

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.***

	Calendar Year
<b>Medical Deductible</b>	\$0 per Member \$0 per Family
<b>Maximum Out-of-Pocket</b> <i>Includes Medical Deductible, Pharmacy Deductible and Copayments.</i>	\$4,000 per Member \$8,000 per Family
<b>Annual Maximum</b>	Unlimited

<b>Medical Benefits</b>	<b>Participating Provider Member Copayment</b>	<b>Non-Participating Provider Member Copayment</b>
<b>Adult PCP Office Visit</b> <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>	No charge for the first non-preventive sick visit in the calendar year. \$25 copayment per visit for subsequent visits in that calendar year	Not covered
<b>Pediatric PCP Office Visit</b> <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>	No charge per visit	Not covered
<b>Specialist Physician Office Visit</b> <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>	\$50 copayment per visit	Not covered
<b>Annual Routine Eye Exam</b>	Not covered	Not covered

<b>Medical Benefits</b>	<b>Participating Provider Member Copayment</b>	<b>Non-Participating Provider Member Copayment</b>
<b>Preventive Care</b> 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	Not covered
<b>Allergy Testing, Serum, and Injections</b>	20% copayment	Not covered
<b>Diagnostic Test</b> Routine lab, EKG, and X-rays.	No charge	Not covered
<b>Imaging and Radiology</b> (Including Facility and Physician charges) Angiography, CT Scans, MRIs, Myelography, PET Scans, Stress Tests.	20% copayment	Not covered
<b>Cardiovascular Disease Screening*</b>	20% copayment	Not covered
<b>Outpatient Surgery Procedure</b> Facility charges, Covered Prescription Drugs, Specialty Drugs, Medical Supplies, Observation Unit, Surgical Procedures, Pain Management.	20% copayment	Not covered
<b>Outpatient Physician Services</b>	20% copayment	Not covered
<b>Emergency Care</b> Copayment waived if episode results in hospitalization for the same condition within 24 hours.	\$500 copayment per visit, plus 20% copayment	\$500 copayment per visit, plus 20% copayment
<b>Ambulance Transportation</b> Ground, Sea, or Air.	\$500 copayment per service, plus 20% copayment	\$500 copayment per service, plus 20% copayment
<b>Urgent Care</b>	\$50 copayment per visit	\$50 copayment per visit
<b>Inpatient Care</b> 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	Not covered
<b>Skilled Nursing Facility*</b>	20% copayment	Not covered
<b>Adult Outpatient Mental Health Care, Serious Mental Illness and Chemical Dependency</b>	\$25 copayment per visit, 20% copayment for all other outpatient services	Not covered
<b>Pediatric Outpatient Mental Health Care, Serious Mental Illness and Chemical Dependency</b>	No charge	Not covered

<b>Medical Benefits</b>	<b>Participating Provider Member Copayment</b>	<b>Non-Participating Provider Member Copayment</b>
<b>Maternity Care and Family Planning</b> Postnatal Care, Family Planning (as medically necessary).	\$25 copayment per visit	Not covered
<b>Infertility (Diagnosis Only)</b>	\$50 copayment per visit	Not covered
<b>Rehabilitation*</b> Physical Therapy, Occupational Therapy, Speech Therapy, Chiropractic Care.	\$25 copayment per visit	Not covered
<b>Habilitation*</b> Physical Therapy, Occupational Therapy, Speech Therapy, Chiropractic Care.	\$25 copayment per visit	Not covered
<b>Chiropractic Care*</b>	\$25 copayment per visit	Not covered
<b>Home Health Care*</b>	20% copayment	Not covered
<b>Hospice Care</b>	No charge	Not covered
<b>Durable Medical Equipment (DME)</b> Orthotics, Prosthetics.	20% copayment	Not covered
<b>Diabetes Management</b> Diabetes Self-Management Training, Diabetes Education, Diabetes Care Management.	\$25 copayment per visit	Not covered
<b>Diabetes Equipment and Supplies</b>	Same as DME or pharmacy, as appropriate	Not covered
<b>Nutritional Counseling</b>	\$25 copayment per visit	Not covered
<b>Hearing Aids* and Cochlear Implants</b>	20% copayment	Not covered
<b>Telehealth Service and Virtual Visits</b>	No charge	Not covered
<b>Other Telehealth Service and Telemedicine Medical Service</b>	The amount of the copayment may not exceed the amount of the copayment required for a comparable medical benefit provided through a face-to-face consultation.	Not covered
<b>Amino Acid Based Elemental Formulas</b>	Same as DME or pharmacy as appropriate	Not covered
<b>Other Medical Benefits</b> 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
<b>All Other Covered Medical Benefits</b> (not specified herein)	20% copayment	Not covered

**Covered Benefit Limitations\***

**Cardiovascular Disease Screening**

*Limited to once every 5 years.*

**Chiropractic Care**

*Limited to 35 visits per calendar year.*

**Rehabilitation**

*Limited to 35 combined PT/OT/SP Outpatient visits per calendar year.*

*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 per calendar year.*

*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 calendar year.*

**Skilled Nursing Facility**

*Limited to 25 days per calendar year.*