Frenship ISD
Medical Schedule of Benefits
Consumer Choice Health Maintenance Organization
Custom $4,750 Deductible HMO Plan
BSW Premier HMO Network
FISD23H1

This Consumer Choice of Benefits Health Maintenance Organization health care plan, either in whole or in part, does not provide state-mandated health benefits normally required in Evidences of Coverage in Texas. This standard health benefit plan may provide a more affordable health plan for you although, at the same time, it may provide you with fewer health plan benefits than those normally included as state-mandated health benefits in Texas. Please consult with your insurance agent to discover which state-mandated health benefits are excluded in the Evidence of Coverage. The following represents the copayment amounts members must pay when receiving the covered benefits listed below. Refer to the Evidence of Coverage for a detailed explanation of covered and non-covered benefits. If you have any questions or would like more information about the Issuer's medical benefits go to **BSWHealthPlan.com** or contact Customer Service, Monday through Friday, 7:00 AM – 7:00 PM CT, at **844.633.5325, TTY Line 711**.

The Issuer does not discriminate based on race, color, national origin, disability, age, sex, gender identity, sexual orientation, political affiliation or expression, or health status in the administration of the plan, including enrollment and benefit determinations.

Plan Year	Calendar Year
Medical Deductible	$4,750 per Member $9,500 per Family
Maximum Out-of-Pocket *Includes Medical Deductible, Pharmacy Deductible and Copayments.*	$7,700 per Member $15,400 per Family
Annual Maximum	Unlimited

Medical Benefits	*Participating Provider Member Copayment*	*Non-Participating Provider Member Copayment*
Adult PCP Office Visit Includes medical services that are not preventive care services. *Office visit charge applies when seen by a physician and/or a licensed clinician under the supervision of the physician.*	$45 copayment per visit, deductible does not apply	Not covered
Pediatric PCP Office Visit For a covered dependent through the age of 18. *Office visit charge applies when seen by a physician and/or a licensed clinician under the supervision of the physician.*	$45 copayment per visit, deductible does not apply	Not covered
Specialist Physician Office Visit Includes medical services that are not preventive care services. *Office visit charge applies when seen by a physician and/or a licensed clinician under the supervision of the physician.*	$90 copayment per visit, deductible does not apply	Not covered

Medical Benefits	*Participating Provider Member Copayment*	*Non-Participating Provider Member Copayment*
Annual Routine Eye Exam*	$45 copayment per visit, deductible does not apply	Not covered
Preventive Care Routine Annual Physical Exam, Immunizations, Well-Baby Care, Well-Child Care, Mammography Screening, Osteoporosis Screening, Prostate Cancer Screening, Colorectal Cancer Screening, Ovarian Cancer Screening, Cervical Cancer Screening, Prenatal Visits, Tubal Ligation, any evidence−based items, or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force.	No charge, deductible does not apply	Not covered
Allergy Testing, Serum, and Injections	20% after deductible	Not covered
Diagnostic Test Routine lab, EKG, and X-rays.	No charge	Not covered
Imaging and Radiology (Including Facility and Physician charges) Angiography, CT Scans, MRIs, Myelography, PET Scans, Stress Tests.	20% after deductible	Not covered
Cardiovascular Disease Screening*	No charge, deductible does not apply	Not covered
Outpatient Surgery Facility charges, Covered Prescription Drugs, Specialty Drugs, Medical Supplies, Observation Unit, Surgical Procedures, Pain Management.	20% after deductible	Not covered
Outpatient Physician Services	20% after deductible	Not covered
Emergency Care Copayment waived if episode results in hospitalization for the same condition within 24 hours.	$400 copayment per visit, plus 20% after deductible	$400 copayment per visit, plus 20% after deductible
Ambulance Transportation Ground, Sea, or Air.	20% after deductible	20% after deductible
Urgent Care	$75 copayment per visit, deductible does not apply	$75 copayment per visit, deductible does not apply
Inpatient Care Facility charges, Physician charges, Pre-admission Testing, Covered Prescription Drugs, Specialty Drugs, Medical Supplies, Blood and Blood Products, Laboratory Tests and X-rays, Pain Management, Maternity Labor and Delivery, Surgical Procedures, Operating and Recovery Room, Neonatal Intensive Care Unit (NICU), Intensive Care Unit (ICU), Coronary Care Unit, Rehabilitation Facility, Mental Health Care, Serious Mental Illness, Chemical Dependency.	20% after deductible	Not covered
Skilled Nursing Facility*	No charge, deductible does not apply	Not covered

Medical Benefits	*Participating Provider Member Copayment*	*Non-Participating Provider Member Copayment*
Adult Outpatient Mental Health Care, Serious Mental Illness and Chemical Dependency	$45 copayment per visit, deductible does not apply; 20% coinsurance for all other services	Not covered
Pediatric Outpatient Mental Health Care, Serious Mental Illness and Chemical Dependency	$45 copayment per visit, deductible does not apply; 20% coinsurance for all other services	Not covered
Maternity Care and Family Planning Postnatal Care, Family Planning (as medically necessary).	$90 copayment per visit, deductible does not apply	Not covered
Infertility (Diagnosis Only)	$90 copayment per visit, deductible does not apply	Not covered
Rehabilitation* Physical Therapy, Occupational Therapy, Speech Therapy.	20% after deductible	Not covered
Habilitation* Physical Therapy, Occupational Therapy, Speech Therapy.	20% after deductible	Not covered
Chiropractic Care	20% after deductible	Not covered
Home Health Care*	No charge, deductible does not apply	Not covered
Hospice Care	No charge, deductible does not apply	Not covered
Durable Medical Equipment (DME) Orthotics, Prosthetics.	20% after deductible	Not covered
Diabetes Management Diabetes Self-Management Training, Diabetes Education, Diabetes Care Management.	20% after deductible	Not covered
Diabetes Equipment and Supplies	Same as DME or pharmacy, as appropriate	Not covered
Nutritional Counseling	20% after deductible	Not covered
Hearing Aids* and Cochlear Implants	20% after deductible	Not covered
Telehealth Service and Virtual Visits	No charge	Not covered
Other Telehealth Service and Telemedicine Medical Service	The amount of the deductible or copayment may not exceed the amount of the deductible or copayment required for a comparable medical service provided through a face-to-face consultation.	Not covered
Amino Acid Based Elemental Formulas	Same as DME or pharmacy as appropriate	Not covered

Medical Benefits	*Participating Provider Member Copayment*	*Non-Participating Provider Member Copayment*
Other Medical Benefits Including, but not limited to Acquired Brain Injury, Autism Spectrum Disorder, Chemotherapy, Craniofacial Abnormalities, Limited Accidental Dental, Organ and Tissue Transplants, Phenylketonuria (PKU) or Heritable Metabolic Disease, Covered Prescription Drugs, Specialty Drugs, Temporomandibular Joint Pain Dysfunction Syndrome (TMJ).	Depending upon location of service, benefits will be the same as those stated under each covered benefit category in this Schedule of Benefits	Not covered
All Other Covered Medical Benefits (not specified herein)	20% after deductible	Not covered

Covered Benefit Limitations*

Annual Routine Eye Exam
Limited to one exam per plan year.

Cardiovascular Disease Screening
Limited to once every 5 years.

Rehabilitation
Limited to 35 combined PT/OT/SP Outpatient visits.
Limits do not apply for therapies for children with developmental delays, autism spectrum disorder, and mental health services.

Habilitation
Limited to 35 combined PT/OT/SP Outpatient visits.
Limits do not apply for therapies for children with developmental delays, autism spectrum disorder, and mental health services.

Hearing Aids
Limited to one device per ear every 3 years.

Home Health Care
Limited to 60 visits per plan year.

Skilled Nursing Facility
Limited to 25 days per plan year.