

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.

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| Plan Year | Calendar Year |
| Medical Deductible | \$3,200 per Member \$6,400 per Family |
| Maximum Out-of-Pocket <i>Includes Medical Deductible, Pharmacy Deductible and Copayments.</i> | \$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. <i>Office visit charge applies when seen by a physician and/or a licensed clinician under the supervision of the physician.</i> | 20% copayment after deductible | Not covered |
| Pediatric PCP Office Visit For a covered dependent through the age of 18. <i>Office visit charge applies when seen by a physician and/or a licensed clinician under the supervision of the physician.</i> | 20% copayment after deductible | Not covered |
| 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% 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.