




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 <http://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. You can view the Glossary at [www.cciio.cms.gov](http://www.cciio.cms.gov) or call 1-800-321-7947 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<a href="#">Network Provider</a> : \$2,850 individual / \$5,700 family; Non-Network Provider: \$5,700 individual / \$11,400 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 primary care services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you have not 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 <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/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>
Are there other <a href="#">deductibles</a> for specific services?	No.	You do not 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> ?	<a href="#">Network Provider</a> : \$6,550 individual / \$13,100 family; Non-Network Provider: \$13,100 individual / \$26,200 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> , the overall family <a href="#">out-of-pocket limit</a> must be met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Copayments</a> on certain services, <a href="#">premiums</a> , <a href="#">balance-billing</a> charges, and health care this <a href="#">plan</a> does not 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="http://www.swhp.org">www.swhp.org</a> or call 1-800-321-7947 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
		Network Provider (You will pay the least)	Out-of-Network Provider (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	30% after <a href="#">deductible</a>	50% after <a href="#">deductible</a>	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.
	<a href="#">Specialist</a> visit	30% after <a href="#">deductible</a>	50% after <a href="#">deductible</a>	
	<a href="#">Preventive care/screening/immunization</a>	No charge	50% after <a href="#">deductible</a>	
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	30% after <a href="#">deductible</a>	50% after <a href="#">deductible</a>	Pre-authorization required for non-network for Sleep Studies or reduce to 50%.
	Imaging (CT/PET scans, MRIs)	30% after <a href="#">deductible</a>	50% after <a href="#">deductible</a>	None
If you need drugs to treat your illness or condition More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.optumrx.com/mycatamaranrx.com">www.optumrx.com/mycatamaranrx.com</a>	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	<ul style="list-style-type: none"> <li>• Retail pharmacy claims limited to 30 day supply</li> <li>• Mail order pharmacy claims allow up to 90 day supply</li> <li>• Certain claims may require prior authorization</li> <li>• Certain claims may have quantity limits applied</li> <li>• Specialty claims required to fill at Briova Rx (OptumRx Specialty pharmacy) after 2 retail fills</li> </ul> Please refer to <a href="http://www.optumrx.com/mycatamaranrx.com">www.optumrx.com/mycatamaranrx.com</a> 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 <a href="#">Specialty drugs</a>	Retail pharmacy <a href="#">copays</a> apply		

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% after <u>deductible</u>	50% after <u>deductible</u>	None
	Physician/surgeon fees	30% after <u>deductible</u>	50% after <u>deductible</u>	
If you need immediate medical attention	<a href="#">Emergency room care</a>	30% after <u>deductible</u>	30% after <u>deductible</u>	None
	<a href="#">Emergency medical transportation</a>	30% after <u>deductible</u>	30% after <u>deductible</u>	
	<a href="#">Urgent care</a>	30% after <u>deductible</u>	50% after <u>deductible</u>	
If you have a hospital stay	Facility fee (e.g., hospital room)	30% after <u>deductible</u>	50% after <u>deductible</u>	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	30% after <u>deductible</u>	50% after <u>deductible</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% after <u>deductible</u>	50% after <u>deductible</u>	Pre-authorization required for non-network or reduce to 50%.
	Inpatient services	30% after <u>deductible</u>	50% after <u>deductible</u>	Pre-authorization required for non-network or reduce to 50%.
If you are pregnant	Office visits	30% after <u>deductible</u>	50% after <u>deductible</u>	Cost sharing does not apply to <a href="#">preventive services</a> .  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 <a href="#">copayment</a> , <a href="#">coinsurance</a> , or <a href="#">deductible</a> may apply.
	Childbirth/delivery professional services	30% after <u>deductible</u>	50% after <u>deductible</u>	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	30% after <u>deductible</u>	50% after <u>deductible</u>	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	<a href="#">Home health care</a>	30% after <u>deductible</u>	50% after <u>deductible</u>	120 visits per calendar year combined in-network/non-network. Pre-authorization required for non-network or reduce to 50%.
	<a href="#">Rehabilitation services</a>	30% after <u>deductible</u>	50% after <u>deductible</u>	None
	<a href="#">Habilitation services</a>	30% after <u>deductible</u>	50% after <u>deductible</u>	None
	<a href="#">Skilled nursing care</a>	30% after <u>deductible</u>	50% after <u>deductible</u>	120 days per calendar year combined in-network/non-network. Pre-authorization required for non-network or reduce to 50%.
	<a href="#">Durable medical equipment</a>	30% after <u>deductible</u>	50% after <u>deductible</u>	Pre-authorization required for non-network Durable Medical Equipment over \$1,000 or reduce to 50%.
	<a href="#">Hospice services</a>	30% after <u>deductible</u>	50% after <u>deductible</u>	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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Cosmetic surgery</li> <li>• Dental care (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Infertility treatment</li> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Routine eye care (Adult)</li> <li>• Weight loss programs</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- 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 call 1-866-444-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 call 1-866-444-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 call 1-866-444-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](#) \$2,850
- [Specialist](#) copayment 30%
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

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
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$2,850
<a href="#">Copayments</a>	\$80
<a href="#">Coinsurance</a>	\$3,500
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$6,490

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

- The [plan's](#) overall [deductible](#) \$2,850
- [Specialist](#) copayment 30%
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

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	\$7,400
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$2,000
<a href="#">Copayments</a>	\$1,300
<a href="#">Coinsurance</a>	\$840
What isn't covered	
Limits or exclusions	\$60
The total Joe would pay is	\$4,140

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

- The [plan's](#) overall [deductible](#) \$2,850
- [Specialist](#) copayment 30%
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

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	\$2,000
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$1,400
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$600
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,000

# Nondiscrimination Notice

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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](mailto: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



## 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:

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

## Urdu:

کریں. 1-800-321-7947 (TTY: 711) 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 1-800-321-7947 (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 हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-321-7947 (TTY: 711) पर कॉल करें।

## Persian:

فراهم می باشد. با 1-800-321-7947 (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: 1-800-321-7947 (TTY: 711).

## Gujarati:

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિઃશુલ્ક 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:

ໄປດຊາບ: ຖ້າ ວ່າ ທ່ານ ວ່າ ພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອ ອັດຕະໂນພາສາ, ໂດຍບໍ່ເສຍຄ່າ, ແມ່ນມີໄວ້ ສຳລັບທ່ານ. ໂທ 1-800-321-7947 (TTY: 711).