



# Individual Schedule of Benefits

## Health Maintenance Organization

### BSW Preferred

### BSW Prime Silver HMO 003

### 40788TX0460003-01

### SHIW1M03

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](http://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.***

<b>Plan Year</b>	Calendar Year
<b>Medical Deductible</b>	\$3,000 per Member \$6,000 per Family
<b>Pharmacy Deductible</b>	ACA Preventive Drugs and Tier 1 : \$0 Tier 2-4 and preferred diabetic test strips for blood glucose monitors : Integrated with Medical
<b>Maximum Out of Pocket</b> <i>Includes Medical Deductible, Pharmacy Deductible and Copayments.</i>	\$8,550 per Member \$17,100 per Family
<b>Annual Maximum</b>	Unlimited

<b>Medical Benefits</b>	<i>Participating Provider Member Copayment</i>
<b>Adult PCP Office Visit</b> <i>Office visit charge applies when seen by a physician and/or a licensed clinician under the supervision of the physician.</i>	\$30 copayment per visit
<b>Pediatric PCP Office Visit</b> 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>	No charge
<b>Specialist Physician Office Visit</b> <i>Office visit charge applies when seen by a physician and/or a licensed clinician under the supervision of the physician.</i>	\$60 copayment per visit
<b>Pediatric Prescription Eyewear*</b> For a covered dependent through the age of 18.	\$60 copayment per pair

Medical Benefits	Participating Provider Member Copayment
<b>Preventive Care</b> 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
<b>Allergy Testing, Serum and Injections</b>	40% after deductible
<b>Diagnostic Test</b> Routine lab, EKG and x-rays.	40% after deductible
<b>Imaging and Radiology</b> (Including Facility and Physician charges) Angiography, CT Scans, MRIs, Myelography, PET Scans, Stress Tests.	40% after deductible
<b>Outpatient Surgery Procedure</b> (Including Facility charges) Medical Injectables, Medical Supplies, Observation Unit, Surgical Procedures, Pain Management.	\$600 copayment per visit plus 40% after deductible
<b>Outpatient Physician Services</b>	\$300 copayment per visit plus 40% after deductible
<b>Emergency Care</b> Copayment waived if episode results in hospitalization for the same condition within 24 hours.	\$750 copayment per visit plus 40% after deductible
<b>Ambulance Transportation</b> Ground, Sea or Air	\$750 copayment per service plus 40% after deductible
<b>Urgent Care</b>	\$60 copayment per visit
<b>Inpatient Care</b> (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.	\$1,000 copayment per day plus 40% after deductible, not to exceed \$5,000
<b>Skilled Nursing Facility*</b>	40% after deductible
<b>Outpatient Mental Health Care, Serious Mental Illness and Chemical Dependency</b>	\$30 copayment per office visit, \$600 copayment plus 40% after deductible for all other outpatient services
<b>Maternity Care and Family Planning</b> Postnatal Care, Family Planning (as medically necessary).	\$30 copayment per visit
<b>Infertility (Diagnosis Only)</b>	\$60 copayment per visit
<b>Rehabilitation*</b> Physical Therapy, Occupational Therapy, Speech Therapy, Chiropractic Care.	\$30 copayment per visit

Medical Benefits	<i>Participating Provider Member Copayment</i>
<b>Habilitation*</b> Physical Therapy, Occupational Therapy, Speech Therapy, Chiropractic Care.	\$30 copayment per visit
<b>Home Health Care*</b>	40% after deductible
<b>Hospice Care</b>	40% after deductible
<b>Durable Medical Equipment (DME)</b> Orthotics; Prosthetics	40% after deductible
<b>Diabetes Management</b> Diabetes Self-Management Training, Diabetes Education, Diabetes Care Management.	\$30 copayment per visit
<b>Diabetes Equipment and Supplies</b>	Same as DME or pharmacy, as appropriate
<b>Nutritional Counseling</b>	\$30 copayment per visit
<b>Hearing Aids* and Cochlear Implants</b>	40% after deductible
<b>Telehealth Service and Virtual Visits</b>	No charge
<b>Other Telehealth Service and Telemedicine Medical Service</b>	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.
<b>Amino Acid Based Elemental Formulas</b>	40% after deductible
<b>Other Medical Benefits</b> 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.
<b>All Other Covered Medical Benefits</b> (not specified herein)	40% after deductible

Pharmacy Benefits	Participating Provider Member Copayment	
	30-day Standard	90-day Maintenance**
ACA preventive drugs	No charge	No charge
<b>Tier 1</b> Generic drugs	\$15 copayment per prescription	\$45 copayment per prescription
<b>Tier 2</b> Preferred brand name drugs	\$55 copayment per prescription after deductible	\$165 copayment per prescription after deductible
<b>Tier 3</b> Non-preferred drugs	\$150 copayment per prescription after deductible	\$450 copayment per prescription after deductible
<b>Tier 4</b> Specialty drugs and oral anticancer medications	\$500 copayment per prescription after deductible	Not covered
<b>Preferred diabetes test strips for blood glucose monitors</b>	\$55 copayment per prescription after deductible	\$165 copayment per prescription after deductible
<b>Non-preferred diabetes test strips for blood glucose monitors</b>	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*
<p><b>Cardiovascular Disease Screening</b> <i>Limited to once every 5 years</i></p>
<p><b>Rehabilitation</b> <i>Limited to 35 combined visits per plan year</i> <i>Limits may not apply for therapies for children with developmental delays, Autism Spectrum Disorder and mental health services.</i></p>
<p><b>Habilitation</b> <i>Limited to 35 combined visits per plan year</i> <i>Limits may not apply for therapies for children with developmental delays, Autism Spectrum Disorder and mental health services.</i></p>
<p><b>Hearing Aids</b> <i>Limited to one device per ear every 3 years</i></p>
<p><b>Home Health Care</b> <i>Limited to 60 visits per plan year</i></p>
<p><b>Skilled Nursing Facility</b> <i>Limited to 25 days per plan year</i></p>
<p><b>Pediatric Prescription Eyewear</b> <i>Limited to one pair of glasses or contact lenses per plan year. Refer to plan document for details.</i></p>



# Nondiscrimination Notice

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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](mailto: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>.

**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:**

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

**Urdu:**

کریں۔ 711 (TTY: 711) خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال

**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 हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-844-633-5325 (TTY: 711) पर कॉल करें।

**Persian:**

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

**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 નિ:શુલ્ક 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:**

ໄປດຳລາບ: ຖ້າ ງ່ອ ອໍ ທ ັ າ ນ ຸ າ ມ າ ສ າ າ າ ອ, ການບ ັ າ ການຊ ັ າ ອ ຂ ັ າ ອ ັ າ ນ າ ສ າ, ໂດຍບ ັ າ ສ ັ າ ັ າ, ຄ ັ າ ມ ມ ັ າ ອ ມ ັ າ ັ າ ັ າ. ໂທ 1-844-633-5325 (TTY: 711).