Small Group Schedule of Benefits
Preferred Provider Organization
BSW Plus PPO
Bronze PPO 100 9200 INV
37755TX0260001
BPG25DIV

The following is a summary of the cost share amounts members must pay when receiving the covered benefits listed below. Refer to the Certificate 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 and pharmacy 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.

	Calendar Year	
	Participating Provider	***Non-Participating Provider***
Medical Deductible	$9,200 per Member $18,400 per Family	$18,400 per Member $36,800 per Family
Pharmacy Deductible	ACA Preventive Drugs: $0 Tier 1-4 and Preferred Diabetic: Integrated with Medical	ACA Preventive Drugs: $0 Tier 1-4 and Preferred Diabetic: Integrated with Medical
Maximum Out-of-Pocket *Includes Medical Deductible, Pharmacy Deductible, Copayments, and Coinsurance.*	$9,200 per Member $18,400 per Family	$27,600 per Member $55,200 per Family
Coinsurance	0% coinsurance after deductible	50% coinsurance after deductible
Annual Maximum	Unlimited	
Preauthorization Penalty for Benefits Requiring Preauthorization *For preauthorization requirements refer to* **BSWHealthPlan.com**	Failure to obtain preauthorization of benefits, other than emergency care, will result in a penalty of the lesser of $500 or 50% reduction in benefits.	Failure to obtain preauthorization of benefits, other than emergency care, will result in a penalty of the lesser of $500 or 50% reduction in benefits.
Except for services received from a Participating Provider facility, Emergency Care, Air Ambulance Transportation services, and EMS Provider Transportation services and covered supplies, a Member may be balance billed and will be responsible for Non-Participating Provider balance billing charges over the Usual and Customary Rate. Balance billing charges will not be applied toward the Maximum Out-of-Pocket.		

Medical Benefits	***Participating Provider Member Cost Share***	***Non-Participating Provider Member Cost Share***
Adult PCP Office Visit *Office visit charge applies when seen by a physician and/or a licensed clinician under the supervision of the physician.*	No charge for the first non-preventive sick visit in the calendar year. 0% coinsurance after deductible for subsequent visits in that calendar year	50% coinsurance after deductible
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.*	No charge, deductible does not apply	50% coinsurance after deductible

Medical Benefits	*Participating Provider Member Cost Share*	*Non-Participating Provider Member Cost Share*
Specialist Physician Office Visit *Office visit charge applies when seen by a physician and/or a licensed clinician under the supervision of the physician.*	0% coinsurance after deductible	50% coinsurance after deductible
Adult Annual Routine Eye Exam	Not covered	Not covered
Pediatric Annual Routine Eye Exam For a covered dependent through the age of 18.	0% coinsurance after deductible	50% coinsurance after deductible
Pediatric Prescription Eyewear* For a covered dependent through the age of 18.	0% coinsurance after deductible	50% coinsurance after deductible
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	50% coinsurance after deductible
Allergy Testing, Serum, and Injections	0% coinsurance after deductible	50% coinsurance after deductible
Diagnostic Test Routine lab, EKG, and X-rays.	0% coinsurance after deductible	50% coinsurance after deductible
Imaging and Radiology (Including Facility and Physician charges) Angiography, CT Scans, MRIs, Myelography, PET Scans, Stress Tests.	0% coinsurance after deductible	50% coinsurance after deductible
Cardiovascular Disease Screening*	0% coinsurance after deductible	50% coinsurance after deductible
Outpatient Surgery Procedure (Including Facility charges) Covered Prescription Drugs, Specialty Drugs, Medical Supplies, Observation Unit, Surgical Procedures, Pain Management.	0% coinsurance after deductible	50% coinsurance after deductible
Outpatient Physician Services	0% coinsurance after deductible	50% coinsurance after deductible
Emergency Care Copayment waived if episode results in hospitalization for the same condition within 24 hours.	0% coinsurance after deductible	0% coinsurance after deductible
Ambulance Transportation Ground, Sea, or Air.	0% coinsurance after deductible	0% coinsurance after deductible
Urgent Care	$50 coinsurance per visit, deductible does not apply	$50 coinsurance per visit, deductible does not apply

Medical Benefits	*Participating Provider Member Cost Share*	*Non-Participating Provider Member Cost Share*
Inpatient Care (Including Facility and 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.	0% coinsurance after deductible	50% coinsurance after deductible
Skilled Nursing Facility*	0% coinsurance after deductible	50% coinsurance after deductible
Adult Outpatient Mental Health Care, Serious Mental Illness and Chemical Dependency	0% coinsurance after deductible	50% coinsurance after deductible
Pediatric Outpatient Mental Health Care, Serious Mental Illness and Chemical Dependency	No charge, deductible does not apply	50% coinsurance after deductible
Maternity Care and Family Planning Postnatal Care, Family Planning (as medically necessary).	0% coinsurance after deductible	50% coinsurance after deductible
Infertility (Diagnosis Only)	0% coinsurance after deductible	50% coinsurance after deductible
Rehabilitation* Physical Therapy, Occupational Therapy, Speech Therapy, Chiropractic Care.	0% coinsurance after deductible	50% coinsurance after deductible
Habilitation* Physical Therapy, Occupational Therapy, Speech Therapy, Chiropractic Care.	0% coinsurance after deductible	50% coinsurance after deductible
Home Health Care*	0% coinsurance after deductible	50% coinsurance after deductible
Hospice Care	0% coinsurance after deductible	50% coinsurance after deductible
Durable Medical Equipment (DME) Orthotics, Prosthetics.	0% coinsurance after deductible	50% coinsurance after deductible
Diabetes Management Diabetes Self-Management Training, Diabetes Education, Diabetes Care Management.	0% coinsurance after deductible	50% coinsurance after deductible
Diabetes Equipment and Supplies	0% coinsurance after deductible	50% coinsurance after deductible
Nutritional Counseling	0% coinsurance after deductible	50% coinsurance after deductible
Hearing Aids* and Cochlear Implants	0% coinsurance after deductible	50% coinsurance after deductible
Telehealth Service and Virtual Visits	No charge, deductible does not apply	50% coinsurance after deductible
Other Telehealth Service and Telemedicine Medical Service	The amount of the deductible, copayment or coinsurance may not exceed the amount of the deductible, copayment or coinsurance required for a comparable medical benefit	50% coinsurance after deductible

Medical Benefits	*Participating Provider Member Cost Share*	*Non-Participating Provider Member Cost Share*
	provided through a face-to-face consultation.	
Amino Acid Based Elemental Formulas	0% coinsurance after deductible	50% coinsurance after deductible
Other Medical Benefits Including, but not limited to Acquired Brain Injury, Autism Spectrum Disorder, Biomarker Testing, Chemotherapy, Craniofacial Abnormalities, Fertility Preservation, Limited Accidental Dental, Organ and Tissue Transplants, Phenylketonuria (PKU) or Heritable Metabolic Disease, Covered Prescription Drugs, Specialty Drugs, Temporomandibular Joint Pain Dysfunction Syndrome (TMJ).	0% coinsurance after deductible	50% coinsurance after deductible
All Other Covered Medical Benefits (not specified herein)	0% coinsurance after deductible	50% coinsurance after deductible

Pharmacy Benefits	*Participating Provider Member Cost Share*		*Non-Participating Provider Member Cost Share*
	30-day Standard	*90-day Maintenance***	
ACA preventive drugs	No charge, deductible does not apply	No charge, deductible does not apply	50% coinsurance
Tier 1 Generic drugs	0% coinsurance after deductible	0% coinsurance after deductible	50% coinsurance after deductible
Tier 2 Preferred drugs	0% coinsurance after deductible	0% coinsurance after deductible	50% coinsurance after deductible
Tier 3 Non-preferred drugs	0% coinsurance after deductible	0% coinsurance after deductible	50% coinsurance after deductible
Tier 4 Specialty drugs and oral anticancer medications	0% coinsurance after deductible	0% coinsurance after deductible	50% coinsurance after deductible
Preferred diabetes test strips for blood glucose monitors	0% coinsurance after deductible	0% coinsurance after deductible	50% coinsurance after deductible
Non-preferred diabetes test strips for blood glucose monitors	Non-Formulary	Non-Formulary	Non-Formulary

Members can access the Health Insurance Marketplace (HIM) formulary online at https://www.bswhealthplan.com/Pages/Pharmacy.aspx or by calling Customer Service at 844.633.5325 for a non-electronic copy free of charge. **Maintenance drugs are allowed up to a 90-day supply 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. Specialty drugs limited to a 30-day supply. Formulary insulin prescriptions have a maximum copayment of $25 per prescription per 30-day supply.

Covered Benefit Limitations*

Cardiovascular Disease Screening
Limited to once every 5 years.

Rehabilitation
Limited to 35 combined visits per calendar year, Limit is combined for physical therapy, occupational therapy, speech therapy and chiropractic care.
Limits do not apply for therapies for children with developmental delays, autism spectrum disorder, and mental health services.

Habilitation
Limited to 35 combined visits per calendar year, Limit is combined for physical therapy, occupational therapy, speech therapy and chiropractic care.
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 calendar year.

Skilled Nursing Facility
Limited to 25 days per calendar year.

Pediatric Prescription Eyewear
Limited to one pair of glasses or contact lenses per calendar year. Refer to plan document for details.

BaylorScott&White Insurance Company

In Vitro Fertilization
Preferred Provider Organization

Covered benefits incurred for in vitro fertilization services will be the same as for maternity benefits provided **all** of the following requirements are met:

1. The patient for the in vitro fertilization procedure is a covered Member under this Plan.
2. The fertilization or attempt at fertilization is made only with the sperm of the Member's spouse.
3. The Member and her spouse have a history of infertility of at least five (5) continuous years duration, or the infertility is associated with one (1) or more of the following conditions:
    - Endometriosis,
    - Exposure in utero to diethylstilbestrol (DES),
    - Blockage of or surgical removal of one or both fallopian tubes; or
    - Oligospermia.
4. The participant has been unable to attain a successful pregnancy through any less costly applicable infertility treatment which is covered by Baylor Scott & White Insurance Company; and
5. The in vitro fertilization procedures are performed in a facility that conforms to the minimal standard for in vitro fertilization programs adopted by the American Society for Reproductive Medicine.

No benefits for in vitro fertilization services are available if:

- Any condition contained in items (1) through (5) indicated above, is not complied with.
- The Plan does not include Maternity Care benefits; or
- The services or supplies are for Inpatient Hospital Expenses.

Medical Benefit	***Participating Provider Member Copayment***	***Non-Participating Provider Member Copayment***
You are required to pay a copayment for in vitro fertilization services.	Same as for other outpatient benefits	Same as for other outpatient benefits

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 Insurance Company 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 Insurance Company does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Baylor Scott & White Insurance Company:

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

If you believe that Baylor Scott & White Insurance Company 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 Insurance Company, 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 1-844-633-5325 (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:
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-844-633-5325 (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 کریں 1-844-633-5325 (TTY: 711).

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 है तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध है। 1-844-633-5325 (TTY: 711) पर कॉल करें।

Persian:
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (TTY: 711) 1-844-633-5325 تماس بگیرید.

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: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-844-633-5325 (TTY:711).