Baylor Scott & White Health Plan

https://bswhealthplan.com/fehb

Customer Service 844-633-5325

2027

A Health Maintenance Organization (Standard, Basic and Value Options)

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 9. This plan is accredited. See page 13.

Standard Option: Serving the Central, North and West Texas Areas

Basic Option: Serving the Central, North and West Texas Areas

Value Option: Serving the Central, North and West Texas Areas

IMPORTANT
- Rates: Back Cover
- Changes for 2027: Page 16
- Summary of Benefits: Page 87

Enrollment in these plans is limited.

You must live or work in the Baylor Scott and White Health Plan geographic service area based upon the plan option selected. Please see Section 1, page 14, under Eligibility Service Area for a list of counties for our Standard, Basic, and Value plan options.

Postal Employees and Annuitants are no longer eligible for this plan (unless currently under Temporary Continuation of Coverage).

Enrollment Codes for the Standard Plan in Central Texas:
A84 Standard Option - Self Only
A86 Standard Option - Self Plus One
A85 Standard Option - Self and Family

Enrollment Codes for the Basic Plan in Central Texas:
A81 Basic Option - Self Only
A83 Basic Option - Self Plus One
A82 Basic Option - Self and Family

Enrollment Codes for the Value Plan in Central Texas:
YZ1 Value Option - Self Only
YZ3 Value Option - Self Plus One
YZ2 Value Option - Self and Family

Enrollment Codes for the Standard Plan in North and West Texas:
P84 Standard Option - Self Only
P86 Standard Option - Self Plus One
P85 Standard Option - Self and Family

Enrollment Codes for the Basic Plan in North and West Texas:
P81 Basic Option - Self Only
P83 Basic Option - Self Plus One
P82 Basic Option - Self and Family

Enrollment Codes for the Value Plan in North and West Texas:
RE1 Value Option - Self Only
RE3 Value Option - Self Plus One
RE2 Value Option - Self and Family

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Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

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Important Notice from Baylor Scott & White Health Plan About
Our Prescription Drug Coverage and Medicare

The Office of Personnel Management (OPM) has determined that BSWHP's prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1 percent per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 through December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www. socialsecurity.gov, or call the SSA at 800-772-1213, TTY: 800-325-0778.

Additional Premium for Medicare's High Income Members

Income-Related Monthly Adjustment Amount (IRMAA)

The Medicare Income-Related Monthly Adjustment Amount (IRMAA) is an amount you may pay in addition to your FEHB premium to enroll in and maintain Medicare prescription drug coverage. **This additional premium is assessed only to those with higher incomes and is adjusted based on the income reported on your IRS tax return.** You do not make any IRMAA payments to your FEHB plan. Refer to the Part D-IRMAA section of the Medicare website to see if you would be subject to this additional premium.

You can get more information about Medicare prescription drug plan and about coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help
- Call 800-MEDICARE (1-800-633-4227), (TTY 877-486-2048)

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Introduction

This brochure describes the benefits of FEHB under contract (CS 2942) between Scott and White Health Plan and the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer service may be reached at 844-633-5325 or through our website: https://bswhealthplan.com/fehb. If you are deaf, hearing impaired or speech impaired, you can contact our Customer Service at 844-633-5325, TTY 711. If you need ASL providers see our website at https://bswhealthplan.com/fehb. The address for BSWHP administrative offices is:

Baylor Scott & White Health Plan
1206 West Campus Drive
Temple, TX 76502

This brochure is the official statement of benefits. No verbal statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One or Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2026, unless the benefits are also shown in this brochure.

OPM negotiates benefits and rates for each plan annually. Benefit changes are effective January 1, 2027, and changes are summarized on page 16. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples:

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee and each covered family member, "we" means Baylor Scott & White Health Plan.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

Stop Health Care Fraud!

Fraud increases the cost of healthcare for everyone and increases your Federal Employees Health Benefits Program premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the phone or to people you do not know, except for your healthcare providers, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Periodically review your claim history for accuracy to ensure we have not been billed for services you did not receive.
- Do not ask your doctor to make false entries on certificates, bills, or records in order to get us to pay for an item or service.

If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 844-633-5325 and explain the situation.
- If we do not resolve the issue

CALL - THE HEALTHCARE FRAUD HOTLINE
877-499-7295
OR go to www. opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/

The online reporting form is the desired method of reporting fraud in order to ensure accuracy and a quicker response time.

You can also write to:

United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC; 20415-1100

Do not maintain as a family member on your policy:

- Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise)
- Your child age 26 or over (unless they are disabled and incapable of self-support prior to age 26)

A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB Plan.

- If you have any questions about the eligibility of a family member, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage (TCC).
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage, (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Discrimination is Against the Law

Discrimination is Against the Law

We comply with applicable Federal nondiscrimination laws and do not discriminate on the basis of race, color, national origin, age, disability, religion, or sex (pregnancy, or genetic information). We do not exclude people or treat them differently because of race, color, national origin, age, disability, religion, or sex (pregnancy, genetic information).

The health benefits described in this brochure are consistent with applicable laws prohibiting discrimination. All coverage decisions will be based on nondiscriminatory standards and criteria. An individual's protected trait or traits, will not be used to deny health benefits for items, supplies, or services that are otherwise covered and determined to be medically necessary.

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction of medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own healthcare and that of your family members by learning more about and understanding your risks. Take these simple steps:

1. **Ask questions if you have doubts or concerns.**

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you take notes, ask questions, and understand answers.

2. **Keep and bring a list of all the medications you take.**

- Bring the actual medication or give your doctor and pharmacist a list of all the medications and dosage that you take, including non-prescription (over-the-counter) medications and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as to latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medication is what the doctor ordered. Ask your pharmacist about the medication if it looks different than you expected.
- Read the label and patient package insert when you get your medication, including all warnings and instructions.
- Know how to use your medication. Especially note the times and conditions when your medication should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.
- Understand both the generic and brand names for all of your medications is important. This helps to ensure you do not receive double dosing from taking both a generic and a brand of the same medication. It also helps you taking a medication to which you are allergic.

3. **Get the results of any test or procedure**.

- Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, through the Plan or Provider's portal?
- Don't assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.
- Ask what the results mean for your care.

4. **Talk to your doctor about which hospital or clinic is best for your health needs.**

- Ask your doctor about which hospital or clinic has the best care and results for your condition if you have more than one hospital or clinic to choose from to get the healthcare you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital or clinic.

5. **Make sure you understand what will happen if you need surgery.**

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
  - Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
  - "Exactly what will you be doing?"
  - "About how long will it take?"
  - "What will happen after surgery?"
  - "How can I expect to feel during recovery?"
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

For more information on patient safety, please visit:

- www. jointcommission.org/speakup.aspx. The Joint Commission's Speak Up™ patient safety program.
- www. jointcommission.org/topics/patient_safety.aspx. The Joint Commission helps healthcare organizations to improve the quality and safety of the care they deliver.
- www. ahrq.gov/patients-consumers/. The Agency for Healthcare Research and Quality make available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality healthcare providers and improve the quality of care you receive.
- www. bemedwise.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medications.
- www. leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www. ahqa.org. The American Health Quality Association represents organizations and healthcare professionals working to improve patient safety.
- www. psnet.ahrq.gov/issue/national-patient-safety-foundation. The National Patient Safety Foundation has information on how to ensure safer healthcare for you and your family.
- www. bemedwise.org The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medication.

Preventable Healthcare Acquired Conditions ("Never Events")

When you enter the hospital for treatment of one medical problem, you do not expect to leave with additional injuries, infections or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, can indicate a significant problem in the safety and credibility of a healthcare facility. These conditions and errors are sometimes called "Never Events" or "Serious Reportable Events."

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores, and fractures, and to reduce medical errors that should never happen. When such an event occurs, neither you nor your FEHB plan will incur costs to correct the medical error.

You will not be billed for inpatient services related to the treatment of specific hospital-acquired conditions or for inpatient services needed to correct Never Events if you use BSWHP contracted providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

FEHB Facts

Coverage information

- **No pre-existing condition limitation**

  We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

- **Minimum essential coverage (MEC)**

  Coverage under this plan qualifies as minimum essential coverage. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard**

  Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.

- **Where you can get information about enrolling in the FEHB Program**

  See www.opm.gov/healthcare-insurance for enrollment information as well as:

  - Information on the FEHB Program and plans available to you
  - A health plan comparison tool
  - A list of agencies that participate in Employee Express
  - A link to Employee Express
  - Information on and links to other electronic enrollment systems

  Also, your employing or retirement office can answer your questions, give you other plans' brochures and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

  - When you may change your enrollment;
  - How you can cover your family members;
  - What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
  - When your enrollment ends; and
  - When the next Open Season for enrollment begins.

  We do not determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact your employing or retirement office.

  Once enrolled in your FEHB Program Plus, you should contact your carrier directly for updates and questions about your benefit coverage.

- **Enrollment types available for you and your family**

  Self Only coverage is only for the enrollee. Self Plus One coverage is for the enrollee and one eligible member. Self and Family coverage is for the enrollee, and one or more eligible family members. Family members include your spouse, and your children under 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self Plus One or Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self Plus One or Self and Family enrollment begin on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self Plus One or Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form. Benefits will not be available to your spouse until you are married. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

Contact your employing or retirement office if you want to change from Self to Self Plus One or Self and Family. If you have a Self and Family enrollment, you may contact us to add a family member.

Your employing or retirement office will not notify you when a family member is no longer eligible to receive benefits. Please tell us immediately of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26. We will send written notice to you 60 days before we proactively disenroll your child on midnight of their 26th birthday unless your child is eligible for continued coverage because they are incapable of self-support due to a physical or mental disability that began before age 26.

If you or one of your family members is enrolled in one FEHB plan, you or they cannot be enrolled in or covered as a family member by another enrollee in another FEHB plan.

If you have a qualifying life event (QLE) - such as marriage, divorce, or the birth of a child -outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/ payroll office, or retirement office.

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including your spouse by a valid common law marriage from a state that recognizes common-law marriages) and children as described below. A Self Plus One enrollment covers you and your spouse, or one other eligible family member as described below.

Family members covered under your Self and Family enrollment are your spouse (including your spouse by valid common-law marriage if you reside in a state that recognizes common-law marriages) and children as described in the chart below. A Self Plus One enrollment covers you and your spouse, or one other eligible family member as described in the chart below.

Natural children, adopted children, and stepchildren
Coverage: Natural children, adopted children, and stepchildren are covered until their 26th birthday.

Foster children
Coverage: Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.

Children incapable of self-support
Coverage: Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.

Married children
Coverage: Married children (but NOT their spouse or their own children) are covered until their 26th birthday.

Children with or eligible for employer-provided health insurance
Coverage: Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

You can find additional information at www.opm.gov/healthcare-insurance.

- **Children's Equity Act**

OPM has implements the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the FEHB Program if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll in Self Plus One or Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self Plus One or Self and Family coverage, as appropriate in the lowest-cost nationwide plan option as determined by OPM.
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate in the lowest-cost nationwide plan option as determined by OPM.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that does not serve the area in which your children live, unless you provide documentation that you have other coverage for the children.

If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that does not serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits of this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be processed according to the 2027 benefits of your prior plan or option.** If you have met (or pay cost-sharing that results in your meeting) the out-of-pocket maximum under the prior plan or option, you will not pay cost-sharing for services covered between January 1 and the effective date of coverage under your new plan or option. However, if your prior plan left the FEHB Program at the end of 2026, you are covered under that plan's 2026 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

- **When you retire**

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

- **When FEHB coverage ends**

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment, or
- You are a family member no longer eligible for coverage.

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC).

- **Upon divorce**

If you are an enrollee and your divorce or annulment is final, your ex-spouse cannot remain covered as a family member under your Self Plus One or Self and Family enrollment. You **must** contact us to let us know the date of the divorce or annulment and have us remove your ex-spouse. We may ask for a copy of the divorce decree as proof. In order to change enrollment type, you must contact your employing or retirement office. A change will not automatically be made.

If you were married to an enrollee and your divorce or annulment is final, you may not remain covered as a family member under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get information about your coverage choices. You can also visit OPM's website at https://www.opm.gov/healthcare-insurance/life-events/memy-family/im-separated-or-im-getting-divorced/#url=Health. We may request that you verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

- **Temporary Continuation of Coverage (TCC)**

If you leave Federal service, Tribal employment, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal or Tribal job, or if you are a covered child and you turn 26,

You may not elect TCC if you are fired from your Federal or Tribal job due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC, from your employing or retirement office or from www.opm.gov/healthcare-insurance. It explains what you have to do to enroll.

Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHB Program coverage.

Converting to individual coverage

You may convert to a non-FEHB individual policy if:

- Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert);
- You decided not to receive coverage under TCC or the spouse equity law, or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal or Tribal service, your employing office will notify you of your right to convert. You must contact us in writing within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will not notify you. You must contact us in writing within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, a waiting period will not be imposed, and your coverage will not be limited due to pre-existing conditions. When you contact us we will assist you in obtaining information about health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace in your state. For assistance in finding coverage, please contact us at 844-633-5325 or visit our website at www.bswhealthplan.com/fehb.

- **Health Insurance Marketplace**

If you would like to purchase health insurance through the ACA's Health Insurance Marketplace, please visit www.HealthCare.gov. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

Section 1. How This Plan Works

This Plan is a health maintenance organization (HMO). OPM requires that FEHB plans be accredited to validate that plan operations and/or care management meet nationally recognized standards. Baylor Scott & White Health Plan holds the following accreditation: National Committee for Quality Assurance (NCQA). To learn more about this plan's accreditation, please visit the following website: www. ncqa.org.

We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. We are solely responsible for the selection of these providers in your area. Contact us for a copy of our most recent provider directory. We give you a choice of enrollment in a Standard Option, Basic and a Value Option plan.

HMOs, emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other providers will be available and/or remain under contract with us.

General features of our Standard, Basic and Value Options

We have Open Access benefits

Our HMO offers Open Access benefits. This means you can receive covered services from a participating provider without a required referral from your primary care provider or by another participating provider in the network.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your cost-sharing (copayments, coinsurance, deductibles, and non-covered services and supplies).

Health education resources and account management tools

Health education resources and account management tools are available on our website at htttps://bswhealthplan.com/fehb.

- Wellness programs are available online or by calling Customer Service at 844-633-5325.
- You can access your claims and explanations of benefits (EOBs) by visiting https://bswhealthplan.com/fehb and logging in to the BSWHP member portal.
- You can view, display and order ID cards.

Your rights and responsibilities

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, and our providers. OPM's FEHB website www. opm.gov/healthcare-insurance/ lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Baylor Scott & White Health Plan began operation in January of 1982 as a not-for-profit Health Maintenance Organization (HMO).
- Baylor Scott & White Health Plan is a privately owned, not-for-profit community-based health maintenance organization and does not include any partners.

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities by visiting our website, Baylor Scott & White Health Plan at www. bswhealthplan.com/fehb.

If you want more information about us, call 844-633-5325, or write to Baylor Scott and White Health Plan, 1206 West Campus Drive, Temple, TX 76502. You may also visit our website at https://bswhealthplan.com/fehb. You can also contact us to request that we mail a copy to you.

By law, you have the right to access your protected health information (PHI). For more information regarding access to PHI, visit our website Baylor Scott & White Health Plan at https://bswhealthplan.com/fehb to obtain our Notice of Privacy Practices. You can also contact us to request that we mail a copy of the notice regarding access to PHI.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Service Area:

The Standard Option utilizes the **BSW Premier HMO Network**.

The Basic Option utilizes the **BSW Premier HMO Network**.

The Value Option utilizes the **BSW Premier HMO Network**.

Standard Option Eligibility Area

To enroll in this Option, you must live in or work in one of the counties listed below. This is where our provider's practice. Baylor Scott & White Health Plan has two service areas for the FEHB program. Our service area includes Central, North and West Texas.

The following counties comprise our **Central Texas** service area for this option:

Austin, Bastrop, Bell, Bexar, Blanco, Bosque, Brazos, Burleson, Burnet, Caldwell, Coke, Coleman, Comal, Concho, Coryell, Crockett, Falls, Fayette, Freestone, Grimes, Guadalupe, Hamilton, Hays, Hill, Houston, Irion, Kimble, Lampasas, Lee, Leon, Limestone, Llano, Madison, Mason, McCulloch, McLennan, Menard, Milam, Mills, Reagan, Robertson, Runnels, San Saba, Schleicher, Sterling, Sutton, Tom Green, Travis, Walker, Waller, Washington and Williamson.

The following counties comprise our **North and West Texas** service area for this option:

Andrews, Armstrong, Bailey, Borden, Brewster, Briscoe, Brown, Callahan, Carson, Castro, Childress, Cochran, Collin, Collingsworth, Comanche, Cottle, Crane, Crosby, Dallam, Dallas, Dawson, Deaf Smith, Denton, Dickens, Donley, Eastland, Ector, Ellis, Erath, Fisher, Floyd, Gaines, Garza, Glasscock, Gray, Grayson, Hale, Hall, Hansford, Hartley, Haskell, Hemphill, Hockley, Hood, Howard, Hutchinson, Johnson, Jones, Kent, King, Knox, Lamb, Lipscomb, Loving, Lubbock, Lynn, Martin, Midland, Mitchell, Moore, Motley, Navarro, Nolan, Ochiltree, Oldham, Parmer, Pecos, Potter, Randall, Reeves, Roberts, Rockwall, Scurry, Shackelford, Sherman, Somervell, Stephens, Stonewall, Swisher, Tarrant, Taylor, Terry, Throckmorton, Upton, Ward, Wheeler, Winkler, and Yoakum

Basic Option Eligibility Area

To enroll in this Plan, you must live in or work in one of the counties listed below. This is where our provider's practice. Baylor Scott & White Health Plan has two service areas for the FEHB program. Our service area includes Central, North and West Texas.

The following counties comprise our **Central Texas** service area for this option:

Austin, Bastrop, Bell, Bexar, Blanco, Bosque, Brazos, Burleson, Burnet, Caldwell, Coke, Coleman, Comal, Concho, Coryell, Crockett, Falls, Fayette, Freestone, Grimes, Guadalupe, Hamilton, Hays, Hill, Houston, Irion, Kimble, Lampasas, Lee, Leon, Limestone, Llano, Madison, Mason, McCulloch, McLennan, Menard, Milam, Mills, Reagan, Robertson, Runnels, San Saba, Schleicher, Sterling, Sutton, Tom Green, Travis, Walker, Waller, Washington and Williamson.

The following counties comprise our **North and West Texas** service area for this option:

Andrews, Armstrong, Bailey, Borden, Brewster, Briscoe, Brown, Callahan, Carson, Castro, Childress, Cochran, Collin, Collingsworth, Comanche, Cottle, Crane, Crosby, Dallam, Dallas, Dawson, Deaf Smith, Denton, Dickens, Donley, Eastland, Ector, Ellis, Erath, Fisher, Floyd, Gaines, Garza, Glasscock, Gray, Grayson, Hale, Hall, Hansford, Hartley, Haskell, Hemphill, Hockley, Hood, Howard, Hutchinson, Johnson, Jones, Kent, King, Knox, Lamb, Lipscomb, Loving, Lubbock, Lynn, Martin, Midland, Mitchell, Moore, Motley, Navarro, Nolan, Ochiltree, Oldham, Parmer, Pecos, Potter, Randall, Reeves, Roberts, Rockwall, Scurry, Shackelford, Sherman, Somervell, Stephens, Stonewall, Swisher, Tarrant, Taylor, Terry, Throckmorton, Upton, Ward, Wheeler, Winkler, and Yoakum

Value Option Eligibility Area

To enroll in this Option, you must live in or work in one of the counties listed below. This is where our provider's practice. Baylor Scott & White Health Plan has two service areas for the FEHB program. Our service area includes Central, North and West Texas.

The following counties comprise our **Central Texas** service area for this option:

Austin, Bastrop, Bell, Bexar, Blanco, Bosque, Brazos, Burleson, Burnet, Caldwell, Coke, Coleman, Comal, Concho, Coryell, Crockett, Falls, Fayette, Freestone, Grimes, Guadalupe, Hamilton, Hays, Hill, Houston, Irion, Kimble, Lampasas, Lee, Leon, Limestone, Llano, Madison, Mason, McCulloch, McLennan, Menard, Milam, Mills, Reagan, Robertson, Runnels, San Saba, Schleicher, Sterling, Sutton, Tom Green, Travis, Walker, Waller, Washington and Williamson.

The following counties comprise our **North and West Texas** service area for this option:

Andrews, Armstrong, Bailey, Borden, Brewster, Briscoe, Brown, Callahan, Carson, Castro, Childress, Cochran, Collin, Collingsworth, Comanche, Cottle, Crane, Crosby, Dallam, Dallas, Dawson, Deaf Smith, Denton, Dickens, Donley, Eastland, Ector, Ellis, Erath, Fisher, Floyd, Gaines, Garza, Glasscock, Gray, Grayson, Hale, Hall, Hansford, Hartley, Haskell, Hemphill, Hockley, Hood, Howard, Hutchinson, Johnson, Jones, Kent, King, Knox, Lamb, Lipscomb, Loving, Lubbock, Lynn, Martin, Midland, Mitchell, Moore, Motley, Navarro, Nolan, Ochiltree, Oldham, Parmer, Pecos, Potter, Randall, Reeves, Roberts, Rockwall, Scurry, Shackelford, Sherman, Somervell, Stephens, Stonewall, Swisher, Tarrant, Taylor, Terry, Throckmorton, Upton, Ward, Wheeler, Winkler, and Yoakum

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other healthcare services out of our service area unless the services have prior plan approval.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. Changes for 2027

- **Program-wide changes**
  - The previously considered "Sex Trait Modification Exception Process" which includes surgical procedures, puberty blockers, or hormone therapy for the purpose of the treatment of Gender Dysphoria is no longer in place and has been removed. Counseling will continue when it is provided by a licensed mental health provider
- **Changes to Standard Option Plan**
  - Your share of the premium rate will increase/decrease/stay the same for Self Only or increase/decrease/stay the same for Self and Family. See 2027 Rate Information for Baylor Scott & White Health Plan, page 93.
  - Your share of the Deductible will increase for the Self Only from $300 to $350 and for Self Plus One or Self Plus Family from $600 to $700
  - Your share of the Out-Of-Pocket Maximum will increase for the Self Only Plan from $5,500 to $6,000 and for Self Plus One or Self Plus Family from $11,000 to $12,000.
  - Your share of the Specialist Office Visit Copay will increase for all Standard Plans from $50 to $60 per visit.
  - Your share of the Tier 1 Preferred Generic Drugs Retail (30-day supply) Copay will increase for all Standard Plans from $5 to $8 per prescription.
  - Your share of the Tier 2 Non-Preferred Generic Drugs Retail (30-day supply) Copay will increase for all Standard Plans from $18 to $20 per prescription.
  - Your share of the Tier 2 Non-Preferred Generic Drugs Mail Order (90-day supply) Copay will increase for all Standard Plans from $45 to $50 per prescription.
  - Your share of the Vision Specialist Copay will increase for all Standard Plans from $50 to $60 per visit.
- **Changes to Basic Option Plan**
  - Your share of the premium rate will increase/decrease/stay the same for Self Only or increase/decrease/stay the same for Self and Family. See 2027 Rate Information for Baylor Scott & White Health Plan, page 93.
  - Your share of the Out-Of-Pocket Maximum will increase for the Self Only Plan from $6,000 to $7,000 and for Self Plus One or Self Plus Family from $12,000 to $14,000.
  - Your share of the Specialist Office Visit Copay will increase for all Basic Option Plans from $50 to $60 per visit.
  - Your share of the Tier 2 Non-Preferred Generic Drugs Retail (30-day supply) Copay will increase for all Basic Plans from $20 to $25 per prescription.
  - Your share of the Tier 2 Non-Preferred Generic Drugs Mail Order (90-day supply) Copay will increase for all Basic Plans from $50 to $62.50 per prescription
  - Your share of the Tier 3 Preferred Brand Drugs Retail (30-day supply) Copay will increase for all Basic Plans from $60 to $65 per prescription.
  - Your share of the Tier 3 Preferred Generic Drugs Mail Order (90-day supply) Copay will increase for all Basic Plans from $150 to $162.50 per prescription
  - Your share of the Vision Specialist Copay will increase for all Basic Plans from $50 to $60 per visit.
- **Changes to Value Option Plan**
  - Your share of the premium rate will increase/decrease/stay the same for Self Only or increase/decrease/stay the same for Self and Family. See 2027 Rate Information for Baylor Scott & White Health Plan, page 93.
  - Your share of the Out-Of-Pocket Maximum will increase for the Self Only Plan from $9,000 to $9,500 and for Self Plus One or Self Plus Family from $18,000 to $19,000

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation letter (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 844-633-5325 or write to us at:

Baylor Scott & White Health Plan
1206 West Campus Drive
Temple, TX 76502

You may also request replacement cards through our website: https://bswhealthplan.com/fehb.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments and/or coinsurance. We are an Open Access health plan, so you can receive covered services from a participating provider without a referral from a primary care provider or by another participating provider in the network.

- **Balance Billing Protection**

  FEHB Carriers must have clauses in their in-network (participating) providers agreements. These clauses provide that, for a service that is a covered benefit in the plan brochure or for services determined not medically necessary, the in-network provider agrees to hold the covered individual harmless (and may not bill) for the difference between the billed charge and the in network contracted amount. If an in-network provider bills you for covered services over your normal cost share (deductible, copay, co-insurance) contact your Carrier to enforce the terms of its provider contract.

- **Plan providers**

  Plan providers are physicians and other healthcare professionals in our service area that we contract with to provide covered services to our members. Services by Plan Providers are covered when acting within the scope of their license or certification under applicable state law. We credential Plan providers according to national standards.

  Benefits are provided under this Plan for the services of covered providers, in accordance with Section 2706(a) of the Public Health Service Act. Coverage of practitioners is not determined by your state's designation as a medically underserved area.

  We list covered providers in the provider directory, which we update monthly on our website, https://bswhealthplan.com/fehb. The Standard Plan option, Basic plan and the Value option utilize the BSW Premier HMO network.

  Benefits described in this brochure are available to all members meeting medical necessity guidelines regardless of race, color, national origin, age, disability, religion, sex, pregnancy, or genetic information.

  This plan provides Care Coordinators for complex conditions and can be reached by calling 844-279-7589 for assistance.

- **Plan facilities**

  Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update monthly on our website, https://bswhealthplan.com/fehb.

  All Standard Plan option, Basic option and the Value Plan option utilize the BSW Premier HMO network.

What you must do to get covered care

Now that you have chosen a Baylor Scott & White Health Plan (BSWHP), the next step is choosing the doctor or provider who will handle most of your health care needs. BSWHP is an Open Access Health Plan, which means you can see any doctor or provider in the Plan's network without needing a referral.

- **Primary care**

You can choose a primary care provider (PCP) from the network if you would like. A PCP is not required by BSWHP. If you decide to choose a PCP, you can select from the following:

• Family Medicine doctors treat all age groups from newborn to the elderly
• Internal Medicine doctors treat patients 18+
• Pediatric doctors treat children from birth through age 18

- **Specialty care**

All non-emergent medical care must be provided by BSW Premier HMO network providers. BSWHP does not require a referral from a primary care provider before you can access a specialist. Simply call the specialist's office and make an appointment.

Behavioral health services and other types of care may need approval from BSWHP Health Services before you receive them. Examples of services, procedures, and tests that may require advance notice or approval are listed on page 20.

If you are in your second or third trimester of pregnancy and lose access to your specialist for one of the reasons listed above, you may continue seeing that specialist through your pregnancy and postpartum care. This coverage may continue even if it lasts longer than 90 days.

The special exception process for treatments related to gender dysphoria for people age 19 and older is no longer available. This includes surgeries, puberty blockers, and hormone treatments. Counseling services will still be covered when they are provided by a licensed mental health professional.

Here are some other things you should know about specialty care:

· Some specialty doctors may ask for a referral before they will schedule your appointment. This is the doctor's office policy and is not a requirement of Baylor Scott & White Health Plan (BSWHP).

· If your current specialist is not in the BSWHP network, you will need to see a specialist who is in the network. In most cases, the plan will not pay for visits to specialists who are not part of the BSWHP network.

· If you are seeing a specialist and that specialist leaves the BSWHP network, call Health Services. We will help you find a new specialist. You may be able to continue seeing your current specialist until arrangements are made for you to see another provider.

· If you are being treated for a long-term or disabling health condition and your specialist is no longer available through the plan, you may be able to keep seeing that specialist for up to 90 days. This may apply if:

  · BSWHP ends its contract with your specialist for reasons other than misconduct or quality concerns.

  · BSWHP leaves the Federal Employees Health Benefits (FEHB) Program, and you enroll in a different FEHB plan.

  · BSWHP reduces its service area, and you enroll in another FEHB plan.

Note: If you lose access to your specialist because you changed your carrier or plan option enrollment, contact your new plan.

Contact us at 844-633-5325, or if we drop out of the Program, contact your new plan.

- **Hospital care**

For planned or elective hospital stays and certain procedures, you may need approval (prior authorization) from BSWHP Health Services before the procedure is done. Getting approval ahead of time helps make sure BSWHP will pay for the hospital stay and procedure. While you are in the hospital, BSWHP nurses and medical directors will work with your doctor to review your care and determine how long you need to stay in the hospital.

If you are admitted to the hospital because of an emergency, please call BSWHP Health Services at 844-633-5325 within 24 to 48 hours after you are admitted. To make sure your ongoing treatment is covered, approval must be received from BSWHP Health Services. If the hospital or provider contacts BSWHP, a decision about additional treatment after your condition is stable will be made within one hour. Emergency room visits require a copayment, but the copayment will be waived if you are admitted to the hospital within 24 hours.

- **If you are hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 844-633-5325. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- you are discharged, not merely moved to an alternative care center;
- the day your benefits from your former plan run out; or
- the 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

You need prior Plan approval for certain services

For planned hospital stays (elective hospital admissions) and certain procedures listed under "Other Services," you may need approval (prior authorization) from BSWHP Health Services before the day of the procedure or service. Getting approval ahead of time helps make sure BSWHP will pay for your care. If you do not get the required approval, your benefits may be denied.

- **Inpatient Hospital Admission**

Precertification is the process by which – prior to your inpatient hospital admission – we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition.

- **Other services**

For certain services, your provider must obtain prior approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.

Notification requested:

1. Acute (contracted) hospital admissions (medical, surgical, behavioral health)
2. Admissions to inpatient or outpatient (contracted) hospice programs

Prior Authorization required:

All services requested to be provided by non-contracted providers must have prior authorization.

1. Admissions to LTAC, Rehabilitation, and SNF facilities
2. Admissions to behavioral health/substance abuse residential, partial hospitalization, and day programs (not office visits to contracted providers)
3. Neuropsychological and psychological testing
4. Applied behavioral analysis therapy
5. Outpatient electroconvulsive therapy (ECT)
6. Solid organ and stem cell transplants (Pre-Transplant Eval; Transplant; Post-Transplant Care)
7. Weight loss (bariatric) surgeries (if a covered benefit, not covered by many plans)
8. Procedures which may be considered cosmetic and thus not covered (e.g. facelift, brow lift, blepharoplasty, liposuction, abdominoplasty, breast reconstruction (not associated with medically indicated mastectomy), surgery for gynecomastia, rhinoplasty, genioplasty, treatment of varicose veins, etc.)
9. Orthognathic surgery
10. Treatments for sleep apnea (other than CPAP/CPAP-related supplies)
11. Home health services, including all requests for hourly or private duty nursing
12. Durable medical equipment (DME) – See Addendum A for specific items
13. Orthotics and prosthetics – See Addendum B for specific items
14. Spinal fusion and vertebroplasty
15. X-Stop Spacer for Spinal Stenosis
16. Artificial Disc Implantation/Replacement
17. Ventricular assist devices (VAD)
18. Genetic testing (Except chromosome testing)
19. Intrathecal Pain Pump Implantation/Therapy
20. Spinal Stimulators
21. Vagal Nerve Stimulators
22. Fixed Wing or Jet Medical Transports
23. IVIG Therapy
24. Lung Volume Reduction Surgery
25. Transaortic or Transapical Valve Insertion or Replacement (TAVI/TAVR)
26. Insulin Pumps and/or Continuous Glucose Monitors
27. Bone-Anchored Hearing Aids
28. Cochlear Implants
29. Dental Services and Anesthesia for Dental Services
30. Epidural Adhesiolysis

Addendum A - Durable Medical Equipment (purchase or rental):

- Oral appliances
- Electric, semi-electric, air fluidized, and advanced technology beds and related equipment
- Oxygen and related equipment
- Ventilators and related equipment
- High frequency chest wall oscillation air-pulse generator system; including vest, hose, and related equipment
- Bone stimulators

- Spinal Cord Stimulators
- Functional neuromuscular stimulation, transcutaneous stimulation of sequential muscle groups of ambulation with computer control, the entire system
- Functional electrical stimulation, transcutaneous stimulation of nerve and/or muscle groups, complete system
- Power wheelchairs and related equipment
- Power operated vehicles and related equipment
- Custom made and specially sized wheelchairs and related equipment
- Dialysis equipment
- Defibrillators and related equipment (includes chest/vest defibrillators)
- Non-specific, miscellaneous, and unlisted DME codes

Addendum B – Orthotics and Prosthetics

- Breast implants (unless status post medically indicated mastectomy)
- Lower and upper limb prosthetics (including myoelectric and microprocessor controlled) and related equipment/supplies
- Facial, nasal, and auricular prostheses
- Non-specific, miscellaneous, and unlisted orthotic and prosthetic codes

How to request precertification for an admission or get prior authorization for Other services

First, your physician, your hospital, you, or your representative, must call us at 888-316-7947 before admission or services requiring prior authorization are rendered.

Next, provide the following information:

- enrollee's name and Plan identification number;
- patient's name, birth date, identification number and phone number;
- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting physician;
- name of hospital or facility; and
- number of days requested for hospital stay.

- **Non-urgent care claims**

For non-urgent care claims, we will tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent care claims**

If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether or not it is an urgent care claim by applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to provide notice of the specific information we need to complete our review of the claim. We will allow you up to 48 hours from the receipt of this notice to provide the necessary information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) to end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision or by calling us at 888-316-7947. You may also call OPM's FEHB 3 at 202-606-0737 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 888-316-7947. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

A concurrent care claim involves care provided over time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim we will make a decision within 24 hours after we receive the claim.

- **Emergency inpatient admission**

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone BSWHP Health Services within two business days of any admission at 888-316-7947 following the day of the emergency admission, even if you have been discharged from the hospital. Coverage for continued treatment is assured when approval is obtained from the BSWHP Medical Director through BSWHP Health Services. BSWHP will approve or deny the requested post-stabilization treatment within one hour if contacted by the provider or facility. Emergency care in a hospital emergency room requires a copayment**,** which will be waived if hospital admission occurs within 24 hours.

- **Maternity care**

You do not need precertification of a maternity admission for a routine delivery. However, if your medical condition requires you to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, then your physician or the hospital must contact us for precertification of additional days. Further, if your baby stays after you are discharged, your physician or the hospital must contact us for precertification of additional days for your baby.

Note: When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.

- **If your treatment needs to be extended**

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim we will make a decision within 24 hours after we receive the claim.

What happens when you do not follow the precertification rules when using non-network facilities

Without preauthorization, BSWHP does not pay for out-of-network elective procedures, or treatment for minor illness. BSWHP will not assume financial responsibility for out-of-network treatment if you are well enough to return to a BSWHP provider or facility.

BSWHP out-of-network benefits are limited to accidental injuries and sudden illnesses.

When seeking treatment in an out-of-network emergency room, provide your member identification card. This will speed up the processing and payment of your bill by BSWHP. This will also allow the treating physician to discuss your emergency care with your provider if necessary.

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

If you disagree with our pre-service claim decision

If you have a pre-service claim and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below. If your claim is in reference to a contraceptive, call 844-633-5325.

If you have already received the service, supply, or treatment, then you have a post-service claim and must follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent care claim**

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to:

1. Precertify your hospital stay or, if applicable, arrange for the healthcare provider to give you the care or grant your request for prior approval for a service, drug, or supply; or
2. Ask you or your provider for more information.

   You or your provider must send the information so that we receive it within 60 days, of our request. We will then decide within 30 more days.

   If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by phone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your costs for covered services

This is what you will pay out-of-pocket for covered care:

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., coinsurance and copayments) for the covered care you receive.

Copayments

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc. when you receive certain services.

Example: When you see your primary care physician, you pay a copayment of $25 per office visit, and when you go into an Urgent Care center, you pay $50 per visit.

Deductible

A deductible is an amount you must pay for certain covered services and supplies before BSWHP starts paying. Copayments do not count toward your deductible. Only the amount you pay for covered services and supplies, based on the plan's allowed amount, counts toward your deductible.

Under Standard Option:

·Self Only enrollment: The calendar year deductible is $350 per person. After the deductible amount is satisfied for an individual, covered services are payable for that individual.

·Under Self Plus One enrollment: both family members must meet the individual deductible.

·Under Self and Family enrollment, an individual may meet the individual deductible, or all family members' individual deductibles are considered to be satisfied when the family members' deductibles are combined and reach $700.

Under Basic Option:

· Self Only enrollment: the calendar year deductible is $1,500 per person. After the deductible amount is satisfied for an individual, covered services are payable for that individual.

·Under Self Plus One enrollment, both family members must meet the individual deductible.

·Under Self and Family enrollment, an individual may meet the individual deductible, or all family members' individual deductibles are considered to be satisfied when the family members' deductibles are combined and reach $3,000.

Under Value Option:

·Self Only enrollment: The calendar year deductible is $2,000 per person. After the deductible amount is satisfied for an individual, covered services are payable for that individual.

·Under Self Plus One enrollment, both family members must meet the individual deductible.

·Under Self and Family enrollment, an individual may meet the individual deductible, or all family members' individual deductibles are considered to be satisfied when the family members' deductibles are combined and reach $4,000.

	If you change plans during Open Season, you do not have to start a new deductible under your prior plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan. If you change options in this Plan during the year, we will credit the number of covered expenses already applied toward the deductible of your old option to the deductible of your new option.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. Example: In our Plan, you pay 30% of our allowance for durable medical equipment.
Differences between our Plan allowance and the bill	Our "Plan allowance" is the amount we use to calculate our payment for certain types of covered services. See definition of Plan allowance in Section 10. You should also see section Important Notice About Surprise Billing - Know Your Rights below that describes your protections against surprise billing under the No Surprises Act.
Your catastrophic protection out-of-pocket maximum	After your (deductible, copayments and coinsurance) reaches the out-of-pocket maximum you do not have to pay any more for covered services, with the exception of certain cost sharing for the services below which do not count toward your catastrophic protection out-of-pocket maximum. Your out-of-pocket maximum for services rendered during the 2027 calendar year is: Standard Option - For Self Only enrollment, your out-of-pocket maximum for the deductible, and for eligible coinsurance and copayment amounts, is $6000 for Self Only, $12,000 for Self Plus One, or $12,000 for Self and Family. Basic Option - For Self Only enrollment, your out-of-pocket maximum for the deductible, and for eligible coinsurance and copayment amounts, is $7,000 for Self Only, $14,000 for Self Plus One, or $14,000 for Self and Family. Value Option - For Self Only enrollment, your out-of-pocket maximum for the deductible, and for eligible coinsurance and copayment amounts, is $9,500 for Self Only, $19,000 for Self Plus One, or $19,000 for Self and Family. If you change options in this Plan during the year, we will credit the number of covered expenses already accumulated toward the catastrophic out-of-pocket limit for your old option to the catastrophic protection limit of your new option.
Carryover	If you changed to this Plan during Open Season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your prior plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your prior plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your prior plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your prior plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.
When Government Facilities Bill Us	Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Important Notice About Surprise Billing -Know Your Rights

The No Surprises Act (NSA) is a federal law that provides you with protections against "surprise billing" and "balance billing" for out-of-network emergency services; out-of-network non-emergency services provided with respect to a visit to a participating health care facility; and out-of-network air ambulance services.

A surprise bill is an unexpected bill you receive for:

- emergency care – when you have little or no say in the facility or provider from whom you receive care, or for
- non-emergency services furnished by nonparticipating providers with respect to patient visits to participating health care facilities, or for
- air ambulance services furnished by nonparticipating providers of air ambulance services.

Balance billing happens when you receive a bill from the nonparticipating provider, facility, or air ambulance service for the difference between the nonparticipating provider's charge and the amount payable by your health plan.

Your health plan must comply with the NSA protections that hold you harmless from surprise bills.

In addition, your health plan adopts and complies with the surprise billing laws of Texas.

For specific information on surprise billing, the rights and protections you have, and your responsibilities go to www.bswhealthplan.com/fehb or contact the health plan at 844-633-5325.

The Federal Flexible Spending Account Program - FSAFEDS

- **Healthcare FSA (HCFSA)** - Reimburses you for eligible out-of-pocket healthcare expense (such as copayments, deductibles, over-the-counter drugs and medications, vision and dental expenses, and much more) for their tax dependents, and their adult children (through the end of the calendar year in which they turn 26).
- **FSAFEDS** offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.

Section 5. Standard Option, Basic Option and the Value Option Benefits

See page 16 for how our benefits changed this year. Page 86 is a benefits summary of the Standard Option. Page 88 is a benefits summary of the Basic Option. Page 90 is a benefits summary of the Value Option.

Make sure that you review the benefits that are available under the option in which you are enrolled.

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Section 5. Standard, Basic and Value Option Benefits Overview

This Plan offers Standard, Basic, and Value Option Benefits. All benefit packages are described in Section 5. Be sure to review the benefits included in the health plan option you chose.

The Standard, Basic and Value Option Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also, read the *general exclusions* in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about Standard, Basic and Value Option benefits, contact us at 844-633-5325 or on our website at https://bswhealthplan.com/fehb.

Unique features of our Standard Option:

- Low deductible
- Low copays or coinsurance for most services
- $0 Copay for first non-preventive adult PCP office visit
- $0 Copay for PCP office visit for dependents age 0-18
- No charge for preventive care, lab, x-ray, and preventive mammograms
- Only $8 for Preferred Generic drugs
- BSW Premier HMO Network
- All wellness programs are no charge to members. Programs include:
  - Online Lifestyle Management Programs
  - Levanto
    - Help Me Decide: Personalized guidance on symptoms and treatment options to connect members to the lowest cost, most appropriate care.
    - Muscle & Joint Care: Supporting muscle and joint health with diagnosis and treatment of acute and chronic pain, plus pre-/post-surgical care.
    - Healthy Weight: Promoting positive habits for long-term weight loss with fully integrated tracking. core and support.
    - Pregnancy & Postpartum Care: Comprehensive prenatal and postpartum care, with education and support for new moms when they need it most.
    - Mental Health Care: Coordinated support for emotional well-being across therapy and psychiatry to Improve access and outcomes.
    - Headache Care: Customized diagnosis and fast, effective treatment to overcome headaches and migraines
    - Allergy Care: Delivering fast, personalized allergy relief with seamless access to treatment, tracking and ongoing support.
  - The BSW Be Well™ with Diabetes Program
    - Our wellness program provides coaching support to help improve the health of members with Type 2 diabetes. The goal of the program is to educate and assist members in managing their diabetes, reducing complications, and eliminating their costs for covered diabetes medication and supplies.
  - Health coaches - direct access to a coach for help on over 65 different diseases and conditions
  - Shared decision-making - gives the member reliable tools and information to better make decisions with their physicians on treatment options they may have been given related to “preference-sensitive” conditions.
- 24-hour nurse line included at no charge
- Customer service available from 7 am to 7 pm Central Time, 5 days a week

Unique features of our Basic Option:

- Low deductible
- Low copays or coinsurance for most services

- $0 Copay for first non-preventive adult PCP office visit
- $0 Copay for PCP office visit for dependents age 0-18
- No charge for preventive care, lab, x-ray, and preventive mammograms
- Only $8 for Preferred Generic drugs
- BSW Premier HMO Network
- All wellness programs are no charge to members. Programs include:
  - Online Lifestyle Management Programs
  - Levanto
    - Help Me Decide: Personalized guidance on symptoms and treatment options to connect members to the lowest cost, most appropriate care.
    - Muscle & Joint Care: Supporting muscle and joint health with diagnosis and treatment of acute and chronic pain, plus pre-/post-surgical care.
    - Healthy Weight: Promoting positive habits for long-term weight loss with fully integrated tracking. core and support.
    - Pregnancy & Postpartum Care: Comprehensive prenatal and postpartum care, with education and support for new moms when they need it most.
    - Mental Health Care: Coordinated support for emotional well-being across therapy and psychiatry to Improve access and outcomes.
    - Headache Care: Customized diagnosis and fast, effective treatment to overcome headaches and migraines
    - Allergy Care: Delivering fast, personalized allergy relief with seamless access to treatment, tracking and ongoing support.
  - The BSW Be Well™ with Diabetes Program
    - Our wellness program provides coaching support to help improve the health of members with Type 2 diabetes. The goal of the program is to educate and assist members in managing their diabetes, reducing complications, and eliminating their costs for covered diabetes medication and supplies.
  - Health coaches - direct access to a coach for help on over 65 different diseases and conditions
  - Shared decision-making - gives the member reliable tools and information to better make decisions with their physicians on treatment options they may have been given related to “preference-sensitive” conditions.
- 24-hour nurse line included at no charge
- Customer service available from 7 am to 7 pm Central Time, 5 days a week

Unique features of our Value Option:

- Low deductible
- Low copays or coinsurance for most services
- $0 Copay for first non-preventive adult PCP office visit
- $0 Copay for PCP office visit for dependents age 0-18
- No charge for preventive care, lab, x-ray, and preventive mammograms
- Only $10 for Preferred Generic drugs
- BSW Premier HMO Network
- All wellness programs are no charge to members. Programs include:
  - Online Lifestyle Management Programs
  - Levanto
    - Help Me Decide: Personalized guidance on symptoms and treatment options to connect members to the lowest cost, most appropriate care.

  - Muscle & Joint Care: Supporting muscle and joint health with diagnosis and treatment of acute and chronic pain, plus pre-/post-surgical care.
  - Healthy Weight: Promoting positive habits for long-term weight loss with fully integrated tracking. core and support.
  - Pregnancy & Postpartum Care: Comprehensive prenatal and postpartum care, with education and support for new moms when they need it most.
  - Mental Health Care: Coordinated support for emotional well-being across therapy and psychiatry to Improve access and outcomes.
  - Headache Care: Customized diagnosis and fast, effective treatment to overcome headaches and migraines
  - Allergy Care: Delivering fast, personalized allergy relief with seamless access to treatment, tracking and ongoing support.
- The BSW Be Well™ with Diabetes Program
  - Our wellness program provides coaching support to help improve the health of members with Type 2 diabetes. The goal of the program is to educate and assist members in managing their diabetes, reducing complications, and eliminating their costs for covered diabetes medication and supplies.
- Health coaches - direct access to a coach for help on over 65 different diseases and conditions
- Shared decision-making - gives the member reliable tools and information to better make decisions with their physicians on treatment options they may have been given related to “preference-sensitive” conditions.

- 24-hour nurse line included at no charge
- Customer service available from 7 am to 7 pm Central Time, 5 days a week

Section 5(a). Medical Services and Supplies Provided by Physicians and Other HealthCare Professionals

Important things you should keep in mind about these benefits.

- The Standard Option, Basic and Value Option are HMO plans and are only available in certain areas. Please refer to the Service Area descriptions in *Section 1. How this plan works* to see if your county is included.
- **The Standard Option, the Basic Option and the Value Option utilize the BSW Premier HMO Network.**
- Please remember that all benefit is subject to definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- For the Standard Option, the calendar year deductible is $350 for Self Only, $700 for Self Plus One or $700 for Self and Family. For the Basic Option, the calendar year deductible is $1,500 for Self Only, $3,000 for Self Plus One or $3,000 for Self and Family. For the Value Option, the calendar year deductible is $2,000 for Self Only, $4,000 for Self Plus One or $4,000 for Self and Family. The calendar year deductible is applied to almost all benefits in this Section. We added "(deductible applies)" to show when the calendar year deductible does apply.
- Be sure to read Section 4, *Your Costs for Covered Services,* for valuable information about how cost sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The coverage and cost-sharing listed below are for services provided by physicians and other health care professionals for your medical care. See Section 5(c) for cost-sharing associated with the facility (i.e., hospital, surgical center, etc.).
- The exclusion for hormone treatments for Sex-Trait Modification for gender dysphoria only pertains to chemical and surgical modification of an individual's sex traits (including as part of "gender transition" services). We do not exclude coverage for entire classes of pharmaceuticals, e.g., GnRH agonists may be prescribed during IVF, for reduction of endometriosis or fibroids, and for cancer treatment or prostate cancer/tumor growth prevention.

Benefit Description	You Pay		
Diagnostic and treatment services	**Standard**	**Basic**	**Value**
Outpatient professional services of physicians and other healthcare professionals • Physician's office • Office medical consultations • Second Surgical opinions • Home visits • Advance care planning • Blood Pressure Monitor Training	Primary Care Provider (PCP) Office Visit • $25 Copay • $0 Copay for first adult non-preventive visit • $0 Copay for dependents ages 0 - 18 Specialist Office Visit • $60 Copay	Primary Care Provider (PCP) Office Visit • $25 Copay • $0 Copay for first adult non-preventive visit • $0 Copay for dependents ages 0 - 18 Specialist Office Visit • $60 Copay	Primary Care Provider (PCP) Office Visit • $30 Copay • $0 Copay for first adult non-preventive visit • $0 Copay for dependents ages 0 - 18 Specialist Office Visit • $75 Copay

Diagnostic and treatment services - continued on next page

Benefit Description	You Pay		
Diagnostic and treatment services (cont.)	**Standard**	**Basic**	**Value**
Professional services of physicians • In an urgent care center • During a hospital stay • In a skilled nursing facility • Initial examination of a newborn child • Office medical consultations	$50 per visit to an urgent care center 10% for inpatient hospital stay (deductible applies)	$50 per visit to an urgent care center 20% for inpatient hospital stay (deductible applies)	$50 per visit to an urgent care center 30% for inpatient hospital stay (deductible applies)

Benefit Description	You Pay		
Telehealth via E-Visit	**Standard**	**Basic**	**Value**
1. MyBSWHealth App You can get care through MyBSWHealth anywhere in Texas for things like seasonal allergies, cold and flu, bladder infection (UTI), stomach issues, and more. Access care through the MyBSWHealth App. 2. Teladoc You can access urgent care and behavioral health services through Teladoc anywhere in the US (including Texas). With a same-day virtual visit you can talk to a licensed provider by phone or video for common conditions like sinus problems, allergies, flu symptoms and much more. Private therapy is also available. You can choose a therapist or psychiatrist who fits your needs. You can also select a time that works best for you. Therapists and psychiatrists are available seven days a week from 7:00 AM to 9:00 PM. For More information and how to register go to https://bswhealthplan.com/fehb	$25 per E-Visit	$25 per E-Visit	$30 per E-Visit
Lab, X-ray and other diagnostic tests	**Standard**	**Basic**	**Value**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • Ultrasound • Electrocardiogram and EEG • BRCA testing - Per the PPACA, the Plan will cover BRCA testing for women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2.	Nothing	Nothing	Nothing
• CT/Cat Scan • MRI • Angiograms • Myelography • PET Scans • Stress Tests	10% coinsurance (deductible applies)	20% per procedure (deductible applies)	30% per procedure (deductible applies)

Benefit Description	You Pay		
Preventive care benefits, adult	**Standard**	**Basic**	**Value**
Routine physical every 12 months **The following preventive services are covered at the time interval recommended at each of the links below**. • U.S. Preventive Services Task Force (USPSTF) A and B recommended screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV, and colorectal cancer. For a complete list of screenings go to the U.S. Preventive Services Task Force (USPSTF) website at https ://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations • Individual counseling on prevention and reducing health risks • Obesity counseling, screening and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows: • Intensive nutrition and behavioral weight-loss counseling therapy: The USPSTF recommends that clinicians offer or refer adults with a body mass index (BMI) of 30 or higher (calculated as weight in kilograms divided by height in meters squared) to intensive, multicomponent behavioral interventions. Coverage is for adults, 21years and above. • Family centered programs when medically identified to support obesity prevention and management by an in-network provider. Programs covered includes: - Wondr Health: Digital loss program available at no cost to member. 10-week intensive program with resources available for up to 1yr. - BSW Be Well Nutrition Management Health Coaching Program: 1:1 health coaching program available at no cost to member. 10-session program with access to a coach up to 6 months after program completion.	Nothing	Nothing	Nothing

Preventive care benefits, adult - continued on next page

Benefit Description	You Pay		
Preventive care benefits, adult (cont.)	**Standard**	**Basic**	**Value**
• Obesity screening and referral, for those persons below the USPSTF obesity prevention risk factor level: Programs available are also: - Wondr Health: Digital loss program available at no cost to member. 10-week intensive program with resources available for up to 1yr. - BSW Be Well Nutrition Management Health Coaching Program: 1:1 health coaching program available at no cost to member. 10-session program with access to a coach up to 6 months after program completion. Note: Also see Section 5(h) for nutritional and physical activity programs under Wellness and Other Special Features • Preventive care benefits for women such as Pap smears, gonorrhea prophylactic medication to protect newborns, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. For a complete list of preventive care benefits for women go the Health and Human Services (HHS) website at https :// www. hrsa.gov/womens-guidelines • To build your personalized list of preventive services go to https://health.gov/myhealthfinder	Nothing	Nothing	Nothing
• Routine mammogram	Nothing	Nothing	Nothing
• Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC): based on the Advisory Committee on Immunization Practices (ACIP) schedule. For a complete list of endorsed immunizations go to the Centers for Disease Control (CDC) website at https ://www. cdc. gov/vaccines/imz-schedules/index.html Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service is done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	Nothing	Nothing	Nothing
Not covered:	*All charges*	*All charges*	*All charges*

Preventive care benefits, adult - continued on next page

Benefit Description	You Pay		
Preventive care benefits, adult (cont.)	**Standard**	**Basic**	**Value**
• *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.* • *Medications for travel or work-related exposure.*	*All charges*	*All charges*	*All charges*
Preventive care benefits, children	**Standard**	**Basic**	**Value**
• Well-child visits, examinations, and other preventive services as described in the Bright Future Guidelines provided by the American Academy of Pediatrics. For a complete list of the American Academy of Pediatrics Bright Future Guidelines go to https://brightfutures.aap.org • Children's immunizations endorsed by the Centers for Disease Control (CDC) including DTaP/Tdap, Polio, Measles, Mumps and Rubella (MMR), and Varicella. For a complete list of immunizations go to the website at https ://www. cdc.gov/vaccines/schedules/index.html • You may also find a complete list of U.S. Preventive Services Task Force (USPSTF) online at https ://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations • Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	Nothing	Nothing	Nothing
Maternity care	**Standard**	**Basic**	**Value**
Complete maternity (obstetrical) care, such as: • Prenatal and Postpartum care • Screening for gestational diabetes • Delivery • Screening and counseling for prenatal and postpartum depression • Breastfeeding and lactation support, supplies and counseling for each birth	Nothing for prenatal care, first postpartum care visit, screening for gestational diabetes for pregnant women between 24 and 28 weeks gestation or first prenatal visit for women at a high risk or inpatient professional delivery services.	Nothing for prenatal care, first postpartum care visit, screening for gestational diabetes for pregnant women between 24 and 28 weeks gestation or first prenatal visit for women at a high risk or inpatient professional delivery services.	Nothing for prenatal care, first postpartum care visit, screening for gestational diabetes for pregnant women between 24 and 28 weeks gestation or first prenatal visit for women at a high risk or inpatient professional delivery services.

Maternity care - continued on next page

Benefit Description	You Pay		
Maternity care (cont.)	**Standard**	**Basic**	**Value**
	$60 per office visit for all postpartum care visits thereafter.	$60 per office visit for all postpartum care visits thereafter.	$75 per office visit for all postpartum care visits thereafter.
Breastfeeding and lactation support, supplies, and counseling for each birth. Note: Breastfeeding supplies (see DME, Page 43) Note: Here are some things to keep in mind: • You do not need to recertify your vaginal delivery; see Section 3 for other circumstances, such as extended stays for you or your baby. • As part of your coverage, you have access to in-network certified nurse midwives, home nurse visits and board-certified lactation specialists during the prenatal and post-partum period. • You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will cover an extended stay (you do not need to precertify the normal length of stay). We will extend your inpatient stay for you or your baby if medically necessary, but you, your representative, your doctor, or your hospital must precertify the extended stay. See Section 3 for other circumstances. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment if we cover the infant under a Self Plus One and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b). • Hospital services are covered under Section 5(c) and Surgical benefits Section 5(b). Note: When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits. In addition, circumcision is covered at the same rate as for regular medical or surgical benefits.	Nothing	Nothing	Nothing

Benefit Description	You Pay		
Family Planning	**Standard**	**Basic**	**Value**
Contraceptive counseling on an annual basis	Nothing	Nothing	Nothing
A range of voluntary family planning services, without cost sharing, that includes at least one form of contraception in each of the categories in the HRSA supported guidelines. This list includes: • Voluntary female sterilization • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo Provera) • Intrauterine devices (IUDs) • Diaphragm Note: See additional Family Planning and Prescription drug coverage Section 5(f) or 5(f)(a), if applicable. Note: Your plan offers some type of voluntary female sterilization surgery coverage at no cost to members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). For details visit http://bswhealthplan.com/fehb If you have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov.	Nothing	Nothing	Nothing
Voluntary male Sterilization	$25 Copay for PCP office visit $60 Copay for Specialist office visit	$25 Copay for PCP office visit $60 Copay for Specialist office visit	$30 Copay for PCP office visit $75 Copay for Specialist office visit
Plan exclusions: • *Reversal of voluntary surgical sterilization* • *Genetic testing and counseling*	*All charges*	*All charges*	*All charges*
Infertility services	**Standard**	**Basic**	**Value**
Definition of Infertility: The inability to carry a pregnancy to live birth without the use of birth control after unprotected sexual intercourse / failure of egg and sperm contact and uterine implantation without medical assistance after 12 months if under age 35, or 6 months if age 35 years or older. Infertility may also be justified based on the individual having a medical or other recognized condition as a cause of infertility.	30% of charges after deductible. Annual maximum benefit of $15,000 for IVF and Iatrogenic preservation infertility services.	50% of charges after deductible. Annual maximum benefit of $15,000 for IVF and Iatrogenic preservation infertility services.	50% of charges after deductible. Annual maximum benefit of $15,000 for IVF and Iatrogenic preservation infertility services.

Infertility services - continued on next page

Benefit Description	You Pay		
Infertility services (cont.)	**Standard**	**Basic**	**Value**
Diagnosis and treatment of infertility specific to: • Artificial insemination (up to 6 cycles annually): - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI) • In Vitro Fertilization (up to 3 cycles annually) • Fertilization preservation for iatrogenic infertility: • Procurement of sperm or eggs including medical, surgical, and pharmacy claims associated with retrieval. • Cryopreservation of sperm and mature oocytes; and testicular tissue, ovarian tissue, ART procedures for members who have had iatrogenic fertility preservation; and storage costs for at least one year with an annual maximum of $15,000 • Subject to medical necessity. • Requires prior authorization. If a member terms from the plan benefits for storage are no longer applicable. • Fertility Drugs (see Section 5f) There is no coverage for infertility for any other unlisted service including reversal of previous sterilization procedures. .	30% of charges after deductible. Annual maximum benefit of $15,000 for IVF and Iatrogenic preservation infertility services. .	50% of charges after deductible. Annual maximum benefit of $15,000 for IVF and Iatrogenic preservation infertility services. .	50% of charges after deductible. Annual maximum benefit of $15,000 for IVF and Iatrogenic preservation infertility services. .
Plan exclusions: • *Infertility services after voluntary sterilization* • *Fertility drugs for procedures excluded under this contract* • *Assisted reproductive technology (ART) procedures, such as:* - *Embryo transfer and gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* - *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg*	*All charges*	*All charges*	*All charges*

Benefit Description	You Pay		
Allergy care	**Standard**	**Basic**	**Value**
• Testing and treatment • Allergy injections • Allergy serum	10% coinsurance (deductible applies)	20% coinsurance (deductible applies)	30% coinsurance (deductible applies)
Plan exclusions: • *Provocative food testing* • *Sublingual allergy desensitization* • *All other treatment not specifically listed as covered*	*All charges*	*All charges*	*All charges*
Treatment therapies	**Standard**	**Basic**	**Value**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/ Tissue Transplants on page 38. • Respiratory and inhalation therapy • Cardiac rehabilitation following qualifying event/condition is provided for up to 60 sessions • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Applied Behavior Analysis (ABA) - Children with autism spectrum disorder • Growth hormone therapy (GHT) Note: We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See *Other services under You need prior Plan approval for certain services* on page 18.	$60 per visit to a specialist $25 per visit	$60 per visit to a specialist $25 per visit	$75 per visit to a specialist $30 per visit

Benefit Description	You Pay		
Physical, occupational, and speech therapies	**Standard**	**Basic**	**Value**
Up to 60 visits (combines physical, occupational and/or speech therapy) per condition per benefit period for the services of the following qualified providers. • Physical therapists • Occupational therapist • Speech therapist Note: We only cover therapy when a physician • Orders the care • Identifies the specific professional skills the patient requires and the medical necessity for skilled services; and • Indicates the length of time the services are needed.	$60 per visit to a specialist Nothing per visit during a covered inpatient admission	$60 per visit to a specialist Nothing per visit during a covered inpatient admission	$75 per visit to a specialist Nothing per visit during a covered inpatient admission
Plan exclusions: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*	*All charges*	*All charges*
Habilitative Therapy	**Standard**	**Basic**	**Value**
Habilitative services for children under age 19 with congenital or genetic birth defects including, but not limited to, autism or an autism spectrum disorder, and cerebral palsy. Services included physical, occupational and speech therapy for 60 visits per year, per service.	$25 per visit to a specialist	$25 per visit to a specialist	$30 per visit to a specialist
Hearing services (testing, treatment, and supplies)	**Standard**	**Basic**	**Value**
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by a primary care, specialist or audiologist Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care, children.*	$25 per visit to PCP $60 per visit to specialist	$25 per visit to PCP $60 per visit to specialist	$30 per visit to PCP $75 per visit to specialist

Benefit Description	You Pay		
Vision services (testing, treatment, and supplies)	**Standard**	**Basic**	**Value**
• Annual eye refraction (determining lens prescription) Note: See *Preventive care, children*, for eye exams for children	$60 per visit to a specialist	$60 per visit to a specialist	$75 per visit to a specialist
Plan exclusions: • *Eyeglasses or contact lenses and examinations for them, except as shown above* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges*	*All charges*	*All charges*
Foot care	**Standard**	**Basic**	**Value**
Routine foot care • Active treatment for a metabolic, peripheral vascular disease and systemic conditions, such as diabetes. Note: See Orthopedic and prosthetic devices for information on podiatric shoe inserts.	$25 per visit to PCP $60 per visit to specialist	$25 per visit to PCP $60 per visit to specialist	$30 per visit to PCP $75 per visit to specialist
Plan exclusions: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (except for surgical treatment)*	*All charges*	*All charges*	*All charges*
Orthopedic and prosthetic devices	**Standard**	**Basic**	**Value**
Note: All orthotics and prosthetics must be pre-authorized. • Lower and upper limb prosthetics (including myoelectric and microprocessor controlled) and related equipment/supplies • Facial, nasal, and auricular prostheses • Non-specific, miscellaneous, and unlisted orthotic and prosthetic codes • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy.	30% coinsurance (deductible applies)	30% coinsurance (deductible applies)	30% coinsurance (deductible applies)

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You Pay		
Orthopedic and prosthetic devices (cont.)	**Standard**	**Basic**	**Value**
For information on the professional charges for the surgery to insert an implant, see Section 5 (b) Surgical procedures. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) Services provided by a hospital or other facility, and ambulance services.	30% coinsurance (deductible applies)	30% coinsurance (deductible applies)	30% coinsurance (deductible applies)
Plan exclusions: • *Orthopedic and corrective shoes* • *Arch supports* • *Foot orthotics* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* Prosthetic repairs, maintenance, and cleaning due to abnormal wear and tear or abuse. Prosthetic replacements are subject to preauthorization but do not require a waiting period.	*All charges*	*All charges*	*All charges*
Durable medical equipment (DME)	**Standard**	**Basic**	**Value**
Note: All DME must be pre-authorized for coverage. We cover the rental or purchase of prescribed durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oral appliances • Electric, semi-electric, air fluidized, and advanced technology beds and related equipment • Oxygen and related equipment • Wheelchairs • Crutches • Walkers • Audible prescription reading devices • speech generating devices • Ventilators and related equipment • High frequency chest wall oscillation air-pulse generator system; including vest, hose, and related equipment • Bone stimulators • Spinal Cord Stimulators	30% coinsurance (deductible applies)	30% coinsurance (deductible applies)	30% coinsurance (deductible applies)

Durable medical equipment (DME) - continued on next page

Benefit Description	You Pay		
Durable medical equipment (DME) (cont.)	**Standard**	**Basic**	**Value**
• Functional neuromuscular stimulation, transcutaneous stimulation of sequential muscle groups of ambulation with computer control, the entire system • Functional electrical stimulation, transcutaneous stimulation of nerve and/or muscle groups, complete system • Power wheelchairs and related equipment • Power operated vehicles and related equipment • Custom made and specially sized wheelchairs and related equipment • Dialysis equipment • Defibrillators and related equipment (include chest/vest defibrillators) • Breast Pump Rentals • Insulin pumps • Blood pressure monitors • Continuous glucose monitors • Non-specific, miscellaneous, and unlisted DME codes Call us at 844-633-5325 as soon as your Plan physician prescribes this equipment. We will arrange with a healthcare provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.	30% coinsurance (deductible applies)	30% coinsurance (deductible applies)	30% coinsurance (deductible applies)
Plan exclusions: *Shoe inserts and other removable devices (see 'Plan exclusions' list under Orthopedic and prosthetic devices).*	*All charges*	*All charges*	*All charges*
Home health services	**Standard**	**Basic**	**Value**
• Home healthcare ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications.	$50 per visit	$50 per visit	$50 per visit
Plan exclusions: • *Nursing care requested by, or for the convenience of, the patient or the patient's family;*	*All charges*	*All charges*	*All charges*

Home health services - continued on next page

Benefit Description	You Pay		
Home health services (cont.)	**Standard**	**Basic**	**Value**
• *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative*	*All charges*	*All charges*	*All charges*
Chiropractic	**Standard**	**Basic**	**Value**
• Manipulation of the spine and extremities Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack applications. 35 visit limit per year	$60 per visit	$60 per visit	$75 per visit
Alternative treatments	**Standard**	**Basic**	**Value**
"No benefit"	*All charges*	*All charges*	*All charges*
Educational classes and programs	**Standard**	**Basic**	**Value**
Coverage is provided for: Tobacco Cessation programs, including individual/group/phone counseling, over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence (if prescribed by a physician and purchased at a network pharmacy). • Diabetes self-management	No cost for tobacco cessation programs. $25 per visit to PCP $60 per visit to specialist	No cost for tobacco cessation programs. $25 per visit to PCP $60 per visit to specialist	No cost for tobacco cessation programs. $30 per visit to PCP $75 per visit to specialist
Wellness Programs • Online Lifestyle Management Programs	No cost for participating in wellness programs.	No cost for participating in wellness programs.	No cost for participating in wellness programs.

Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other HealthCare Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- For the Standard Option, the calendar year deductible is $350 for Self Only, $700 for Self Plus One or $700 for Self and Family. For the Basic Option, the calendar year deductible is $1,500 for Self Only, $3,000 for Self Plus One or $3,000 for Self and Family. For the Value Option, the calendar year deductible is $2,000 for Self Only, $4,000 for Self Plus One or $4,000 for Self and Family. The calendar year deductible is applied to almost all benefits in this Section. We added "(deductible applies)" to show when the calendar year deductible does apply.
- Plan physicians must provide or arrange your care.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The services listed below are for the charges billed by a physician or other healthcare professional for your surgical care. See Section 5(c) for charges associated with a facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES**. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You Pay		
Surgical procedures	**Standard**	**Basic**	**Value**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Routine pre-and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Surgical treatment of severe obesity (bariatric surgery). - Coverage is subject to prior authorization and includes for the following expense: • Pre-surgical visits • Surgery related services • Follow-up visits • Insertion of internal prosthetic devices. See 5 (a) –*Orthopedic and prosthetic devices* for device coverage information • Treatment of burns	10% coinsurance (deductible applies)	20% coinsurance (deductible applies)	30% coinsurance (deductible applies)

Surgical procedures - continued on next page

Benefit Description	You Pay		
Surgical procedures (cont.)	**Standard**	**Basic**	**Value**
Note: For female surgical family planning procedures see Family Planning Section 5(a) Note: For male surgical family planning procedures see Family Planning Section 5(a) Note: We pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	10% coinsurance (deductible applies)	20% coinsurance (deductible applies)	30% coinsurance (deductible applies)
Plan exclusions: • *Reversal of voluntary sterilization-* • *Routine treatment of conditions of the foot - (see Section 5(a) Foot care)*	*All charges*	*All charges*	*All charges*
Reconstructive surgery	**Standard**	**Basic**	**Value**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance; and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are protruding ear deformities; cleft lip; cleft palate; birthmarks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - Surgery to produce a symmetrical appearance of breasts; - Treatment of any physical complications, such as lymphedemas; - Breast prostheses and surgical bras and replacements (see Section 5(a) *Prosthetic devices*) Note: Note: We pay for internal breast prostheses under Section 5(c) Hospital benefits. If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	10% coinsurance (deductible applies)	20% coinsurance (deductible applies)	30% coinsurance (deductible applies)
Plan exclusions:	*All charges*	All charges	*All charges*

Reconstructive surgery - continued on next page

Benefit Description	You Pay		
Reconstructive surgery (cont.)	**Standard**	**Basic**	**Value**
• *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury. (See Section 5(d) Accidental injury)* • *Surgery for Sex-Trait Modification to treat gender dysphoria* • Sex-Trait Modification: If you are mid-treatment, within a surgical or chemical regimen for Sex-Trait Modification for diagnosed gender dysphoria, for services for which you received covered under the 2025 Plan brochure, you may seek an exception to continue care. Our exceptions process is as follows: - Counseling services (must be provided by a licensed mental health provider and may include those who provide faith-based counseling) for possible or diagnosed gender dysphoria. - Chemical or surgical treatment for gender reassignment may be covered, with prior authorization, for those who are mid-treatment (defined as initiation of surgical and/or hormonal treatments prior to January 1, 2026) if ALL of the following are met: • 19 years of age or older • Clinical notes documenting surgical and/or hormonal treatments for the purpose of gender transition that were initiated prior to January 1, 2026 • A letter of referral from a qualified mental health professional • Persistent, well-documented gender dysphoria • Capacity to make a fully informed decision and to consent for treatment • No significant medical or mental health concerns are present OR if present, they must be reasonably well controlled • AND, requirements for the specific procedures listed below within this medical policy are met.	*All charges*	All charges	*All charges*

Reconstructive surgery - continued on next page

Benefit Description	You Pay		
Reconstructive surgery (cont.)	**Standard**	**Basic**	**Value**
• The exception process will be applied on a case-by-case basis and in order to apply for an exception to the CL 2025-01-b exclusion of sex-trait medical interventions/ transgender services, please contact our Customer Service Department by writing to: Baylor Scott & White Health Plan Attn: Customer Service Department 1206 West Campus Drive Temple, TX 76502 or call 844-633-5325. You will also find more information on our member website at: https://bswhealthplan.com/fehb. If you disagree with this information, please contact our member service department at 844-633-5325 to speak to a representative. • *Individuals under age 19 are not eligible for exceptions related to services for ongoing surgical or hormonal treatment for diagnosed gender dysphoria.*	*All charges*	All charges	*All charges*
Gender Dysphoria Surgery	**Standard**	**Basic**	**Value**
Gender Dysphoria Care Surgical treatment includes but may not be limited to the following, based on medical necessity and with prior authorization: • Urethroplasty (reconstruction of female urethra) • Amputation of penis • Mastectomy - Penile prothesis - Orchiectomy - Insertion of testicular prosthesis - Scrotoplasty - Intersex surgery male to female [a series of staged procedures] - Intersex surgery female to male [a series of staged procedures] - Vulvectomy - Plastic repair of introitus - Clitoroplasty for intersex state - Perineoplasty - Vaginectomy - Construction of artificial vagina - Vaginoplasty for intersex state - Hysterectomy	10% Coinsurance (deductible applies)	20% Coinsurance (deductible applies)	30% Coinsurance (deductible applies)

Benefit Description	You Pay		
Oral and maxillofacial surgery	**Standard**	**Basic**	**Value**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures.	10% coinsurance (deductible applies)	20% coinsurance (deductible applies)	30% coinsurance (deductible applies)
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*	All charges	All charges
Organ/tissue transplants	**Standard**	**Basic**	**Value**
These solid organ and tissue transplants are subject to medical necessity and experimental/investigational review by the Plan. See Other Services in Section 3 for prior authorization procedures. • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Cornea • Heart • Heart-lung • Intestinal transplants - Isolated Small intestine - Small intestine with the liver - Small intestine with multiple organs such as the liver, stomach, and pancreas • Kidney • Kidney-Pancreas • Liver • Lung: Single/bilateral/lobar • Pancreas	10% coinsurance (deductible applies)	20% coinsurance (deductible applies)	30% coinsurance (deductible applies)

Organ/tissue transplants - continued on next page

Benefit Description	You Pay		
Organ/tissue transplants (cont.)	**Standard**	**Basic**	**Value**
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to Other services in Section 3 for prior authorization procedures. • Autologous tandem transplants for - AL Amyloidosis - Multiple myelomas (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	10% coinsurance (deductible applies)	20% coinsurance (deductible applies)	30% coinsurance (deductible applies)
These tandem Blood or marrow stem cell transplants for covered transplants are subject to medical necessity review by the Plan. Refer to Other services in Section 3 for prior authorization procedures. The Plan extends coverage for the diagnoses as indicated below. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i. e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hematopoietic stem cell trasnplant - Hemoglobinopathy - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i. e., Fanconi's, Paroxysmal Nocturna Hemoglobinuria, Pure Red Cell Aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy)	10% coinsurance (deductible applies)	20% coinsurance (after deductible)	30% coinsurance (deductible applies)

Organ/tissue transplants - continued on next page

Benefit Description	You Pay		
Organ/tissue transplants (cont.)	**Standard**	**Basic**	**Value**
- Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/Myelodysplastic Syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Breast Cancer - Ependymoblastoma - Epithelial ovarian cancer - Ewing's sarcoma - Medulloblastoma - Multiple myelomas - Pineoblastoma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors	10% coinsurance (deductible applies)	20% coinsurance (after deductible)	30% coinsurance (deductible applies)
Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to Other services in Section 3 for prior authorization procedures: • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed)	10% coinsurance (deductible applies)	20% coinsurance (deductible applies)	30% coinsurance (deductible applies)

Organ/tissue transplants - continued on next page

Benefit Description	You Pay		
Organ/tissue transplants (cont.)	**Standard**	**Basic**	**Value**
- Advanced Myeloproliferative Disorders (MPDs) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic Syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i. e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma	10% coinsurance (deductible applies)	20% coinsurance (deductible applies)	30% coinsurance (deductible applies)
These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of health **approved clinical trial** or a Plan-designated center of excellence if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, X-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for: - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome)	10% coinsurance (deductible applies)	20% coinsurance (deductible applies)	30% coinsurance (deductible applies)

Organ/tissue transplants - continued on next page

Benefit Description	You Pay		
Organ/tissue transplants (cont.)	**Standard**	**Basic**	**Value**
• Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) • Autologous Transplants for - Advanced Childhood kidney cancers - Advanced Ewing sarcoma - Childhood rhabdomyosarcoma - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma) - National Transplant Program (NTP) - Note: When we cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.	10% coinsurance (deductible applies)	20% coinsurance (deductible applies)	30% coinsurance (deductible applies)
Plan exclusions: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*	All charges	*All charges*
Anesthesia	**Standard**	**Basic**	**Value**
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	10% coinsurance (deductible applies)	20% coinsurance (deductible applies)	30% coinsurance (deductible applies)

Section 5(c). Services Provided by a Hospital or Other Facility, and Ambulance Services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- For the Standard Option, the calendar year deductible is $350 for Self Only, $700 for Self Plus One or $700 for Self and Family. For the Basic Option, the calendar year deductible is $1,500 for Self Only, $3,000 for Self Plus One or $3,000 for Self and Family. For the Value Option, the calendar year deductible is $2,000 for Self Only, $4,000 for Self Plus One or $4,000 for Self and Family. The calendar year deductible is applied to almost all benefits in this Section. We added "(deductible applies)" to show when the calendar year deductible does apply.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i. e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You Pay		
Inpatient hospital	**Standard**	**Basic**	**Value**
Room and board, such as • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	10% coinsurance (deductible applies)	20% coinsurance (deductible applies)	30% coinsurance (deductible applies)
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests and X-rays • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	10% coinsurance (deductible applies)	20% coinsurance (deductible applies)	30% coinsurance (deductible applies)

Inpatient hospital - continued on next page

Benefit Description	You Pay		
Inpatient hospital (cont.)	**Standard**	**Basic**	**Value**
Plan exclusions: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as phone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges*	All charges	All charges
Outpatient hospital or ambulatory surgical center	**Standard**	**Basic**	**Value**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service • Vasectomies • Laparoscopies Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	10% coinsurance (deductible applies)	20% coinsurance (deductible applies)	30% coinsurance (deductible applies)
Extended care benefits/Skilled nursing care facility benefits	**Standard**	**Basic**	**Value**
• Extended care benefit • Skilled nursing facility (SNF)	10% coinsurance (deductible applies) 60 visit limit per year	20% coinsurance (deductible applies) 25 visit limit per year	30% coinsurance (deductible applies) 25 visit limit per year
Plan exclusions: Custodial care	*All charges*	All charges	All charges

Benefit Description	You Pay		
Hospice care	**Standard**	**Basic**	**Value**
Hospice services consist of medically necessary Hospice care that is recommended by a designated Participating Physician, approved in advance by the Medical Director, and provided by a licensed Hospice agency with which Health Plan has arranged for you or your covered dependent's care and treatment.	Nothing	Nothing	Nothing
Plan exclusions: Independent nursing, homemaker services.	*All charges*	All charges	*All charges*
Ambulance	**Standard**	**Basic**	**Value**
• Local professional ambulance service when medically appropriate	$125 per trip (deductible applies)	20% coinsurance (deductible applies)	30% coinsurance (deductible applies)

Section 5(d). Emergency Services/Accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- For the Standard Option, the calendar year deductible is $350 for Self Only, $700 for Self Plus One or $700 for Self and Family. For the Basic Option, the calendar year deductible is $1,500 for Self Only, $3,000 for Self Plus One or $3,000 for Self and Family. For the Value Option, the calendar year deductible is $2,000 for Self Only, $4,000 for Self Plus One or $4,000 for Self and Family. The calendar year deductible is applied to almost all benefits in this Section. We added "(deductible applies)" to show when the calendar year deductible does apply.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

Emergencies within our service area

If you have symptoms of heart attack or stroke or feel that your "life or limb" is in danger, go immediately to the emergency room or call 911. If you have any of the following, go to the emergency room or call 911:

- Chest pain or pressure
- Uncontrolled bleeding
- Sudden or severe pain
- Coughing or vomiting blood
- Difficulty breathing or shortness of breath
- Sudden dizziness, weakness, or changes in vision
- Severe or persistent vomiting or diarrhea
- Changes in mental status, such as confusion

Emergencies outside our service area

In all emergency situations, you are encouraged to seek care with the nearest BSWHP approved provider; however, if the time needed to reach an BSWHP approved provider might endanger your health, go to the nearest emergency room. Medically necessary emergency care is covered. If you are hospitalized as a result of the emergency, you should contact the BSWHP Health Services Department within 24-48 hours of any admission at 888-316-7947.

Benefit Description	You pay		
Emergency within our service area	**Standard**	**Basic**	**Value**
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient at a hospital, including doctors' services Note: We waive the ER copay if you are admitted to the hospital.	$25 PCP $60 Specialist $50 per visit to an Urgent Care Center 10% coinsurance (deductible applies)	$25 PCP $60 Specialist $50 per visit to an Urgent Care Center 20% coinsurance (deductible applies)	$30 PCP $75 Specialist $50 per visit to an Urgent Care Center 30% coinsurance (deductible applies)
Plan exclusions: Elective care or non-emergency care	*All charges*	All charges	All charges
Emergency outside our service area	**Standard**	**Basic**	**Value**
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient at a hospital, including doctors' services Note: We waive the ER copay if you are admitted to the hospital.	All charges $50 per visit to an Urgent Care Center 10% coinsurance per visit to an Emergency Room (deductible applies)	All charges $50 per visit to an Urgent Care Center 20% coinsurance per visit to an Emergency Room (deductible applies)	All charges $50 per visit to an Urgent Care Center 30% coinsurance per visit to an Emergency Room (deductible applies)
Plan exclusions: • *Elective care or non-emergency care and follow-up care recommended by non-Plan providers that have not been approved by the Plan or provided by Plan providers* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a Normal full-term delivery of a baby outside the service area*	*All charges*	All charges	*All charges*
Ambulance	**Standard**	**Basic**	**Value**
Professional ambulance service when medically appropriate Note: See 5(c) for non-emergency service.	$125 per trip (deductible applies)	20% coinsurance (deductible applies)	30% coinsurance (deductible applies)
Plan exclusions: Health Plan will not cover air transportation if ground transportation is medically appropriate and more economical.	*All charges*	All charges	All charges

Section 5(e). Mental Health and Substance Use Disorder Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- For the Standard Option, the calendar year deductible is $350 for Self Only, $700 for Self Plus One or $700 for Self and Family. For the Basic Option, the calendar year deductible is $1,500 for Self Only, $3,000 for Self Plus One or $3,000 for Self and Family. For the Value Option, the calendar year deductible is $2,000 for Self Only, $4,000 for Self Plus One or $4,000 for Self and Family. The calendar year deductible is applied to almost all benefits in this Section. We added "(deductible applies)" to show when the calendar year deductible does apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Benefit Description	You Pay		
Professional services	**Standard**	**Basic**	**Value**
When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance use disorder treatment practitioners when acting within the scope of their licenses, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	$25 per visit	$25 per visit	$30 per visit
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of substance use disorders, including detoxification, treatment, and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	$25 per visit	$25 per visit	$30 per visit

Professional services - continued on next page

Benefit Description	You Pay		
Professional services (cont.)	**Standard**	**Basic**	**Value**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance use disorder treatment practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	$25 per visit	$25 per visit	$30 per visit
Inpatient hospital or other covered facility	**Standard**	**Basic**	**Value**
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services	10% coinsurance (deductible applies)	20% coinsurance (deductible applies)	30% coinsurance (deductible applies)
Outpatient hospital or other covered facility	**Standard**	**Basic**	**Value**
Outpatient services provided and billed by a hospital or other covered facility • Services in approved treatment programs, such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment	10% coinsurance (deductible applies)	20% coinsurance (deductible applies)	30% coinsurance (deductible applies)

Precertification If your provider requests out-of-network services, they must be preauthorized by the BSWHP Medical Director for you to receive any benefits. Emergency admissions must be reported within two business days following the day of admission even if you have been discharged. Otherwise, there will be no coverage. See Section 3 for details.

See these sections of the brochure for more valuable information about these benefits:

- Section 4, *Your cost for covered services*, for information about catastrophic protection for these benefits.
- Section 7, *Filing a claim for covered services*, for information about submitting out-of-network claims.

Section 5(f). Prescription Drug Benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Your prescribers must obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused medications.
- For the Standard Option, the calendar year deductible is $350 for Self Only, $700 for Self Plus One or $700 for Self and Family. For the Basic Option, the calendar year deductible is $1,500 for Self Only, $3,000 for Self Plus One or $3,000 for Self and Family. For the Value Option, the calendar year deductible is $2,000 for Self Only, $4,000 for Self Plus One or $4,000 for Self and Family. The calendar year deductible is applied to almost all benefits in this Section. We added "(deductible applies)" to show when the calendar year deductible does apply.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- A PDP EGWP provides prescription drug coverage only, while an MAPD EGWP combines prescription drug, physician, and hospital coverage. Enrollees are encouraged to review their options under the plan to choose what best serves their needs as the PDP EGWP or MAPD EGWP may not offer the same coverage or pricing.
- The exclusion for hormone treatments for Sex-Trait Modification for gender dysphoria only pertains to chemical and surgical modification of an individual's sex traits (including as part of "gender transition" services). We do not exclude coverage for entire classes of pharmaceuticals, e.g., GnRH agonists may be prescribed during IVF, for reduction of endometriosis or fibroids, and for cancer treatment or prostate cancer/ tumor growth prevention.

We cover prescribed drugs and medications, as described in the chart beginning on the next page.

There are important features you should be aware of. These include:

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed/or certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medication.
- **Where you can obtain them.** You can fill your retail prescriptions at in-network pharmacies within the broad retail network with over 60,000+ options including all major chains. Specialty drug prescriptions can be filled at Costco Specialty Pharmacy by calling 833.502.3339 or BSW Specialty Pharmacy by calling 844.288.3179.
- **Mail Order Prescription Drugs.** Mail order is available through Costco Mail Order. Access Costco Mail Order through the member portal or call 833.502.3339.
- **We use a managed formulary.** BSWHP uses a standard formulary called the Group Value Formulary which is a list of medications that are both medically appropriate and cost-effective. All drugs have been reviewed and approved by a team of health care providers including doctors and pharmacists to be included on our formulary. If your drug is not listed on the formulary, you can talk with your doctor about switching to a formulary drug that may be lower in cost and as effective. If you need to continue using the drug not listed and the drug is not excluded, you or your physician may submit a request for coverage based on medical necessity. If approved, you'll pay the applicable copayment or coinsurance. If not approved and you still want to take it, you'll pay the full cost. Please visit https://bswhealthplan.com/fehb for the formulary list of drugs.
- **These are the dispensing limitations.** There may be limitations on drugs that require prior authorization. "Prior Authorization Required" drugs are usually those that have multiple uses, have a high potential for waste, or require close monitoring by the physician. These are the dispensing limitations:
  - **Prior Authorization**: BSWHP requires you or your physician to get prior authorization before filling certain drugs. Drugs needing prior authorization are noted on the formulary by a "PA" next to the drug name.

- **Step Therapy**: In some cases, BSWHP requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. Drugs with step therapy are noted on the formulary by an "ST" next to the drug name.
- **Drug Exception**: A medication may require a drug exception for a variety of reasons, i.e.; may be limited to certain Specialty prescribers, limited to certain pharmacies, may be a medication that is part of the therapeutic interchange programs, or various other reasons. Please contact our customer service department for questions regarding these medications.
- **Quantity Limit**: For certain drugs, BSWHP limits the amount of medication covered. Quantity limits help ensure the appropriate use of medications. Quantity limits are often applied for safety reasons (e.g. limiting products containing acetaminophen to maximum safe limits). Drugs with quantity limits are noted on the formulary by a "QL" next to the drug name.
- **Age Restriction**: There are certain medications which may be limited to a certain age group. Drugs with age restrictions are noted on the formulary by an "AL" next to the drug name.

- **A generic equivalent will be dispensed if it is available,** unless your physician specifically requires a name brand.
- **Dispense as Written (DAW):** If you or your provider requests a brand-name drug when a generic equivalent is available, then you are responsible for the non-preferred co-payment plus the difference in cost of the brand name drug and the generic equivalent drug. The difference in cost will apply to the maximum out-of-pocket from the plan.
- **Why use generic drugs?** The BSWHP Group Value Formulary provides high-quality pharmaceutical care at the lowest possible cost. The structure of the formulary promotes the use of safe, effective medications while decreasing the use of higher-priced, low-value drugs such as high-cost brands with generic alternatives or generic equivalents available. Generic drugs offer the same active ingredients, dosage, and effectiveness as brand-name drugs, but at a significantly lower cost, making medications more affordable and accessible
- **When you have to submit a claim?**
  Mail completed form(s) with register receipts and other supporting documents to: Judi Rx, Inc. Attn: Claims Dept. 9450 SW Gemini Dr., #87234, Beaverton, OR 97008. You can also email all documents for processing to dmr@cap-rx.com. Also see the link to the Prescription Drug Claim Form at https ://www. bswhealthplan.com/fehb/pharmacy.

Benefits Description	You Pay		
Covered medications and supplies	**Standard**	**Basic**	**Value**
Each new enrollee will receive a description of our prescription drug program, a combined prescription drug/Plan identification card, a mail order form/patient profile and a preaddressed reply envelope. **Retail Prescription Drugs – (30-day supply)** 30-day supplies of medications listed on the formulary are covered at the applicable copays. The following medications and supplies must be prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program. To fill a new prescription: present your ID card at a network retail pharmacy or ask your doctor to electronically send your mail order prescription to Costco Mail Order or your specialty prescription to Costco Specialty Pharmacy. We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medications that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered* • Insulin • Diabetic supplies limited to: - Disposable needles, test strips, lancets, lancet devices, meters, and syringes for the administration of covered medications.	**Retail-30-day supply** Tier 1 (Preferred Generic) $8 Tier 2 (Non-Preferred Generic) $20 Tier 3 (Preferred Brand) 30%, up to a maximum of a $75 copay Tier 4 (Non-Preferred Brand) 50%, up to a maximum of a $200 copay Tier 5 (Preferred Generic Specialty) 20%, up to a maximum of $400 Tier 6 (Preferred Brand Specialty) $400	**Retail 30-day supply** Tier 1 (Preferred Generic) $8 Tier 2 (Non-Preferred Generic) $25 Tier 3 (Preferred Brand) $65 Tier 4 (Non-Preferred Brand) $120 Tier 5 (Preferred Generic Specialty) 20%, up to a maximum of $400 Tier 6 (Preferred Brand Specialty) $400 Tier 7 (Non-Preferred Specialty) $600	**Retail 30-day supply** Tier 1 (Preferred Generic) $10 Tier 2 (Non-Preferred Generic) $25 Tier 3 (Preferred Brand) $90 Tier 4 (Non-Preferred Brand) $200 Tier 5 (Preferred Generic Specialty) 20%, up to a maximum of $400 Tier 6 (Preferred Brand Specialty) $450 Tier 7 (Non-Preferred Specialty) $650

Covered medications and supplies - continued on next page

Benefits Description	You Pay		
Covered medications and supplies (cont.)	**Standard**	**Basic**	**Value**
• Drugs for sexual dysfunction (covered at Non-Preferred copay) • Medications prescribed to treat obesity - Anti-obesity medications such as phentermine, GLP-1 agonists (e.g., Wegovy, Zepbound), phentermine-topiramate ER, Contrave, and Xenical may be covered under the pharmacy benefit. Refer to the formulary for a list of covered products. These medications may be subject to prior authorization review and quantity limits. **Preventive Care** medications to promote better health as recommended by ACA. The following drugs and supplements are covered without cost-share, even if over-the-counter, are prescribed by a healthcare professional and filled at a network pharmacy. Preventive Medications with USPSTF recommendation of A and B are recommendations. These may include some over-the-counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations Opioid rescue agents are covered under this Plan with no cost sharing when obtained with a prescription from a network pharmacy in any over the counter or prescription form available such as nasal sprays and intramuscular injections. For more information consult the FDA guidance at: www. fda.gov/consumers/consumer-updates/access-naloxone-can-save-life-during-opioid-overdose Or call SAMHSA's National Helpline 1-800-662-HELP (4357) or go to www. findtreatment.samhsa.gov/ **Medical Foods (Pharmacy):** Medical foods are available to members for the treatment and/or management for PKU and for the indication of inborn errors of metabolism. This is available through the pharmacy benefit at either a Tier 2 or Tier 3 cost share for 30 day supply. Medical foods offered on an OTC basis, or through internet sites, are not covered. Not covered: • Drugs and supplies for cosmetic purposes • Nonprescription medications	**Retail-30-day supply** Tier 1 (Preferred Generic) $8 Tier 2 (Non-Preferred Generic) $20 Tier 3 (Preferred Brand) 30%, up to a maximum of a $75 copay Tier 4 (Non-Preferred Brand) 50%, up to a maximum of a $200 copay Tier 5 (Preferred Generic Specialty) 20%, up to a maximum of $400 Tier 6 (Preferred Brand Specialty) $400 Tier 7 (Non-Preferred Specialty) $600 Note Plan benefit: Some drugs do not have a generic equivalent, in this case, the brand name copay is required.	**Retail 30-day supply** Tier 1 (Preferred Generic) $8 Tier 2 (Non-Preferred Generic) $25 Tier 3 (Preferred Brand) $65 Tier 4 (Non-Preferred Brand) $120 Tier 5 (Preferred Generic Specialty) 20%, up to a maximum of $400 Tier 6 (Preferred Brand Specialty) $400 Tier 7 (Non-Preferred Specialty) $600 Note Plan benefit: Some drugs do not have a generic equivalent, in this case, the brand name copay is required.	**Retail 30-day supply** Tier 1 (Preferred Generic) $10 Tier 2 (Non-Preferred Generic) $25 Tier 3 (Preferred Brand) $90 Tier 4 (Non-Preferred Brand) $200 Tier 5 (Preferred Generic Specialty) 20%, up to a maximum of $400 Tier 6 (Preferred Brand Specialty) $450 Tier 7 (Non-Preferred Specialty) $650 Note Plan benefit: Some drugs do not have a generic equivalent, in this case, the brand name copay is required.
• Maintenance drugs are allowed up to a 90-day supply if obtained through a participating pharmacy or when using the mail-order prescription service. • Specialty drugs are limited to a 30-day supply.	Mail Order **Maintenance Medication 90-day supply** Tier 1 (Preferred Generic) $20 Tier 2 (Non-Preferred Generic) $50	Mail Order **Maintenance Medication 90-day supply** Tier 1 (Preferred Generic) $20 Tier 2 (Non-Preferred Generic) $62.50	Mail Order **Maintenance Medication 90-day supply** Tier 1 (Preferred Generic) $20 Tier 2 (Non-Preferred Generic) $62.50

Covered medications and supplies - continued on next page

Benefits Description	You Pay		
Covered medications and supplies (cont.)	**Standard**	**Basic**	**Value**
	Tier 3 (Preferred Brand) Lesser of $187.50 copay or 30% Tier 4 (Non-Preferred Brand) Lesser of $500 copay or 50%	Tier 3 (Preferred Brand) Lesser of $162.50 copay or 30% Tier 4 (Non-Preferred Brand) $300	Tier 3 (Preferred Brand)Lesser of $225 copay or 30% Tier 4 (Non-Preferred Brand) $500
Contraceptive drugs and devices as listed in the Health Resources and Services Administration site https ://www. hrsa.gov/womens-guidelines. Contraceptive coverage is available at no cost to FEHB members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described below. Over-the-counter and prescription drugs approved by the FDA to prevent unintended pregnancy. For details visit http://bswhealthplan.com/fehb If you have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov. Non-formulary branded contraceptives can be requested without cost-sharing through the exception process. These will be covered without cost sharing if using the requested product for contraception and are medically necessary. Reimbursement for covered over-the-counter contraceptives can be submitted in accordance with Section 7. Refer to the list of Women's contraception drugs and devices that are covered at $0 copay at: https ://www. bswhealthplan.com/fehb/Pages/default.aspx#pharmacy including: Morning after pill (this is an over-the-counter emergency contraceptive drug) Note: For additional Family Planning benefits see Section 5(a). We cover clinician-administered contraceptives under the medical benefit. We cover oral and self-administered contraceptives under the prescription drug benefit.	$0 copay Morning after pill is covered at no cost to the member if prescribed by a physician and purchased at a network pharmacy.	$0 copay Morning after pill is covered at no cost to the member if prescribed by a physician and purchased a network pharmacy.	$0 copay Morning after pill is covered at no cost to the member if prescribed by a physician and purchased a network pharmacy.
Plan exclusions:	*All charges*	All charges	All charges

Covered medications and supplies - continued on next page

Benefits Description	You Pay		
Covered medications and supplies (cont.)	**Standard**	**Basic**	**Value**
Note: Over-the-counter and appropriate prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation Educational Classes and Programs in Section 5(a) *Not covered* • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Nonprescription medications unless specifically indicated elsewhere* • *A prescription that has an over the counter alternative* • *Drugs prescribed in connection with Sex-Trait Modification for treatment of gender dysphoria* • *No individuals are eligible for exceptions related to services for ongoing surgical or hormonal treatment for diagnosed gender dysphoria.*	*All charges*	All charges	All charges
Fertility Drugs: medication coverage under the pharmacy benefit for fertility and assisted reproductive technology (ART) procedures, including in vitro fertilization (IVF). Includes coverage for oral and injectable medications in the following categories: oral ovulation induction, gonadotropins, follicle stimulating hormones, and progestins.	30% of Charges. Deductible does not apply. Limit of up to three (3) cycles for IVF drugs.	50% of Charges. Deductible does not apply. Limit of up to three (3) cycles for IVF drugs.	50% of Charges. Deductible does not apply. Limit of up to three (3) cycles for IVF drugs.

Section 5(g). Dental Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be the First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care.
- For the Standard Option, the calendar year deductible is $350 for Self Only, $700 for Self Plus One or $700 for Self and Family. For the Basic Option, the calendar year deductible is $1,500 for Self Only, $3,000 for Self Plus One or $3,000 for Self and Family. For the Value Option, the calendar year deductible is $2,000 for Self Only, $4,000 for Self Plus One or $4,000 for Self and Family. The calendar year deductible is applied to almost all benefits in this Section. We added "(deductible applies)" to show when the calendar year deductible does apply.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

Accidental injury benefit	You Pay		
Accidental injury benefit	**Standard**	**Basic**	**Value**
We only cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. **The need for these services must result from an accidental injury.** **We have no other dental benefits.**	$60 office visit copay with a specialist	$60 office visit copay with a specialist	$75 office visit copay with a specialist
Dental benefits	**Standard**	**Basic**	**Value**
Plan exclusions: Routine/Restorative	*All charges*	All charges	*All charges*

Section 5(h). Wellness and Other Special Features

Special feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process see page xxx.
24 hour nurse line	For any of your health concerns, 24 hours a day, 7 days a week, you may call and talk with a registered nurse who will discuss treatment options and answer your health questions. Our nurses can give you information about how to take care of yourself at home or can help you decide if an appointment, an urgent care visit or an emergency room visit is best for your symptoms. If you want to talk to a nurse, call **800-724-7037.** The nurse advice line is available to all BSWHP members.
Services for deaf and hearing impaired	BSWHP utilizes a toll-free TTY number **711** to assist with communication services for Members with hearing or speech difficulties.
Appointment Advocates	Baylor Scott & White Health Plan will help you get an appointment when you need to be seen! If you are having difficulty getting an appointment to see one of our participating providers, please call us. Our personalized service will get you an appointment to see a clinician when you need to be seen. Please call us at **844-633-5325**.
Language Line	In an effort to improve communication with non-English speaking members, BSWHP uses the interpretive services of CQfluency. Members do not have to call a special line for this service. When contacting BSWHP, Members may notify the Health Services (HSD) staff and/or Customer Advocates of their primary language and the call will be completed with the help of a CQfluency interpreter at no charge to the Member. BSWHP HSD staff follows established internal BSWHP policies related to the provision of interpretive services for BSWHP members.
Health Education Resources	An exhaustive list of wellness programs can be found at **https://www.bswhealthplan.com/fehb/pages/default.aspx** under the *Health and Wellness* heading. • **WebMD digital wellness platform**

	The WebMD digital wellness platform encourages members to be healthy, while providing personal health support for various health conditions and health risks. • **Wondr Health** Have you ever wondered why some people can eat the foods they love and not gain weight? Wondr Health reveals the secret sauce behind the unexpected concept through behavioral science. • **Wellness Webinar series** BSWHP has free health education opportunities you can access from the comfort of home, your workplace, or wherever you may be. There's a series of topics that include nutrition, happiness, and other health topics. Webinars take place midday, so grab your lunch and plan to join us! • ***Be Well* newsletter** *Be Well* is a collection of news, tips and reminders designed to help you and your family make the most of your wellness benefits and live a healthy lifestyle.
High risk pregnancies	Baylor Scott & White Health Plan provides the following services for expectant mothers during pregnancy and for one year after birth: Access to a nurse 24/7 during pregnancy with use of our nurse line found on the ID card In-home support for higher risk conditions including: diabetes, hypertension, and severe nausea Depression screening following delivery Planning for returning to work Members can obtain these services by contacting Customer Service at 844-633-5325
Levanto	• Help Me Decide: Personalized guidance on symptoms and treatment options to connect members to the lowest cost, most appropriate care. • Muscle & Joint Care: Supporting muscle and joint health with diagnosis and treatment of acute and chronic pain, plus pre-/post-surgical care. • Healthy Weight: Promoting positive habits for long-term weight loss with fully integrated tracking. core and support. • Pregnancy & Postpartum Care: Comprehensive prenatal and postpartum care, with education and support for new moms when they need it most. • Mental Health Care: Coordinated support for emotional well-being across therapy and psychiatry to Improve access and outcomes. • Headache Care: Customized diagnosis and fast, effective treatment to overcome headaches and migraines • Allergy Care: Delivering fast, personalized allergy relief with seamless access to treatment, tracking and ongoing support.
Be Well with Diabetes	Our Be Well with Diabetes program provides coaching support to help improve the health of members with Type 2 diabetes. The goal of the program is to educate and assist members in managing their diabetes, reducing complications, and eliminating their costs for covered diabetes medication and supplies. The BSW Be Well™ Coaching program can identify simple changes that will improve your health—and provide tips on how to make those changes as easy as possible. Having a pharmacist available to answer your questions will help you stay better informed about your medications and how they may be affecting your health. Complete and submit the application form online at www.BSWHealthPlan.com/BeWell/Diabetes

Non-FEHB benefits available to Plan members

The discounts on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them**. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. For more information, please call **844-633-5325** or visit https://bswhealthplan.com/fehb.

Section 6. General Exclusions – Things We Don’t Cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. Although we may list a specific service as a benefit, we will not cover it unless it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For information on obtaining prior approval for specific services, such as transplants, see Section 3 When you need prior Plan approval for certain services. We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency services/accidents).
- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services, drugs, or supplies not medically necessary.
- Services or supplies we are prohibited from covering under the Federal Law.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice.
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants).
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.
- Services, drugs, or supplies you receive without charge while in active military service.
- Chemical or surgical modification of an individual's sex traits through medical interventions (to include “gender transition” services), see Section 3. How You Get Care.

Section 7. Filing a Claim for Covered Services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. When you see Plan providers, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment or coinsurance. This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment or coinsurance.

You will only need to file a claim when you receive emergency services from non-Plan providers. Sometimes these providers bill us directly. Check with the provider. If you need to file the claim, here is the process:

Medical and hospital benefits

In most cases, providers and facilities file HIPAA compliant electronic claims for you. In cases where a paper claim must be used, the providers must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, contact us at 844-633-5325, or at our website at https://bswhealthplan.com/fehb.

When you must file a claim – such as for services you received outside the Plan's service area – submit it via the secured member portal for consideration at: https://my.bswhealth.com/login or submit by mail on the CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name, date of birth, address, phone number and ID number
- Name and address of the provider or facility that provided the service or supplies
- Dates you received the services or supplies
- Diagnosis
- Type of each service or supply
- The charge for each service or supply
- A copy of the explanation of benefits, payments, or denial from any primary payer – such as the Medicare Summary Notice (MSN)
- Receipts, if you paid for your services

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills. Submit your claims to:

Baylor Scott & White Health Plan
Attn: Claims Department
1206 West Campus Drive
Temple, TX 76502

Prescription drugs

Submit your claims to:

Baylor Scott and White Health Plan
Attn: Pharmacy Claims Department
1206 West Campus Drive
Temple, TX 76502

Other supplies or services

Submit your claims to:

Baylor Scott & White Health Plan
Attn: Claims Department
1206 West Campus Drive
Temple, TX 76502

Deadline for filing your claim	Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.
Post-service claims procedures	We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected. If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information. If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.
• **Records**	Keep a separate record of the medical expenses of each covered family member.
• **Deadline for filing your claim**	Send us all the documents for your claim as soon as possible via the secure member portal at: https://my.bswhealth.com/login or mail to: Baylor Scott & White Health Plan Attn: Claims Department 1206 West Campus Drive Temple, TX 76502.
• **When we need more information**	Please reply promptly when we ask for additional information via our secured online portal or mail to: Baylor Scott & White Health Plan Attn: Claims Department 1206 West Campus Drive Temple, TX 76502.
Authorized Representative	You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, we will permit a healthcare professional with knowledge of your medical condition to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.
Notice Requirements	If you live in a county where at least 10% of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as phone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language. Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the healthcare provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes.

Section 8. The Disputed Claims Process

You may be able to appeal directly to the Office of Personnel Management (OPM) if we do not follow the required claims processes. For more information or to make an inquiry about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please call your Baylor Scott & White Health Plan's customer service representative at the phone number found on your enrollment card, plan brochure, or plan website.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3 *If you disagree with our pre-service claim decision,* we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing to:

Baylor Scott & White Health Plan
Attn: Customer Service Department
1206 West Campus Drive
Temple, TX 76502

or calling 844-633-5325.

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/investigational), we will consult with a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration decision will not afford deference to the initial decision and will not be conducted by a plan representative who is neither the individual who made the initial decision that is the subject of the reconsideration or their subordinate of that individual.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

1

Ask us in writing to reconsider our initial decision. You must:

- Write to us within 6 months from the date of our decision; and
- Send your request to us at Baylor Scott & White Health Plan, Attn: Customer Service Department, 1206 West Campus Drive, Temple, TX 76502; and
- Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and
- Include copies of documents that support your claims, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
- Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly.

We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.

2 In the case of a post-service claim, we have 30 days from the date we receive your request to:

- Pay the claim or
- Write to you and maintain our denial or
- Ask you or your provider for more information

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

3 If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Healthcare, and Insurance, Federal Employees Insurance Operations, FEHB 3, 1900 E Street, NW, Washington, DC 20415-3630.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claims, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call;
- Your email address, if you would like to receive OPM’s decision via email. Please note that by providing your email address, you may receive OPM’s decision more quickly.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a healthcare professional with knowledge of your medical condition may act as your authorized representative without your express consent.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

4 OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision or notify you of the status of OPM's review within 60 days. There are no other administrative appeals.

If you do not agree with OPM’s decision, your only recourse is to file a lawsuit. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not file a lawsuit until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life-threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at 844-633-5325. We will expedite our review (if we have not yet responded to your claim), or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 3 at 202-606-0737 between 8 a.m. and 5 p. m. Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a family member is covered under this plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Section 9. Coordinating Benefits with Other Coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays healthcare expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payor or and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit our website at https://bswhealthplan.com/fehb.

When we are the primary payor, we will pay the benefits described in this brochure.

When we are the secondary payor, we will determine our allowance. After the primary plan processes the benefit, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

- **TRICARE and CHAMPVA**

TRICARE is the healthcare program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. IF TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

- **Workers' Compensation**

Every job-related injury or illness should be reported as soon as possible to your supervisor. Injury also means any illness or disease that is caused or aggravated by the employment as well as damage to medical braces, artificial limbs and other prosthetic devices. if you are a federal or postal employee, ask your supervisor to authorize medical treatment by use of form CA-16 before you obtain treatment. If your medical treatment is accepted by the Dept. of Labor Office of Workers" Compensation (OWCP), the provider will be compensated by OWCP. If your treatment is determined not job-related, we will process your benefit according to the terms of this plan, including use of in-network providers. Take form CA-16 and form OWCP-1500/HCFA-1500 to your provider, or send it to your provider as soon as possible after treatment, to avoid complications about whether your treatment is covered by this plan or by OWCP.

We do not cover services that:

- You (or a covered family member) need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

- **Medicaid**

When you have this Plan and Medicaid, we pay first.

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, State, or Federal government agency directly or indirectly pays for them.

When others are responsible for injuries

We are entitled to reimbursement to the extent of the benefits we have paid or provided in connection with your injury or illness. However, we will cover the cost of treatment that exceeds the amount of the payment you received.

Reimbursement to us out of the payment shall take first priority (before any of the rights of any other parties are honored) and is not impacted by how the judgment, settlement, or other recovery is characterized, designated, or apportioned. Our right of reimbursement is not subject to reduction based on attorney fees or costs under the "common fund" doctrine and is fully enforceable regardless of whether you are "made whole" or fully compensated for the full amount of damages claimed.

We may, at our option, choose to exercise our right of subrogation and pursue a recovery from any liable party as successor to your rights.

If you do pursue a claim or case related to your injury or illness, you must promptly notify us and cooperate with our reimbursement or subrogation efforts.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on www.BENEFEDS.gov or by phone at 1-877-888-3337, (TTY 1-877-889-5680) you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical trials

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs - costs for routine services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy.
- Extra care costs - costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care.
- Research costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

When you have Medicare

For more detailed information on "What is Medicare?" and "Should I Enroll in Medicare?" please contract Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or at www.medicare.gov.

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B when Medicare is primary. This is true whether or not they accept Medicare.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

Claims process when you have the Original Medicare Plan - You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payor, we process the claim first. When Original Medicare is the primary payor, Medicare processes your claim first.

In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 844-633-5325 or see our website at https://bswhealthplan.com/fehb.

We waive all costs if the Original Medicare Plan is your primary payor - We will waive some out-of-pocket costs as follows:

- Medical services and supplies provided by physicians and other healthcare professionals.

We do not waive any costs if the Original Medicare Plan is not your primary payor.

Please review the following examples which illustrate your cost share if you are enrolled in Medicare Part B. If you purchase Medicare Part B, your provider is in our network and participates in Medicare, then we waive some costs because Medicare will be the primary payor.

Benefit Description: Deductible
Standard Option You Pay **Without** Medicare: $350
Standard Option You Pay **With** Medicare Part B: $0

Benefit Description: Out of Pocket Maximum
Standard Option You Pay **Without** Medicare: $6,000
Standard Option You Pay **With** Medicare Part B: $6,000

Benefit Description: Part B Premium Reimbursement Offered
Standard Option You Pay **Without** Medicare: N/A
Standard Option You Pay **With** Medicare Part B: N/A

Benefit Description: Primary Care Provider
Standard Option You Pay **Without** Medicare: $25
Standard Option You Pay **With** Medicare Part B: $0

Benefit Description: Specialist
Standard Option You Pay **Without** Medicare: $60
Standard Option You Pay **With** Medicare Part B: $0

Benefit Description: Inpatient Hospital
Standard Option You Pay **Without** Medicare: 10% Coinsurance
Standard Option You Pay **With** Medicare Part B: $0

Benefit Description: Outpatient Hospital
Standard Option You Pay **Without** Medicare: 10% Coinsurance
Standard Option You Pay **With** Medicare Part B: $0

Benefit Description: Incentives Offered
Standard Option You Pay **Without** Medicare: N/A
Standard Option You Pay **With** Medicare Part B: N/A

Benefit Description: Deductible
Basic Option You Pay **Without** Medicare: $1,500
Basic Option You Pay **With** Medicare Part B: $0

Benefit Description: Out of Pocket Maximum
Basic Option You Pay **Without** Medicare: $7,000
Basic Option You Pay **With** Medicare Part B: $7,000

Benefit Description: Part B Premium Reimbursement Offered
Basic Option You Pay **Without** Medicare: N/A
Basic Option You Pay **With** Medicare Part B: N/A

Benefit Description: Primary Care Physician
Basic Option You Pay **Without** Medicare: $25
Basic Option You Pay **With** Medicare Part B: $0

Benefit Description: Specialist
Basic Option You Pay **Without** Medicare: $60
Basic Option You Pay **With** Medicare Part B: $0

Benefit Description: Inpatient Hospital
Basic Option You Pay **Without** Medicare: 20% Coinsurance
Basic Option You Pay **With** Medicare Part B: $0

Benefit Description: Outpatient Hospital
Basic Option You Pay **Without** Medicare: 20% Coinsurance
Basic Option You Pay **With** Medicare Part B: $0

Benefit Description: Incentives Offered
Basic Option You Pay Without Medicare: N/A
Basic Option You Pay With Medicare Part B: N/A

You can find more information about how our plan coordinates benefits with Medicare online at https://bswhealthplan.com/fehb.

- **Tell us about your Medicare coverage**

  You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **Medicare Advantage (Part C)**

  If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private healthcare choices (like HMOs and regional PPOs) in some areas of the country.

  To learn more about Medicare Advantage plans, contact Medicare at 800-MEDICARE (800-633-4227), (TTY: 877-486-2048) or at www.medicare.gov.

  If you enroll in a Medicare Advantage plan, the following options are available to you:

This Plan and our Medicare Advantage plan: You may enroll in our plan's Medicare Advantage plan and also remain enrolled in our FEHB plan.

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers). However, we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation	✓*	
9) Are a Federal employee receiving disability benefits for six months or more	✓	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

Section 10. Definitions of Terms We Use in this Brochure

Assignment

An authorization by you (the enrollee or covered family member) that is approved by us (the Carrier), for us to issue payment of benefits directly to the provider.

- We reserve the right to pay you directly for all covered services. Benefits payable under the contract are not assignable by you to any person without express written approval from us, and in the absence of such approval, any assignment shall be void.
- Your specific written consent for a designated authorized representative to act on your behalf to request reconsideration of a claim decision (or, for an urgent care claim, for a representative to act on your behalf without designation) does not constitute an Assignment.
- OPM's contract with us, based on federal statute and regulation, gives you a right to seek judicial review of OPM's final action on the denial of a health benefits claim but it does not provide you with authority to assign your right to file such a lawsuit to any other person or entity. Any agreement you enter into with another person or entity (such as a provider, or other individual or entity) authorizing that person or entity to bring a lawsuit against OPM, whether or not acting on your behalf, does not constitute an Assignment, is not a valid authorization under this contract, and is void.

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Clinical trials cost categories

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

- Routine care costs – costs for routine services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient's cancer, whether the patient is in a clinical trial or is receiving standard therapy
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

Coinsurance

See Section 4, page 24.

Copayment

See Section 4, page 24.

Cost-sharing

See Section 4, page 24.

Covered services

Care we provide benefits for, as described in this brochure.

Custodial Care

"Custodial Care" means care designed principally to assist an individual in engaging in the activities of daily living, or services which constitute personal care, such as help in walking and getting in and out of bed; assistance in bathing, dressing, feeding and using the toilet; preparation of special diets; and supervision of medication, which can usually be self-administered and which does not entail or require the continuing attention of trained medical or other paramedical personnel. Custodial Care is normally, but not necessarily, provided in a nursing home, convalescent home, or rest home or similar institution.

Deductible	See Section 4, age 24.
Experimental or investigational services	"**Experimental**" **or** "**Investigational**" means, in the opinion of the Medical Director, Treatment that has not been proven successful in improving the health of patients.
Group health coverage	Health coverage, such as FEHB, that is provided through an employer group.
Healthcare professional	A physician or other healthcare professional licensed, accredited or certified to perform specified health services consistent with state law.
Infertility	The inability to carry a pregnancy to live birth without the use of birth control after unprotected sexual intercourse / failure of egg and sperm contact and uterine implantation without medical assistance after 12 months if under age 35, or 6 months if age 35 years or older. Infertility may also be justified based on the individual having a medical or other recognized condition as a cause of infertility.
Medical necessity	Those Health Care Services which, in the opinion of Member's Primary Care Provider or Referral Physician, whose opinions are subject to the review, approval or disapproval, and actions of the Medical Director or the Quality Assurance Committee in their appointed duties, are: 1. Essential to preserving the health of Member; and 2. Consistent with the symptoms or diagnosis and Treatment of the Member's condition, disease, ailment or injury; and 3. Appropriate with regard to standards of good medical practice within the surrounding community; and 4. Not solely for the convenience of the Member, Member's Physician, Hospital, or other health care provider; and 5. The most appropriate supply or level of service which can be safely provided to the Member.
Plan allowance	Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance as follows: Our plan allowance is the amount our contracted providers have agreed to accept as payment in full. For emergency care received at any doctor's office, outside our Plan's service area, our Plan's allowance is the amount BSWHP has determined to be the allowable prevailing charge for a particular professional service in the geographical area in which the service is performed. You should also see Important Notice About Surprise Billing - Know Your Rights in Section 4 that describes your protections against surprise billing under the No Surprises Act.
Post-service claims	Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.
Pre-service claims	Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.

Reimbursement

A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.

Subrogation

A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.

Surprise bill

An unexpected bill you receive for:

- emergency care – when you have little or no say in the facility or provider from whom you receive care, or for
- non-emergency services furnished by nonparticipating providers with respect to patient visits to participating health care facilities, or for
- air ambulance services furnished by nonparticipating providers of air ambulance services.

Urgent care claims

A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent care claims usually involve Pre-service claims and not Post-service claims. We will determine whether or not a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at **844-633-5325.** You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Us/We

Us and We refer to Baylor Scott & White Health Plan

You

You refers to the enrollee and each covered family member.

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Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

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Summary of Benefits for the Standard Option of Baylor Scott & White Health Plan - 2027

Do not rely on this chart alone. This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this FEHB brochure. You can also obtain a copy of our Summary Of Benefits and Coverage as required by the Affordable Care Act at https://bswhealthplan.com/fehb

- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

Below, an asterisk (*) means the item is subject to the calendar year deductible. Self Only $350, Self Plus One and Self and Family $700.

Standard Option Benefits	You Pay	Page
Medical services provided by physicians: Diagnostic and treatment services provided in the office	Primary Care Provider (PCP) Office visit copay: $25 First Adult non-preventive PCP Copay: $0 PCP Copay for dependents ages 0-18: $0 Specialist Office visit copay: $60	27
Services provided by a hospital: • Inpatient	10% coinsurance*	45
Services provided by a hospital: • Outpatient	10% coinsurance*	46
Emergency benefits: • In and out-of-area	10% coinsurance*	47
Mental health and substance use disorder treatment:	• Outpatient - $25 per visit • 10% coinsurance*	49
Prescription drugs: • Retail Pharmacy Drugs (30 day supply)	**Retail-30-day supply** Tier 1 (Preferred Generic) $8 Tier 2 (Non-Preferred Generic) $25 Tier 3 (Preferred Brand) 30%, up to a maximum of a $75 copay Tier 4 (Non-Preferred Brand) 50%, up to a maximum of a $200 copay Tier 5 (Preferred Generic Specialty)20%, up to a maximum of $400 Tier 6 (Preferred Brand Specialty) $400 Tier 7 (Non-Preferred Specialty) $600 **Note Plan benefit: Some drugs do not have a generic equivalent, in this case, the brand name copay is required.**	51

Standard Option Benefits	You Pay	Page
• **Prescription drugs:** - Maintenance or Mail Order Prescription Drugs – (90-day supply)	Tier 1 (Preferred Generic) $20 Tier 2 (Non-Preferred Generic) $50 Tier 3 (Preferred Brand) Lesser of $187.50 copay or 30% coinsurance Tier 4 (Non-Preferred Brand) Lesser of $500 copay or 50% coinsurance	53
Dental Care: No benefit except for services related to accidental injury.	$60 outpatient	55
Vision care: Annual eye refraction	$60 specialist copay	34
Protection against catastrophic costs (out-of-pocket maximum)**:**	$6,000 Self Only, $12,000 Self Plus One , $12,000 Self and Family	24

Summary of Benefits for the Basic Option for Baylor Scott & White Health Plan - 2027

Do not rely on this chart alone. This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at https://bswhealthplan.com/fehb.

- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

Below, an asterisk (*) means the item is subject to the calendar year deductible. Self Only $1,500, Self Plus One and Self Plus Family $3,000.

Basic Option Benefits	You pay	Page
Medical services provided by physicians: Diagnostic and treatment services provided in the office	Primary Care Provider (PCP) Office visit copay: $25 First Adult non-preventive PCP Copay: $0 PCP Copay for dependents ages 0-18: $0 Specialist Office visit copay: $60	27
Services provided by a hospital: • Inpatient	20% coinsurance*	45
Services provided by a hospital: • Outpatient	20% coinsurance*	46
Emergency benefits: • In and out-of-area	In Area: $25 PCP $60 Specialist $50 per visit to an Urgent Care Center 20% coinsurance (deductible applies) Out-of-Area: All charges $50 per visit to an Urgent Care Center 20% coinsurance per visit to an Emergency Room (deductible applies)	47
Mental Health and substance use disorder treatment:	• Inpatient - 20% coinsurance* • Outpatient - $25 per visit	49
Prescription drugs: • Retail Pharmacy Drugs (30-day supply)	Tier 1 (Preferred Generic) $8 Tier 2 (Non-Preferred Generic) $25 Tier 3 (Preferred Brand) $65 Tier 4 (Non-Preferred Brand) $120 Tier 5 (Preferred Generic Specialty) 20%, up to a maximum of $400	51

	Tier 6 (Preferred Brand Specialty) $400 Tier 7 (Non-Preferred Specialty) $600 Note Plan benefit: Some drugs do not have a generic equivalent, in this case, the brand name copay is required.	
• **Prescription drugs:** - Maintenance or Mail Order Prescription Drugs - (90 day supply)	Tier 1 (Preferred Generic) $20 Tier 2 (Non-Preferred Generic) $62.50 Tier 3 (Preferred Brand) $187.50 Tier 4 (Non-Preferred Brand) Lesser of $500 copay or 50%	53
Dental care: No benefit except for services related to accidental injury	$60 outpatient	55
Vision care: Annual eye refraction	$60 specialist copay	34
Protection against catastrophic costs (out-of-pocket maximium):	$7,000 Self Only, $14,000 Self Plus One, $14,000 Self and Family	24

Summary of Benefits for the Value Option for Baylor Scott & White Health Plan - 2027

Do not rely on this chart alone. This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at https://bswhealthplan.com/fehb.

- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

Below, an asterisk (*) means the item is subject to the calendar year deductible. Self Only $2,000, Self Plus One and Self Plus Family $4,000.

Value Option Benefits	You pay	Page
Medical services provided by physicians: Diagnostic and treatment services provided in the office	Primary Care Provider (PCP) Office visit copay: $30 First Adult non-preventive PCP Copay: $0 PCP Copay for dependents ages 0-18: $0 Specialist Office visit copay: $75	27
Services provided by a hospital: • Inpatient	30% coinsurance*	48
Services provided by a hospital: • Outpatient	30% coinsurance*	55
Emergency benefits: • In and out-of-area	30% coinsurance*	58
Mental Health and substance use disorder treatment:	• Inpatient - 30% coinsurance* • Outpatient - $30 per visit	59
Prescription drugs: • Retail Pharmacy Drugs (30-day supply)	Tier 1 (Preferred Generic) $10 Tier 2 (Non-Preferred Generic) $25 Tier 3 (Preferred Brand) $90 Tier 4 (Non-Preferred Brand) $200 Tier 5 (Preferred Generic Specialty) 20%, up to a maximum of $400 Tier 6 (Preferred Brand Specialty) $450 Tier 7 (Non-Preferred Specialty) $650	62
• **Prescription drugs:** - Maintenance or Mail Order Prescription Drugs - (90 day supply)	Tier 1 (Preferred Generic) $20 Tier 2 (Non-Preferred Generic) $62.50 Tier 3 (Preferred Brand) Lesser of $187.50 copay or 30%	63

	Tier 4 (Non-Preferred Brand) Lesser of $500 copay or 50%	
Dental care: No benefit except for services related to accidental injury	$75 outpatient	67
Vision care: Annual eye refraction	$75 specialist copay	42
Protection against catastrophic costs (out-of-pocket maximium):	$9,500 Self Only, $19,000 Self Plus One, $19,000 Self and Family	26

2027 Rate Information for Baylor Scott & White Health Plan

To compare your FEHB health plan options please go to www. opm.gov/fehbcompare.

To review premium rates for all FEHB health plan options please go to www. opm.gov/FEHBpremiums or www. opm.gov/Tribalpremium.

Premiums for Tribal employees are shown under the Monthly Premium Rate column. The amount shown under employee pay is the maximum you will pay. Your Tribal employer may choose to contribute a higher portion of your premium. Please contact your Tribal Benefits Officer for exact rates.

Please see rates on the next page.

Type of Enrollment	Enrollment Code	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share
Texas					
Standard Option Self Only	A84	$352.04	$149.79	$762.75	$324.55
Standard Option Self Plus One	A86	$767.53	$346.52	$1,662.98	$750.80
Standard Option Self and Family	A85	$843.82	$335.46	$1,828.28	$726.83
Basic Option Self Only	A81	$244.39	$81.46	$529.51	$176.50
Basic Option Self Plus One	A83	$542.54	$180.84	$1,175.49	$391.83
Basic Option Self and Family	A82	$574.31	$191.43	$1,244.33	$414.77
Texas					
Standard Option Self Only	P84	$352.04	$186.53	$762.75	$404.15
Standard Option Self Plus One	P86	$767.53	$428.09	$1,662.98	$927.53
Standard Option Self and Family	P85	$843.82	$421.82	$1,828.28	$913.94
Basic Option Self Only	P81	$251.01	$83.67	$543.86	$181.28
Basic Option Self Plus One	P83	$557.26	$185.75	$1,207.40	$402.46
Basic Option Self and Family	P82	$589.89	$196.63	$1,278.10	$426.03
Texas					
Value Option Self Only	YZ1	$202.23	$67.41	$438.17	$146.05
Value Option Self Plus One	YZ3	$448.95	$149.65	$972.73	$324.24
Value Option Self and Family	YZ2	$475.25	$158.41	$1,029.70	$343.23
Texas					
Value Option Self Only	RE1	$208.48	$69.49	$451.70	$150.57
Value Option Self Plus One	RE3	$462.83	$154.27	$1,002.79	$334.26
Value Option Self and Family	RE2	$489.93	$163.31	$1,061.51	$353.84