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 swhp.org/plandocs, 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 cciio.cms.gov.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network Provider: $1,500 individual / $3,000 family; Non-Network Provider: $3,000 individual / $6,000 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?	Yes. 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 preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	No.	You do not have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Network Provider: $5,200 individual / $10,400 family; Non-Network Provider: $10,400 individual / $20,800 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 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% after deductible	40% after deductible	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	20% after deductible	40% after deductible	
	Preventive care/screening/ immunization	No Charge	40% after deductible	
If you have a test	Diagnostic test (x-ray, blood work)	20% after deductible	40% after deductible	Pre-authorization required for non-network for Sleep Studies or reduce to 50%.
	Imaging (CT/PET scans, MRIs)	20% after deductible	40% after deductible	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.optumrx.com/mycatamaranrx.com	Preferred generic drugs	Retail: 30% of charges Min: $10 Max: $20 Mail Order: 30% of charges Min: $25 Max: $50	Retail: 30% of charges Min: $10 Max: $20 Mail Order: Not Covered	• Retail pharmacy claims limited to 30 day supply • Mail order pharmacy claims allow up to 90 day supply • Certain claims may require prior authorization • Certain claims may have quantity limits applied • Specialty claims required to fill at Briova Rx (OptumRx Specialty pharmacy) after 2 retail fills Please refer to www.optumrx.com/mycatamaranrx.com for most current benefits.
	Preferred brand drugs	Retail: 30% of charges Min: $25 Max: $50 Mail Order: 30% of charges Min: $62.50 Max: $125	Retail: 30% of charges Min: $25 Max: $50 Mail Order: Not Covered	
	Non-preferred generic drugs and non-preferred brand drugs	Retail: 45% of charges Min: $40 Max: $80 Mail Order: 30% of charges Min: $100 Max: $200	Retail: 45% of charges Min: $40 Max: $80 Mail Order: Not Covered	
	Preferred Specialty drugs	Retail pharmacy copays apply		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% after deductible	40% after deductible	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)	
	Physician/surgeon fees	20% after deductible	40% after deductible	
If you need immediate medical attention	Emergency room care	20% after deductible	20% after deductible	None
	Emergency medical transportation	20% after deductible	20% after deductible	
	Urgent care	20% after deductible	40% after deductible	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% after deductible	40% after deductible	Pre-authorization required for non-network or reduce to 50%. Pre-authorization required for non-network for Sleep Studies or reduce to 50%.
	Physician/surgeon fees	20% after deductible	40% after deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% after deductible	40% after deductible	Pre-authorization required for non-network or reduce to 50%.
	Inpatient services	20% after deductible	40% after deductible	Pre-authorization required for non-network or reduce to 50%.
If you are pregnant	Office visits	20% after deductible	40% after deductible	Cost sharing does not apply to preventive services. In-network routine pre-natal care is covered at no charge. Your cost in this category includes Physician Delivery Charges. Depending on the type of services, a copayment, coinsurance, or deductible may apply.
	Childbirth/delivery professional services	20% after deductible	40% after deductible	Your cost in this category includes physician delivery charges and inpatient services only. For physician delivery

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)	
	Childbirth/delivery facility services	20% after deductible	40% after deductible	charges, see pre/postnatal care. Pre-authorization required for non-network or reduce to 50%.
If you need help recovering or have other special health needs	Home health care	20% after deductible	40% after deductible	120 visits per calendar year combined in-network/non-network. Pre-authorization required for non-network or reduce to 50%.
	Rehabilitation services	20% after deductible	40% after deductible	None
	Habilitation services	20% after deductible	40% after deductible	None
	Skilled nursing care	20% after deductible	40% after deductible	120 days per calendar year combined in-network/non-network. Pre-authorization required for non-network or reduce to 50%.
	Durable medical equipment	20% after deductible	40% after deductible	Pre-authorization required for non-network Durable Medical Equipment over $1,000 or reduce to 50%.
	Hospice services	20% after deductible	40% after deductible	Pre-authorization required for Hospice Inpatient only non-network or reduce to 50%.
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
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside U.S.
- Routine eye care (Adult)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
• Bariatric surgery (one per lifetime, no dollar maximum) • Chiropractic care (limited to 30 visits per Calendar year) • Hearing aids (limited to one per ear every three years for covered members including 18 years of age or younger)	• Private-duty nursing • Routine foot care • Wigs (limited to $300 per year)

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 swhp.org , or call 1-800-321-7947; Department of Labor Employee Benefits Security Administration, visit dol.gov/ebsa/healthreform , or call1-866-444-EBSA (3272). 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 1-800-318-2596; Department of Labor Employee Benefits Security Administration, visit dol.gov/ebsa/healthreform , or call1-866-444-EBSA (3272).

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 swhp.org , or call 1-800-321-7947; Texas Department of Insurance, visit tdi.texas.gov , or call 1-800-252-3439; Department of Labor Employee Benefits Security Administration, visit dol.gov/ebsa/healthreform , or call1-866-444-EBSA (3272).

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.————————————

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	$1500
Specialist copayment	20%
Hospital (facility) coinsurance	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	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$80
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$3,880

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

The plan's overall deductible	$1500
Specialist copayment	20%
Hospital (facility) coinsurance	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	$7,500

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$1,300
Coinsurance	$600
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	$3,460

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

The plan's overall deductible	$1500
Specialist copayment	20%
Hospital (facility) coinsurance	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	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1500
Copayments	$0
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,900

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

Nondiscrimination Notice

Scott&White HEALTH PLAN
PART OF BAYLOR SCOTT & WHITE HEALTH

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-321-7947 (TTY: 711).

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

Scott and White Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - 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 Scott and White Health Plan (SWHP) Compliance Officer at 1-254-820-8888 or send an email to SWHPComplianceDepartment@BSWHealth.org.

If you believe that Scott and White Health 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:

SWHP Compliance Officer
1206 West Campus Drive, Suite 151
Temple, Texas 76502

Compliance HelpLine; 1-888-484-6977 or https://app.mycompliancereport.com/report.aspx?cid=swhp

You can file a grievance in person or by mail, online, or email. If you need help filing a grievance, the SWHP 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.

Language Assistance

Scott&White HEALTH PLAN
PART OF BAYLOR SCOTT & WHITE HEALTH

English:
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-321-7947 (TTY: 711).

Spanish:
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-321-7947 (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 1-800-321-7947 (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 1-800-321-7947(TTY：711)。

Korean:
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-321-7947 (TTY: 711) 번으로 전화해 주십시오.

Arabic:
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-866-334-3141 (رقم هاتف الصم والبكم: 711.

Urdu:
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال 1-800-321-7947 (TTY: 711). کریں

Tagalog:
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-321-7947 (TTY: 711).

French:
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-321-7947 (ATS : 711).

Hindi:
ध्यान दें: यदि आप हिंदी बोलते है तो आपके लिए मुफ्त मे भाषा सहायता सेवाएं उपलब्ध है। 1-800-321-7947 (TTY: 711) पर कॉल करे।

Persian:
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-321-7947 (TTY: 711) تماس بگیرید.

German:
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-321-7947 (TTY: 711).

Gujarati:
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-321-7947 (TTY: 711).

Russian:
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-321-7947 (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。1-800-321-7947 (TTY:711) まで、お電話にてご連絡ください。

Laotian:
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-321-7947 (TTY: 711).