Small Group Schedule of Benefits
State Mandated
Health Maintenance Organization
BSW Plus HMO
Gold HMO SM 0 9200
40788TX0370021
GHG25A29

A copayment will not exceed 50% of the total cost of benefits provided. Copayments made by the member in a calendar year will not total more than 200% of the total annual premium paid during the calendar year, if the member can demonstrate the amount that has been paid. The following is a summary of 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 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
Medical Deductible	$0 per Member $0 per Family
Pharmacy Deductible	$0 per Member $0 per Family
Maximum Out of Pocket *Includes Copayments.*	$9,200 per Member $18,400 per Family
Annual Maximum	Unlimited

Medical Benefits	*Participating Provider Member Copayment*	*Non-Participating Provider Member Copayment*
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. $50 copayment per visit for subsequent visits in that calendar year.	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.*	No charge	Not covered
Specialist Physician Office Visit *Office visit charge applies when seen by a physician and/or a licensed clinician under the supervision of the physician.*	$85 copayment per visit	Not covered
Adult Annual Routine Eye Exam	Not covered	Not covered
Pediatric Annual Routine Eye Exam For a covered dependent through the age of 18.	$85 copayment per visit	Not covered

Medical Benefits	*Participating Provider Member Copayment*	*Non-Participating Provider Member Copayment*
Pediatric Prescription Eyewear* For a covered dependent through the age of 18.	$85 copayment per pair	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	Not covered
Allergy Testing, Serum, and Injections	30% copayment	Not covered
Diagnostic Test Routine lab, EKG, and X-rays.	30% copayment	Not covered
Imaging and Radiology (Including Facility and Physician charges) Angiography, CT Scans, MRIs, Myelography, PET Scans, Stress Tests.	30% copayment	Not covered
Cardiovascular Disease Screening*	30% copayment	Not covered
Outpatient Surgery Procedure (Including Facility charges) Covered Prescription Drugs, Specialty Drugs, Medical Supplies, Observation Unit, Surgical Procedures, Pain Management.	30% copayment	Not covered
Outpatient Physician Services	30% copayment	Not covered
Emergency Care Copayment waived if episode results in hospitalization for the same condition within 24 hours.	$750 copayment per visit	$750 copayment per visit
Ambulance Transportation Ground, Sea, or Air.	$750 copayment per service	$750 copayment per service
Urgent Care	$50 copayment per visit	$50 copayment per visit
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.	30% copayment	Not covered
Skilled Nursing Facility*	30% copayment	Not covered
Adult Outpatient Mental Health Care, Serious Mental Illness and Chemical Dependency	$50 copayment per office visit. 30% copayment per visit	Not covered

Medical Benefits	*Participating Provider Member Copayment*	*Non-Participating Provider Member Copayment*
	for all other outpatient services	
Pediatric Outpatient Mental Health Care, Serious Mental Illness and Chemical Dependency	No charge	Not covered
Maternity Care and Family Planning Postnatal Care, Family Planning (as medically necessary).	$50 copayment per visit	Not covered
Infertility (Diagnosis Only)	$85 copayment per visit	Not covered
Rehabilitation Physical Therapy, Occupational Therapy, Speech Therapy, Chiropractic Care.	$50 copayment per visit	Not covered
Habilitation Physical Therapy, Occupational Therapy, Speech Therapy, Chiropractic Care.	$50 copayment per visit	Not covered
Home Health Care	30% copayment	Not covered
Hospice Care	30% copayment	Not covered
Durable Medical Equipment (DME) Orthotics, Prosthetics.	30% copayment	Not covered
Diabetes Management Diabetes Self-Management Training, Diabetes Education, Diabetes Care Management.	$50 copayment per visit	Not covered
Diabetes Equipment and Supplies	30% copayment	Not covered
Nutritional Counseling	$50 copayment per visit	Not covered
Hearing Aids* and Cochlear Implants	30% copayment	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	30% copayment	Not covered
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).	30% copayment	Not covered
All Other Covered Medical Benefits (not specified herein)	30% copayment	Not covered

Pharmacy Benefits	*Participating Provider Member Copayment*		*Non-Participating Provider Member Copayment*
	30-day Standard	*90-day Maintenance***	
ACA preventive drugs	No charge	No charge	Not covered
Tier 1 Generic drugs	$3 copayment per prescription	$9 copayment per prescription	Not covered
Tier 2 Preferred drugs	$50 copayment per prescription	$150 copayment per prescription	Not covered
Tier 3 Non-preferred drugs	$125 copayment per prescription	$375 copayment per prescription	Not covered
Tier 4 Specialty drugs and oral anticancer medications	$250 copayment per prescription	Not covered	Not covered
Preferred diabetes test strips for blood glucose monitors	$50 copayment per prescription	$150 copayment per prescription	Not covered
Non-preferred diabetes test strips for blood glucose monitors	Non-Formulary	Non-Formulary	Not covered

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

Baylor Scott & White Health Plan

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

Baylor Scott & White Health Plan:

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

If you believe that Baylor Scott & 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:

Baylor Scott & White Health Plan, 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

BaylorScott&White Health Plan

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:
هاتف الصم والبكم: 711 .ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-844-633-5325 (رقم

Urdu:
1-844-633-5325 (TTY: 711). خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں

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

Persian:
فراهم می باشد. با 1-844-633-5325 (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: 1-844-633-5325 (TTY: 711).

Gujarati:
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક 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).