

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

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	\$3,200 per Member \$6,400 per Family	\$6,400 per Member \$12,800 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 Covered HMO benefits will not be applied to the POS Maximum Out-of-Pocket.
Coinsurance	80% coinsurance after deductible	50% coinsurance 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 from a Participating Provider facility, Emergency Care, Air Ambulance Transportation services, and EMS Provider Transportation services and covered supplies, 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. <i>Office visit charge applies when seen by a physician and/or a licensed clinician under the supervision of the physician.</i>	20% coinsurance after deductible	50% coinsurance 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. <i>Office visit charge applies when seen by a physician and/or a licensed clinician under the supervision of the physician.</i>	20% coinsurance after deductible	50% coinsurance after deductible
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% coinsurance after deductible	50% coinsurance 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% coinsurance after deductible
Allergy Testing, Serum, and Injections	20% coinsurance after deductible	50% coinsurance after deductible
Diagnostic Test Routine lab, EKG, and X-rays.	20% coinsurance after deductible	50% coinsurance after deductible
Imaging and Radiology (Including Facility and Physician charges) Angiography, CT Scans, MRIs, Myelography, PET Scans, Stress Tests.	20% coinsurance after deductible	50% coinsurance after deductible
Cardiovascular Disease Screening*	20% coinsurance after deductible	50% coinsurance after deductible
Outpatient Surgery Procedure Facility charges, Covered Prescription Drugs, Specialty Drugs, Medical Supplies, Observation Unit, Surgical Procedures, Pain Management.	20% coinsurance after deductible	50% coinsurance after deductible
Outpatient Physician Services	20% coinsurance after deductible	50% coinsurance after deductible
Emergency Care Copayment waived if episode results in hospitalization for the same condition within 24 hours.	20% coinsurance after deductible	20% coinsurance after deductible

Medical Benefits	Participating Provider Member Copayment	Non-Participating Provider Member Copayment
Ambulance Transportation Ground, Sea, or Air.	20% coinsurance after deductible	20% coinsurance after deductible
Urgent Care	20% coinsurance after deductible	20% coinsurance 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% coinsurance after deductible	50% coinsurance after deductible
Skilled Nursing Facility*	20% coinsurance after deductible	50% coinsurance after deductible
Adult Outpatient Mental Health Care, Serious Mental Illness and Chemical Dependency	20% coinsurance after deductible	50% coinsurance after deductible
Pediatric Outpatient Mental Health Care, Serious Mental Illness and Chemical Dependency	20% coinsurance after deductible	50% coinsurance after deductible
Maternity Care and Family Planning Postnatal Care, Family Planning (as medically necessary).	20% coinsurance after deductible	50% coinsurance after deductible
Infertility (Diagnosis Only)	20% coinsurance after deductible	50% coinsurance after deductible
Rehabilitation* Physical Therapy, Occupational Therapy, Speech Therapy, Chiropractic Care.	20% coinsurance after deductible	50% coinsurance after deductible
Habilitation* Physical Therapy, Occupational Therapy, Speech Therapy, Chiropractic Care.	20% coinsurance after deductible	50% coinsurance after deductible
Chiropractic Care*	20% coinsurance after deductible	50% coinsurance after deductible
Home Health Care*	20% coinsurance after deductible	50% coinsurance after deductible
Hospice Care	20% coinsurance after deductible	50% coinsurance after deductible
Durable Medical Equipment (DME) Orthotics, Prosthetics.	20% coinsurance after deductible	50% coinsurance after deductible

Medical Benefits	Participating Provider Member Copayment	Non-Participating Provider Member Copayment
Diabetes Management Diabetes Self-Management Training, Diabetes Education, Diabetes Care Management.	20% coinsurance after deductible	50% coinsurance after deductible
Diabetes Equipment and Supplies	Same as DME or pharmacy, as appropriate	50% coinsurance after deductible
Nutritional Counseling	20% coinsurance after deductible	50% coinsurance after deductible
Hearing Aids* and Cochlear Implants	20% coinsurance after deductible	50% coinsurance after deductible
Telehealth Service and Virtual Visits	20% coinsurance after deductible	50% coinsurance 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% coinsurance after deductible
Amino Acid Based Elemental Formulas	Same as DME or pharmacy as appropriate	50% coinsurance after deductible
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	50% coinsurance after deductible
All Other Covered Medical Benefits (not specified herein)	20% coinsurance after deductible	50% coinsurance after deductible

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.