Baylor Scott & White Insurance Company

Frenship ISD
Medical Schedule of Benefits
Preferred Provider Organization
BSW Access PPO Network
Custom $4,750 Deductible PPO Plan
UHCFISD3

The following is a summary of the copayment 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.

Plan Year	Calendar Year	
	Participating Provider	***Non-Participating Provider***
Medical Deductible	$4,750 per Member $9,500 per Family	$15,000 per Member $30,000 per Family
Maximum Out-of-Pocket *Includes Medical Deductible, Pharmacy Deductible, Copayments, and Coinsurance.*	$7,700 per Member $15,400 per Family	$30,000 per Member $60,000 per Family
Coinsurance	80% after deductible	50% 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 at a Participating Provider facility, Emergency Care and Air Ambulance Transportation services, a Member may be balance billed and will be responsible for Non-Participating Provider balance billing charges over the Usual and Customary Rate. The balance billing charges will not be applied toward the Maximum Out-of-Pocket.		

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	40% after deductible

Medical Benefits	*Participating Provider Member Copayment*	*Non-Participating Provider Member Copayment*
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	40% after deductible
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	40% after deductible
Annual Routine Eye Exam*	$45 copayment per visit, deductible does not apply	40% 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	40% after deductible
Allergy Testing, Serum, and Injections	20% after deductible	40% after deductible
Diagnostic Test Routine lab, EKG, and X-rays.	No charge	40% after deductible
Imaging and Radiology (Including Facility and Physician charges) Angiography, CT Scans, MRIs, Myelography, PET Scans, Stress Tests.	20% after deductible	40% after deductible
Cardiovascular Disease Screening*	No charge, deductible does not apply	40% after deductible
Outpatient Surgery Facility charges, Covered Prescription Drugs, Specialty Drugs, Medical Supplies, Observation Unit, Surgical Procedures, Pain Management.	20% after deductible	40% after deductible
Outpatient Physician Services	20% after deductible	40% after deductible
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

Medical Benefits	*Participating Provider Member Copayment*	*Non-Participating Provider Member Copayment*
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	40% after deductible
Skilled Nursing Facility*	No charge, deductible does not apply	40% after deductible
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	40% after deductible
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	40% after deductible
Maternity Care and Family Planning Postnatal Care, Family Planning (as medically necessary).	$90 copayment per visit, deductible does not apply	40% after deductible
Infertility (Diagnosis Only)	$90 copayment per visit, deductible does not apply	40% after deductible
Rehabilitation* Physical Therapy, Occupational Therapy, Speech Therapy.	20% after deductible	40% after deductible
Habilitation* Physical Therapy, Occupational Therapy, Speech Therapy.	20% after deductible	40% after deductible
Chiropractic Care*	20% after deductible	40% after deductible
Home Health Care*	No charge, deductible does not apply	40% after deductible
Hospice Care	No charge, deductible does not apply	40% after deductible
Durable Medical Equipment (DME) Orthotics, Prosthetics.	20% after deductible	40% after deductible
Diabetes Management Diabetes Self-Management Training, Diabetes Education, Diabetes Care Management.	20% after deductible	40% after deductible
Diabetes Equipment and Supplies	Same as DME or pharmacy, as appropriate	40% after deductible
Nutritional Counseling	20% after deductible	40% after deductible
Hearing Aids* and Cochlear Implants	20% after deductible	40% after deductible
Telehealth Service and Virtual Visits	No charge	40% after deductible

Medical Benefits	*Participating Provider Member Copayment*	*Non-Participating Provider Member Copayment*
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.	40% after deductible
Amino Acid Based Elemental Formulas	Same as DME or pharmacy as appropriate	40% after deductible
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	40% after deductible
All Other Covered Medical Benefits (not specified herein)	20% after deductible	40% after deductible

Covered Benefit Limitations*

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

Cardiovascular Disease Screening
Limited to once every 5 years.

Chiropractic Care
Limited to 35 visits per plan year.

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.