**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 kisd.swhp.org, or call 1-800-321-7947. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at cciio.cms.gov or call 1-800-321-7947 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | Network Provider:<br>Tier 1: $0 individual / $0 family<br>Tier 2: $0 individual / $0 family<br>Tier 3: $5,000 ind./ $10,000 fam. | 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, urgent care, office visits, pediatric eye exam, and prescription drugs are covered before you meet your deductible. | This plan covers some items and services even if you haven't 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 don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | Network Provider:<br>Tier 1: $6,500 ind. / $13,000 fam.<br>Tier 2: $7,350 ind./ $14,700 fam.<br>Tier 3: $15,000 ind./ $30,000 fam. | 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, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billing charges, and health care this plan doesn't 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 kisd.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 |
|---|---|---|---|---|---|
| | | Tier 1 Preferred Network PROVIDER (You will pay the least) | Tier 2 In-Network PROVIDER | Tier 3 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 | $0 copay first visit, then $30 copay per visit; deductible does not apply | $35 copay per visit; deductible does not apply | 50% after deductible | None |
| | Specialist visit | $70 copay per visit; deductible does not apply | $80 copay per visit; deductible does not apply | 50% after deductible | |
| | Preventive care/screening/ immunization | No charge Deductible does not apply. | No charge Deductible does not apply. | 50% after deductible No charge for child immunizations through the 6th birthday. | 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. |
| **If you have a test** | Diagnostic test (X-ray, blood work) | No charge | No charge | 50% after deductible | For prior authorization requirements and penalties see kisd.swhp.org. Failure to obtain Prior Authorization will result in the lesser of $500 or 50% reduction in benefits. |
| | Imaging (CT/PET scans, MRIs) | $400 copay; deductible does not apply | $500 copay; deductible does not apply | 50% after deductible | |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Tier 1 Preferred Network PROVIDER (You will pay the least) | Tier 2 In-Network PROVIDER | Tier 3 Out-of-Network PROVIDER (You will pay the most) | |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available **here.** Once the website is open, select the option "Performance 3 Tier", under "Select A Drug List". | ACA Preventive Drugs | $0 copay. Deductible does not apply. | $0 copay. Deductible does not apply. | 50% after deductible | Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription). Required use of Cigna 90 Now network pharmacies for maintenance day supply (90-day). |
| | Tier 1: Preferred Generic Drugs | $10 copay per 30-day supply /retail, $20 copay per 90-day supply / maintenance; deductible does not apply | $10 copay per 30-day supply/retail, $20 copay per 90-day supply / maintenance; deductible does not apply | 50% after deductible | |
| | Tier 2: Preferred Brand Name Drugs | $45 copay per 30-day supply /retail, $90 copay per 90-day supply / maintenance; deductible does not apply | $45 copay per 30-day supply /retail, $90 copay per 90-day supply / maintenance; deductible does not apply | 50% after deductible | If brand name drug is dispensed when a generic is available, member is responsible for the applicable brand copayment plus the difference between the cost of the brand and generic. |
| | Tier 3: Non-Preferred Generic / Brand Name Drugs | $90 copay per 30-day supply /retail, $180 copay per 90-day supply / maintenance; deductible does not apply | $90 copay per 30-day supply /retail, $180 copay per 90-day supply / maintenance; deductible does not apply | 50% after deductible | |
| | Specialty Drugs | Tier 1 and 2: 15% of charges; Tier 3: 25% of charges; deductible does not apply | Tier 1 and 2: 15% of charges; Tier 3: 25% of charges; deductible does not apply | 50% after deductible | Required use of Cigna Specialty Pharmacy Services. Some specialty drugs may require prior authorization. 30-day supply only. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | $800 copay per visit; deductible does not apply | $1,000 copay per visit; deductible does not apply | 50% after deductible | Failure to obtain pre-authorization of services, other than Emergency Care, will result in a penalty of the lesser of $500 or 50%. |
| | Physician/surgeon fees | Not applicable | Not applicable | 50% after deductible | |
| **If you need immediate medical attention** | Emergency room care | $500 copay per visit; deductible does not apply | $500 copay per visit; deductible does not apply | $500 copay per visit; deductible does not apply | Copay waived if episode results in hospitalization for the same condition within 24 hours. |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Tier 1 Preferred Network PROVIDER (You will pay the least) | Tier 2 In-Network PROVIDER | Tier 3 Out-of-Network PROVIDER (You will pay the most) | |
| | Emergency medical transportation | $500 copay per visit; deductible does not apply | $500 copay per visit; deductible does not apply | $500 copay per visit; deductible does not apply | None |
| | Urgent care | $75 copay per visit; deductible does not apply | $75 copay per visit; deductible does not apply | $75 copay per visit; deductible does not apply | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $800 copay per visit (max 3 days); deductible does not apply | $1,000 copay per visit (max 3 days); deductible does not apply | 50% after deductible | For prior authorization requirements and penalties see kisd.swhp.org. Failure to obtain Prior Authorization will result in the lesser of $500 or 50% reduction in benefits, or denial in the case of Health Care Services, other than Emergency Care, provided by an In-Network Provider. |
| | Physician/surgeon fees | Not applicable | Not applicable | 50% after deductible | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $30 copay per visit; deductible does not apply. | $35 copay per visit; deductible does not apply. | 50% after deductible | Failure to obtain pre-authorization of services, other than Emergency Care, will result in a penalty of the lesser of $500 or 50%. |
| | Inpatient services | $800 copay per visit (max 3 days); deductible does not apply | $1,000 copay per visit (max 3 days); deductible does not apply | 50% after deductible | |
| **If you are pregnant** | Office visits | $70 copay per visit; deductible does not apply | $80 copay per visit; deductible does not apply | 50% after deductible | Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Tier 1 Preferred Network PROVIDER (You will pay the least) | Tier 2 In-Network PROVIDER | Tier 3 Out-of-Network PROVIDER (You will pay the most) | |
| | Childbirth/delivery professional services | Not applicable | Not applicable | 50% after deductible | Failure to obtain pre-authorization of services, other than Emergency Care, will result in a penalty of the lesser of $500 or 50%. |
| | Childbirth/delivery facility services | $800 copay per visit (max 3 days); deductible does not apply | $1,000 copay per visit (max 3 days); deductible does not apply | 50% after deductible | |
| **If you need help recovering or have other special health needs** | Home health care | $70 copay per visit; deductible does not apply | $80 copay per visit; deductible does not apply | 50% after deductible | Limited to 60 visits per plan year. Failure to obtain pre-authorization of services, other than Emergency Care, will result in a penalty of the lesser of $500 or 50%. |
| | Rehabilitation services | $70 copay per visit; deductible does not apply | $80 copay per visit; deductible does not apply | 50% after deductible | Limited to 35 visits per plan year. Limits may not apply for Therapies for Children with Developmental Delays and Autism Spectrum Disorder. Failure to obtain pre-authorization of services, other than Emergency Care, will result in a penalty of the lesser of $500 or 50%. |
| | Habilitation services | $70 copay per visit; deductible does not apply | $80 copay per visit; deductible does not apply | 50% after deductible | Limited to 35 visits per plan year. Limits may not apply for Therapies for Children with Developmental Delays and Autism Spectrum Disorder. Failure to obtain pre-authorization of services, other than Emergency Care, will result in a penalty of the lesser of $500 or 50%. |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|---|
| | | Tier 1 Preferred Network PROVIDER (You will pay the least) | Tier 2 In-Network PROVIDER | Tier 3 Out-of-Network PROVIDER (You will pay the most) | |
| | Skilled nursing care | $800 copay per visit (max 3 days); deductible does not apply | $1,000 copay per visit (max 3 days); deductible does not apply | 50% after deductible | Limited to 25 days per plan year. Failure to obtain pre-authorization of services, other than Emergency Care, will result in a penalty of the lesser of $500 or 50%. |
| | Durable medical equipment | 20% of charges | 20% of charges | 50% after deductible | Services that are not preauthorized will be denied. Refer to kisd.swhp.org or Customer Service at 1-800-321-7947. |
| | Hospice services | 20% of charges | 20% of charges | 50% after deductible | |
| **If your child needs dental or eye care** | Children's eye exam | $70 copay per visit; deductible does not apply | Not covered | Not covered | Limited to one eye exam per calendar year. |
| | Children's glasses | Not covered | Not covered | Not covered | None |
| | Children's dental check-up | Not covered | Not covered | Not covered | None |

**Excluded Services & Other Covered Services:**

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult and Child)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

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

- Chiropractic care (Limited to 35 visits per plan year)
- Hearing aids (Limited to one per ear every three years for covered members 18 years of age or younger)
- Routine eye care (Adult) (Limited to an annual eye exam conducted by a licensed ophthalmologist or optometrist, Tier 1 only)

**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: Insurance Company of Scott and White, visit swhp.org, or call 1-800-321-7947; Department of Labor's Employee Benefits Security Administration at 1-

866-444-EBSA (3272) or dol.gov/ebsa/healthreorm. 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.

**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: Insurance Company of Scott and White, visit swhp.org, or call 1-800-321-7947; Texas Department of Insurance, visit tdi.texas.gov or call 1-800-578-4677; Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or dol.gov/ebsa/healthreform, Texas Department of Insurance Texas Health Options at 1-800-252-3439 or texashealthoptions.com.

**Does this plan provide Minimum Essential Coverage?** **Yes**

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

**Does this plan meet the Minimum Value Standards?** **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-321-7947.

*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

## About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist copayment | $70 |
| Hospital (facility) copay | $800 |
| 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** | **$12,840** |

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $2,900 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$2,960** |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist copayment | $70 |
| Hospital (facility) copay | $800 |
| 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** | **$7,460** |

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $1,280 |
| Coinsurance | $300 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Joe would pay is** | **$1,640** |

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

| | |
|---|---|
| The plan's overall deductible | $0 |
| Specialist copayment | $70 |
| Hospital (facility) copay | $800 |
| 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 | $0 |
| Copayments | $1,890 |
| Coinsurance | $10 |
| *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

INSURANCE COMPANY OF Scott&White 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).

Insurance Company of Scott and White complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Insurance Company of Scott and White does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Insurance Company of Scott and White:

- 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 Insurance Company of Scott and White Compliance Officer at 1-214-820-8888 or send an email to SWHPComplianceDepartment@BSWHealth.org

If you believe that Insurance Company of Scott and White 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:

Insurance Company of Scott and White, 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 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/ Asistencia de idiomas


**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 1-800-321-7947 (رقم

**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 दे: 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 નઃશુલ્ક 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, ການບໍ ວິການຊ່ ວຍເຫ ືອດ້ ານພາສາ, ໂດຍບ ໍ່ ເສ ັຽຄ່ າ, ແມ ່ ນມ ີພ ້ ອມໃຫ ້ ທ ່ ານ. ໂທຣ 1-800-321-7947 (TTY: 711).