

A Qualified High Deductible Health Plan as defined by IRC Section 223

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 | \$3,000 per Member \$6,000 per Family | \$6,000 per Member \$12,000 per Family |
| Maximum Out-of-Pocket <i>Includes Medical Deductible, Pharmacy Deductible, Copayments, and Coinsurance.</i> | \$5,250 per Member \$10,500 per Family | \$15,750 per Member \$31,500 per Family |
| Coinsurance | 80% after deductible | 50% after deductible |
| Annual Maximum | Unlimited | |
| Preauthorization Penalty for Benefits Requiring Preauthorization <i>For preauthorization requirements refer to BSWHealthPlan.com</i> | 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 <i>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.</i> | 20% after deductible | 50% after deductible |
| Pediatric PCP Office Visit <i>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.</i> | 20% after deductible | 50% after deductible |

| Medical Benefits | Participating Provider Member Copayment | Non-Participating Provider Member Copayment |
|---|--|--|
| Specialist Physician Office Visit Includes medical services that are not preventive care services. <i>Office visit charge applies when seen by a physician and/or a licensed clinician under the supervision of the physician.</i> | 20% after deductible | 50% after deductible |
| Annual Routine Eye Exam | Not covered | 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 | 50% after deductible |
| Allergy Testing, Serum, and Injections | 20% after deductible | 50% after deductible |
| Diagnostic Test Routine lab, EKG, and X-rays. | 20% after deductible | 50% after deductible |
| Imaging and Radiology (Including Facility and Physician charges) Angiography, CT Scans, MRIs, Myelography, PET Scans, Stress Tests. | 20% after deductible | 50% after deductible |
| Cardiovascular Disease Screening* | 20% after deductible | 50% after deductible |
| Outpatient Surgery Facility charges, Covered Prescription Drugs, Specialty Drugs, Medical Supplies, Observation Unit, Surgical Procedures, Pain Management. | 20% after deductible | 50% after deductible |
| Outpatient Physician Services | 20% after deductible | 50% after deductible |
| Emergency Care Copayment waived if episode results in hospitalization for the same condition within 24 hours. | 20% after deductible | 50% after deductible |
| Ambulance Transportation Ground, Sea, or Air. | 20% after deductible | 50% after deductible |
| Urgent Care | 20% after deductible | 50% after deductible |
| 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 | 50% after deductible |
| Skilled Nursing Facility* | 20% after deductible | 50% after deductible |

| Medical Benefits | Participating Provider Member Copayment | Non-Participating Provider Member Copayment |
|--|--|--|
| Adult Outpatient Mental Health Care, Serious Mental Illness and Chemical Dependency | 20% after deductible | 50% after deductible |
| Pediatric Outpatient Mental Health Care, Serious Mental Illness and Chemical Dependency | 20% after deductible | 50% after deductible |
| Maternity Care and Family Planning Postnatal Care, Family Planning (as medically necessary). | 20% after deductible | 50% after deductible |
| Infertility (Diagnosis Only) | 20% after deductible | 50% after deductible |
| Rehabilitation* Physical Therapy, Occupational Therapy, Speech Therapy. | 20% after deductible | 50% after deductible |
| Habilitation* Physical Therapy, Occupational Therapy, Speech Therapy. | 20% after deductible | 50% after deductible |
| Chiropractic Care* | 20% after deductible | 50% after deductible |
| Home Health Care* | 20% after deductible | 50% after deductible |
| Hospice Care | 20% after deductible | 50% after deductible |
| Durable Medical Equipment (DME) Orthotics, Prosthetics. | 20% after deductible | 50% after deductible |
| Diabetes Management Diabetes Self-Management Training, Diabetes Education, Diabetes Care Management. | 20% after deductible | 50% after deductible |
| Diabetes Equipment and Supplies | Same as DME or pharmacy, as appropriate | 50% after deductible |
| Nutritional Counseling | 20% after deductible | 50% after deductible |
| Hearing Aids* and Cochlear Implants | 20% after deductible | 50% after deductible |
| Telehealth Service and Virtual Visits | 20% after deductible | 50% after deductible |
| 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. | 50% after deductible |
| Amino Acid Based Elemental Formulas | Same as DME or pharmacy as appropriate | 50% 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 | 50% after deductible |

| Medical Benefits | Participating Provider Member Copayment | Non-Participating Provider Member Copayment |
|---|--|--|
| All Other Covered Medical Benefits (not specified herein) | 20% after deductible | 50% after deductible |

| Covered Benefit Limitations* |
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| <p>Cardiovascular Disease Screening <i>Limited to once every 5 years.</i></p> <p>Chiropractic Care <i>Limited to 35 visits per plan year.</i></p> <p>Rehabilitation <i>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.</i></p> <p>Habilitation <i>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.</i></p> <p>Hearing Aids <i>Limited to one device per ear every 3 years. Limited to members through the age of 18.</i></p> <p>Home Health Care <i>Limited to 60 visits per plan year.</i></p> <p>Skilled Nursing Facility <i>Limited to 25 days per plan year.</i></p> |