Individual Schedule of Benefits

Exclusive Provider Organization EPO Individual - Off Exchange

BSW Vital Bronze EPO 001

37755TX0250001-00

The following is a summary of the copayment amounts members must pay when receiving the covered benefits listed below. Refer to the Policy 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 swhp.org or contact Customer Service, Monday through Friday, 7:00 a.m. – 7:00 p.m. 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, or health status in the administration of the plan, including enrollment and benefit determinations.

Plan Year	Calendar Year
Medical Deductible	$7,600 per Member $15,200 per Family
Pharmacy Deductible	ACA Preventive Drugs and Tier 1 : $0 Tier 2-4 and preferred diabetic test strips for blood glucose monitors : Integrated with Medical
Maximum Out of Pocket *Includes Medical Deductible, Pharmacy Deductible, Copayments, and Coinsurance.*	$8,550 per Member $17,100 per Family
Annual Maximum	Unlimited

Medical Benefits	*Participating Provider Member Copayment*
Adult PCP Office Visit *Office visit charge applies when seen by a physician and/or a licensed clinician under the supervision of the physician.*	$45 copayment per visit
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.*	No charge
Specialist Physician Office Visit *Office visit charge applies when seen by a physician and/or a licensed clinician under the supervision of the physician.*	$95 copayment per visit
Pediatric Annual Routine Eye Exam For a covered dependent through the age of 18.	$95 copayment per visit
Pediatric Prescription Eyewear* For a covered dependent through the age of 18.	$95 copayment per pair
Dental Care For a covered dependent through the age of 18. See dental plans available through the Issuer	Not covered

Medical Benefits	*Participating Provider Member Copayment*
Preventive Care Routine Annual Physical Exam, Immunizations, Well-Baby Care, Well-Child Care, Cancer Screening Mammography, Bone Mass Measurement for Osteoporosis, Prostate Cancer Screening Exam, Colorectal Cancer Screening Exam, Ovarian and Cervical Cancer Screening Exam, Prenatal Visits, Tubal Ligation, Cardiovascular Disease Screening*, 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
Allergy Testing, Serum and Injections	20% after deductible
Diagnostic Test Routine lab, EKG and x-rays.	20% after deductible
Imaging and Radiology (Including Facility and Physician charges) Angiography, CT Scans, MRIs, Myelography, PET Scans, Stress Tests.	20% after deductible
Outpatient Surgery Procedure (Including Facility charges) Medical Injectables, Medical Supplies, Observation Unit, Surgical Procedures, Pain Management.	20% after deductible
Outpatient Physician Services	20% after deductible
Emergency Care Copayment waived if episode results in hospitalization for the same condition within 24 hours.	20% after deductible
Ambulance Transportation Ground, Sea or Air	20% after deductible
Urgent Care	$95 copayment per visit
Inpatient Care (Including Facility and Physician charges) Pre-admission Testing, Prescription Drugs, Specialty Pharmacy Drugs, Medical Injectables, 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
Skilled Nursing Facility*	20% after deductible
Outpatient Mental Health Care, Serious Mental Illness and Chemical Dependency	$45 copayment per visit, 20% after deductible for all other outpatient services
Maternity Care and Family Planning Postnatal Care, Family Planning (as medically necessary).	$45 copayment per visit
Infertility (Diagnosis Only)	$95 copayment per visit
Rehabilitation* Physical Therapy, Occupational Therapy, Speech Therapy, Chiropractic Care.	$45 copayment per visit

Medical Benefits	*Participating Provider Member Copayment*
Habilitation* Physical Therapy, Occupational Therapy, Speech Therapy, Chiropractic Care.	$45 copayment per visit
Home Health Care*	20% after deductible
Hospice Care	20% after deductible
Durable Medical Equipment (DME) Orthotics; Prosthetics	20% after deductible
Diabetes Management Diabetes Self-Management Training, Diabetes Education, Diabetes Care Management.	$45 copayment per visit
Diabetes Equipment and Supplies	Same as DME or pharmacy, as appropriate
Nutritional Counseling	$45 copayment per visit
Hearing Aids* and Cochlear Implants	20% after deductible
Telehealth Service and Virtual Visits	No charge
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.
Amino Acid Based Elemental Formulas	20% 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, 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.
All Other Covered Medical Benefits (not specified herein)	20% after deductible

Pharmacy Benefits	Participating Provider Member Copayment	
	30-day Standard	***90-day Maintenance*****
ACA preventive drugs	No charge	No charge
Tier 1 Generic drugs	$25 copayment per prescription	$75 copayment per prescription
Tier 2 Preferred brand name drugs	$55 copayment per prescription after deductible	$165 copayment per prescription after deductible
Tier 3 Non-preferred drugs	$150 copayment per prescription after deductible	$450 copayment per prescription after deductible
Tier 4 Specialty drugs and oral anticancer medications	$500 copayment per prescription after deductible	Not covered
Preferred diabetes test strips for blood glucose monitors	$55 copayment per prescription after deductible	$165 copayment per prescription after deductible
Non-preferred diabetes test strips for blood glucose monitors	Non-formulary	Non-formulary
**Maintenance drugs are allowed up to a 90-day supply if obtained through a Baylor Scott & White Pharmacy or participating pharmacy. Mail Order: Available for a 1- to 90-day supply. Non-maintenance drugs obtained through mail order are limited to a 30-day supply maximum. Some specialty drugs may require preauthorization. 30-day supply only.		

Covered Benefit Limitations*

Cardiovascular Disease Screening
Limited to once every 5 years

Rehabilitation
Limited to 35 combined visits per plan year
Limits may not apply for therapies for children with developmental delays and Autism Spectrum Disorder and mental health services.

Habilitation
Limited to 35 combined visits per plan year
Limits may not apply for therapies for children with developmental delays and Autism Spectrum Disorder and mental health services.

Hearing Aids
Limited to one device per ear every 3 years

Home Health Care
Limited to 60 visits per plan year

Skilled Nursing Facility
Limited to 25 days per plan year

Pediatric Prescription Eyewear
Limited to one pair of glasses or contact lenses per plan year. Refer to plan document for details.