Individual Schedule of Benefits

Health Maintenance Organization
HMO Individual - Off Exchange
BSW Vital Bronze HMO 001
40788TX0410001-00

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 is a summary of 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 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 and Copayments.*	$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 Prescription Eyewear* For a covered dependent through the age of 18.	$95 copayment per pair

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, 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, 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.

Nondiscrimination Notice

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-844-633-5325 (TTY: 711).

Scott and White Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Scott and White Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Scott and White Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Written information in other formats (large print and accessible electronic formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Scott and White Health Plan (SWHP) Compliance Officer at 1-214-820-8888 or send an email to SWHPComplianceDepartment@BSWHealth.org

If you believe that Scott and White Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

SWHP Compliance Officer
1206 West Campus Drive, Suite 151
Temple, Texas 76502

Compliance HelpLine; 1-888-484-6977 or https://app.mycompliancereport.com/report.aspx?cid=swhp

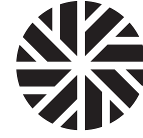
You can file a grievance in person or by mail, online, or email. If you need help filing a grievance, the SWHP Compliance Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at https://www.hhs.gov/civil-rights/filing-a-complaint/index.html.

Language Assistance/ Asistencia de idiomas



Scott&White
HEALTH PLAN
PART OF BAYLOR SCOTT & WHITE HEALTH

English:
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-844-633-5325 (TTY: 711).

Spanish:
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-633-5325 (TTY: 711).

Vietnamese:
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-633-5325 (TTY: 711).

Chinese:
注意：如果 使用繁體中文, 可以免費獲得語言援助服務。請致電 1-844-633-5325 (TTY：711)。

Korean:
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-633-5325 (TTY: 711) 번으로 전화해 주십시오.

Arabic:
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-844-633-5325 (رقم هاتف الصم والبكم: 711).

Urdu:
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-844-633-5325 (TTY: 711).

Tagalog:
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-633-5325 (TTY: 711).

French:
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-844-633-5325 (ATS : 711).

Hindi:
ध्यान दें: यदि आप हिंदी बोलते है तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध है। 1-844-633-5325 (TTY: 711) पर कॉल करें।

Persian:
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (TTY: 711) 1-844-633-5325 تماس بگیرید.

German:
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-844-633-5325 (TTY: 711).

Gujarati:
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-844-633-5325 (TTY: 711).

Russian:
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-633-5325 (телетайп: 711).

Japanese:
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-844-633-5325 (TTY:711) まで、お電話にてご連絡ください。

Laotian:
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-844-633-5325 (TTY: 711).