

**Southwestern University #55863  
Basic PPO Summary of Benefits 2009**

BlueChoice

TYPE OF SERVICE	NETWORK	OUT-OF-NETWORK
<b>GENERAL PROVISIONS</b>		
Calendar Year Deductible (Applies to Non-Inpatient Hospital Services)	\$500 Indiv/\$1,000 Family	\$1,000 Indiv/\$2,000 Family
4 <sup>th</sup> Quarter Carryover Applies	Yes	Yes
Deductible Credit from Prior Carrier	Yes	Yes
Coshare Stoploss Maximum *NOTE *(Does not include deductibles)	\$3,000 Indiv/\$6,000 Family per cal. yr. <i>Network deductible and coshare will only apply toward Network deductible and coshare</i>	\$6,000 Indiv/\$12,000 Family per cal. yr. <i>Out-of-Network deductible and coshare will also apply toward Network deductible and coshare</i>
Lifetime Maximum per Participant	\$2,000,000	
<b>INPATIENT HOSPITAL SERVICES</b> –Semi-Private Room (must be preauthorized)	70% after per adm. deductible	50% after per adm. deductible
Per Admission Deductible	\$250	\$500
Penalty for Failure to Preauthorize	None	\$250
<b>EMERGENCY ROOM/TREATMENT ROOM</b>		
<b>Accident &amp; Medical Emergency Situation within 48 Hours</b>		
Facility Charges	70% after \$100 copay, waived if admitted	
Physician Charges	70%	
Ambulance	70%	
<b>Non-Emergency Situations</b>		
Facility Charges	70% after \$100 copay, waived if admitted	50% after \$50 copay & cal. yr. deductible, waived if admitted
Physician Charges	70% after cal. Yr. deductible	50% after cal. Yr. deductible
<b>Hospital Treatment Room Only</b>	100% after \$40 copay	70% after cal. Yr. deductible
<b>Maternity Care/Complications of Pregnancy for Dependent Daughters</b>	Covered as any other sickness	Covered as any other sickness
<b>MEDICAL-SURGICAL SERVICES</b>		
Services Performed in Physician Office (non-surgical), Including Lab & X-ray	100% after \$30 copay per visit (Specialist \$40 copay)	70% after cal. yr. deductible
Lab & X-ray outside Physician Office	70%	50% after cal. Yr. deductible
Immunizations (birth to the day of the 6 <sup>th</sup> birth date)	100%	100%
Allergy Testing and Injections	70%	50% after cal. Yr. deductible
Physician Surgical Services in any Setting	70% after cal. yr. deductible	50% after cal. yr. deductible
Lab & X-Ray in Other Outpatient Facilities (excluding Certain Diagnostic Procedures) when included with other outpatient services	100%	70% after cal. yr. deductible
<ul style="list-style-type: none"> <li>• Certain Diagnostic Procedures: Bone Scan, Cardiac Stress Test, CT Scan (with or without contrast), Ultrasound, MRI, Myelogram, PET Scan</li> </ul>	70%	50% after cal. yr. deductible

**\*Note** (your maximum out of pocket amount for the calendar year)

Most of your Eligible Expense payment obligations, including Copayment Amounts, if any, are considered Co-Share Amounts and are applied to the Co-Share Stop-Loss benefits. Refer to **CO-SHARE STOP-LOSS** in **MEDICAL BENEFITS PROVIDED** of your Benefit Booklet for additional information.

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<b>MEDICAL-SURGICAL SERVICES (Continued)</b> Home Infusion Therapy (must be preauthorized) In-Vitro Fertilization Chiropractic Care – Office Services	70% after cal. yr. deductible	50% after cal. yr. deductible
	70% after cal. yr. deductible	50% after cal. yr. deductible
	Declined \$500 cal. yr. max.	
	<i>All Other Physical Medicine Services (such as Physical Therapy and Occupational Therapy) rendered by any other eligible Provider will be allowed on the same basis as any other sickness.</i>	
Speech and Hearing Services with Hearing Aids	Covered as any other sickness \$1,000 Maximum benefit per 36-month period for Hearing Aids	Covered as any other sickness
All Other Outpatient Services and Supplies (such as Durable Medical Equipment)	70% after cal. yr. deductible	50% after cal. yr. deductible
<b>PREVENTIVE CARE</b> Routine Physicals, Well Baby Care, Immunizations (after 6 <sup>th</sup> birthdate), Vision & Hearing Exams	100% after \$30 copay per visit	70% after cal. yr. deductible
<b>EXTENDED CARE SERVICES</b> (must be preauthorized) Home Health Care Calendar Year Maximum Skilled Nursing Facility Hospice Care	100%	70% after cal. yr. deductible
	\$10,000 per cal. yr.	\$7,000 per cal. yr.
	\$10,000 per cal. yr.	\$7,000 per cal. yr.
	\$20,000 lifetime max.	\$14,000 lifetime max.
<i>Benefits used in Network or Out-of-Network apply towards satisfying both maximums.</i>		
<b>MENTAL HEALTH/CHEMICAL DEPENDENCY</b> (must be preauthorized) <b>Inpatient Services</b> Hospital Services (Facility) Physician Services	70% after per adm. deductible 70% 30 inpatient days 30 physician visits	50% after per adm. deductible 50% after cal. yr. deductible 15 inpatient days 15 physician visits
	<i>Days and visits used in Network or Out-of-Network apply towards satisfying both maximums.</i>	
<b>Outpatient Services</b> Services Performed in Physician Office (non-surgical) Emergency Room/Treatment Room/Facility Charges  Professional Provider: To include Marriage Counseling Visits Allowed <b>Chemical Dependency Maximum for each Covered Individual</b>	100% after \$40 copay 70% after \$100 copay, waived if admitted  70%	70% after cal. yr. deductible 50% after \$50 copay & cal. yr. deductible, waived if admitted 50% after cal. yr. deductible
	50 outpatient visits per cal. yr. Three separate series of treatments in a lifetime	
<b>SERIOUS MENTAL ILLNESS</b> (must be preauthorized) <b>Inpatient Services</b> Hospital Services (Facility) Physician Services Calendar Year Limitations <b>Outpatient Services</b> Services Performed in Physician Office (non-surgical) Emergency Room/Treatment Room/Facility Charges  Professional Provider Number of Outpatient Visits	70% after per adm. deductible 70%  45 inpatient days/45 physician visits	50% after per adm. deductible 50% after cal. yr. deductible
	100% after \$40 copay 70% after \$100 copay, waived if admitted  70%	70% after cal. yr. deductible 50% after \$50 copay & cal. yr. deductible, waived if admitted 50% after cal. yr. deductible
60 visits per cal. yr.		

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**EMPLOYEE INFORMATION**

- This is a general Summary of your benefit design. Please refer to your benefit booklet for other details and for limitations and exclusions.
- The following benefits apply to dependent coverage:
  - Dependent children are covered to age 25.
  - Automatic coverage for newborns for the first 31 days following birth. Infants not enrolled for coverage within the first 31 days after birth will not be eligible for coverage until the following open enrollment period or special enrollment event.
- Provider charges are paid according to BCBSTX determined Allowable Amount and negotiated prices.
- Preexisting conditions are defined in the benefit booklet and are excluded for 12 months. Appropriate credit will be given for time served under another health benefit plan as defined under the law.
- Replacement of Medical Coverage: In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the following provisions apply to each eligible participant who has health coverage under the employer's plan immediately prior to the effective date of the health contract between the employer and BCBSTX (the contract date):
  - Benefits for eligible expenses incurred for any service or supplies prior to the contract date, are not covered under the contract.
  - Eligible expenses for services or supplies incurred on or after the effective date will be considered for benefits subject to all applicable contract provisions.
- *Specialty/biotech drugs (specialty injectable via McKesson): Member pays 25% of the prescription up to a max of \$500 per prescription. \$50,000 calendar year benefit max per person.*