Baylor Scott & White Care Plan

Large Group
Medical Schedule of Benefits
Consumer Choice
Health Maintenance Organization
BSW Plus HMO Network
HC24_3200_02HD
LE4HA2H2

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

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	$3,200 per Member $6,400 per Family
Maximum Out-of-Pocket *Includes Medical Deductible, Pharmacy Deductible and Copayments.*	$5,250 per Member $10,500 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.*	20% copayment after deductible	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.*	20% copayment after deductible	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.*	20% copayment after deductible	Not covered

Medical Benefits	*Participating Provider Member Copayment*	*Non-Participating Provider Member Copayment*
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	Not covered
Allergy Testing, Serum, and Injections	20% copayment after deductible	Not covered
Diagnostic Test Routine lab, EKG, and x-rays.	20% copayment after deductible	Not covered
Imaging and Radiology (Including Facility and Physician charges) Angiography, CT Scans, MRIs, Myelography, PET Scans, Stress Tests.	20% copayment after deductible	Not covered
Cardiovascular Disease Screening*	20% copayment after deductible	Not covered
Outpatient Surgery Facility charges, Covered Prescription Drugs, Specialty Drugs, Medical Supplies, Observation Unit, Surgical Procedures, Pain Management.	20% copayment after deductible	Not covered
Outpatient Physician Services	20% copayment after deductible	Not covered
Emergency Care Copayment waived if episode results in hospitalization for the same condition within 24 hours.	20% copayment after deductible	20% copayment after deductible
Ambulance Transportation Ground, Sea, or Air.	20% copayment after deductible	20% copayment after deductible
Urgent Care	20% copayment after deductible	20% copayment after deductible

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% copayment after deductible	Not covered
Skilled Nursing Facility*	20% copayment after deductible	Not covered
Adult Outpatient Mental Health Care, Serious Mental Illness and Chemical Dependency	20% copayment after deductible	Not covered
Pediatric Outpatient Mental Health Care, Serious Mental Illness and Chemical Dependency	20% copayment after deductible	Not covered
Maternity Care and Family Planning Postnatal Care, Family Planning (as medically necessary).	20% copayment after deductible	Not covered
Infertility (Diagnosis Only)	20% copayment after deductible	Not covered
Rehabilitation* Physical Therapy, Occupational Therapy, Speech Therapy, Chiropractic Care.	20% copayment after deductible	Not covered
Habilitation* Physical Therapy, Occupational Therapy, Speech Therapy, Chiropractic Care.	20% copayment after deductible	Not covered
Chiropractic Care*	20% copayment after deductible	Not covered
Home Health Care*	20% copayment after deductible	Not covered
Hospice Care	20% copayment after deductible	Not covered
Durable Medical Equipment (DME) Orthotics, Prosthetics.	20% copayment after deductible	Not covered
Diabetes Management Diabetes Self-Management Training, Diabetes Education, Diabetes Care Management.	20% copayment after deductible	Not covered
Diabetes Equipment and Supplies	Same as DME or pharmacy, as appropriate	Not covered

Medical Benefits	*Participating Provider Member Copayment*	*Non-Participating Provider Member Copayment*
Nutritional Counseling	20% copayment after deductible	Not covered
Hearing Aids* and Cochlear Implants	20% copayment after deductible	Not covered
Telehealth Service and Virtual Visits	20% copayment after deductible	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
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).	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% copayment after deductible	Not covered

Covered Benefit Limitations*
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. Limited to members through the age of 18.* **Home Health Care** *Limited to 60 visits per plan year.* **Skilled Nursing Facility** *Limited to 25 days per plan year.*