?               | 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 <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<br>(You will pay the least)                                                                                                                                                                                                                                          | Non-Participating Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                   |
| If you visit a health care <a href="#">provider's</a> office or clinic                                                                                                           | Primary care visit to treat an injury or illness       | Adult: No charge for the first non-preventive sick visit in the calendar year. \$15 <a href="#">copayment</a> per visit for subsequent visits in that calendar year, <a href="#">deductible</a> does not apply<br>Pediatric: No charge per visit, <a href="#">deductible</a> does not apply | Not covered                                           | None                                                                                                                                                                                                                                                                                                                                                              |
|                                                                                                                                                                                  | <a href="#">Specialist</a> visit                       | \$45 <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)    | 20% <a href="#">copayment</a> , after <a href="#">deductible</a>                                                                                                                                                                                                                            | Not covered                                           | None                                                                                                                                                                                                                                                                                                                                                              |
|                                                                                                                                                                                  | Imaging (CT/PET scans, MRIs)                           | 20% <a href="#">copayment</a> , after <a href="#">deductible</a>                                                                                                                                                                                                                            | 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.                                                                                                                                                                                   |
| If you need drugs to treat your illness or condition<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="#">BSWHealthPlan.com/Grou</a> | Affordable Care Act (ACA) preventive drugs             | No charge, <a href="#">deductible</a> does not apply                                                                                                                                                                                                                                        | Not covered                                           | <a href="#">Copayments</a> are per 30-day supply. Maintenance drugs are allowed up to a 90-day supply for 2.5 <a href="#">copayments</a> 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. <a href="#">Specialty drugs</a> |
|                                                                                                                                                                                  | Tier 1: Preferred generic drugs                        | \$5 <a href="#">copayment</a> per prescription                                                                                                                                                                                                                                              | Not covered                                           |                                                                                                                                                                                                                                                                                                                                                                   |
|                                                                                                                                                                                  | Tier 2: Non-preferred                                  | \$15 <a href="#">copayment</a> per                                                                                                                                                                                                                                                          | Not covered                                           |                                                                                                                                                                                                                                                                                                                                                                   |

| Common Medical Event                    | Services You May Need                            | What You Will Pay                                                                                                                                                                |                                                                                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                               |
|-----------------------------------------|--------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                         |                                                  | Participating Provider<br>(You will pay the least)                                                                                                                               | Non-Participating Provider<br>(You will pay the most)                                                              |                                                                                                                                                                                                                                                                                                                                                                                                      |
| <a href="#">p/Pages/Pharmacy.</a>       | generic drugs                                    | prescription                                                                                                                                                                     |                                                                                                                    | limited to a 30-day supply. <a href="#">Formulary</a> insulin prescriptions have a maximum <a href="#">copayment</a> 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 <a href="#">copayment</a> plus the difference in cost of the brand name drug and generic equivalent drug. |
|                                         | Tier 3: Preferred brand drugs                    | \$60 <a href="#">copayment</a> per prescription                                                                                                                                  | Not covered                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                      |
|                                         | Tier 4: Non-preferred brand drugs                | \$130 <a href="#">copayment</a> per prescription                                                                                                                                 | Not covered                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                      |
|                                         | <a href="#">Specialty drugs</a>                  | Tier 1: \$125 <a href="#">copayment</a> per prescription<br>Tier 2: \$200 <a href="#">copayment</a> per prescription<br>Tier 3: \$400 <a href="#">copayment</a> per prescription | Not covered                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                      |
| If you have outpatient surgery          | Facility fee (e.g., ambulatory surgery center)   | 20% <a href="#">copayment</a> , after <a href="#">deductible</a>                                                                                                                 | 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% <a href="#">copayment</a> , after <a href="#">deductible</a>                                                                                                                 | Not covered                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                      |
| If you need immediate medical attention | <a href="#">Emergency room care</a>              | \$250 <a href="#">copayment</a> per visit, plus 20% <a href="#">copayment</a> , after <a href="#">deductible</a>                                                                 | \$250 <a href="#">copayment</a> per visit, plus 20% <a href="#">copayment</a> , after <a href="#">deductible</a>   | Emergency room <a href="#">copayment</a> waived if episode results in <a href="#">hospitalization</a> for the same condition within 24 hours.                                                                                                                                                                                                                                                        |
|                                         | <a href="#">Emergency medical transportation</a> | \$250 <a href="#">copayment</a> per service, plus 20% <a href="#">copayment</a> , after <a href="#">deductible</a>                                                               | \$250 <a href="#">copayment</a> per service, plus 20% <a href="#">copayment</a> , after <a href="#">deductible</a> | None                                                                                                                                                                                                                                                                                                                                                                                                 |
|                                         | <a href="#">Urgent care</a>                      | \$50 <a href="#">copayment</a> per visit, <a href="#">deductible</a> does not apply                                                                                              | \$50 <a href="#">copayment</a> per visit, <a href="#">deductible</a> does not apply                                |                                                                                                                                                                                                                                                                                                                                                                                                      |
| If you have a hospital stay             | Facility fee (e.g., hospital room)               | 20% <a href="#">copayment</a> , after <a href="#">deductible</a>                                                                                                                 | 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                                | 20% <a href="#">copayment</a> , after                                                                                                                                            | Not covered                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                      |

| Common Medical Event                                                      | Services You May Need                     | What You Will Pay                                                                                                                                                                                                             |                                                       | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                            |
|---------------------------------------------------------------------------|-------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                           | Participating Provider<br>(You will pay the least)                                                                                                                                                                            | Non-Participating Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                   |
|                                                                           | fees                                      | <u>deductible</u>                                                                                                                                                                                                             |                                                       |                                                                                                                                                                                                                                                                                   |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | Adult: \$15 <u>copayment</u> per visit, <u>deductible</u> does not apply 20% <u>copayment</u> , after <u>deductible</u> for all other outpatient services<br>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                                           |                                                                                                                                                                                                                                                                                   |
| If you are pregnant                                                       | Office visits                             | 20% <u>copayment</u> , after <u>deductible</u>                                                                                                                                                                                | 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                                           |                                                                                                                                                                                                                                                                                   |
| If you need help recovering or have other special health needs            | <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>   | 20% <u>copayment</u> , after <u>deductible</u>                                                                                                                                                                                | Not covered                                           | Limited to 35 visits for <u>rehabilitation services</u> and 35 visits for <u>habilitation services</u> per calendar year. The limit is combined for physical therapy, occupational therapy, and                                                                                   |
|                                                                           | <a href="#">Habilitation services</a>     | 20% <u>copayment</u> , after                                                                                                                                                                                                  | Not covered                                           |                                                                                                                                                                                                                                                                                   |

| Common Medical Event                   | Services You May Need                     | What You Will Pay                                  |                                                       | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                |
|----------------------------------------|-------------------------------------------|----------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                        |                                           | Participating Provider<br>(You will pay the least) | Non-Participating Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                       |
|                                        |                                           | <u>deductible</u>                                  |                                                       | speech therapy. Limits do not apply for therapies for children with developmental delays, autism spectrum disorder and mental health services. Services requiring <a href="#">preauthorization</a> that are not <a href="#">preauthorized</a> will be denied. Refer to <a href="http://BSWHealthPlan.com">BSWHealthPlan.com</a> or call 844-633-5325. |
|                                        | <a href="#">Skilled nursing care</a>      | 20% <u>copayment</u> , after <u>deductible</u>     | Not covered                                           | Limited to 25 days per calendar year. Services requiring <a href="#">preauthorization</a> that are not <a href="#">preauthorized</a> will be denied. Refer to <a href="http://BSWHealthPlan.com">BSWHealthPlan.com</a> or call 844-633-5325.                                                                                                          |
|                                        | <a href="#">Durable medical equipment</a> | 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="http://BSWHealthPlan.com">BSWHealthPlan.com</a> or call 844-633-5325.                                                                                                                                                |
|                                        | <a href="#">Hospice services</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](#).)

- 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 (Limited to 35 visits per calendar year)
- 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](#). Limitations apply when used under [Home Health Care](#))

**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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$7,500 |
| ■ <a href="#">Specialist copayment</a>                          | \$45    |
| ■ 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$7,500        |
| <a href="#">Copayments</a>        | \$0            |
| <a href="#">Coinsurance</a>       | \$1,000        |
| What isn't covered                |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$8,560</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> | \$7,500 |
| ■ <a href="#">Specialist copayment</a>                          | \$45    |
| ■ 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$900          |
| <a href="#">Copayments</a>        | \$600          |
| <a href="#">Coinsurance</a>       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,520</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> | \$7,500 |
| ■ <a href="#">Specialist copayment</a>                          | \$45    |
| ■ 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$2,100        |
| <a href="#">Copayments</a>        | \$200          |
| <a href="#">Coinsurance</a>       | \$0            |
| What isn't covered                |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,300</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>.

**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 711)

**Urdu:**

کریں (711 TTY: 1-844-633-5325 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 નિઃશુલ્ક 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, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-844-633-5325 (TTY: 711).