

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

BlueChoice

TYPE OF SERVICE	NETWORK	OUT-OF-NETWORK
GENERAL PROVISIONS		
Calendar Year Deductible (Applies to Non-Inpatient Hospital Services)	\$500 Indiv/\$1,000 Family	\$1,000 Indiv/\$2,000 Family
4 th 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	
INPATIENT HOSPITAL SERVICES —Semi-Private Room (must be preauthorized)	80% after per adm. deductible	60% after per adm. deductible
Per Admission Deductible	\$250	\$500
Penalty for Failure to Preauthorize	None	\$250
EMERGENCY ROOM/TREATMENT ROOM Accident & Medical Emergency Situation within 48 Hours		
Facility Charges	80% after \$75 copay, waived if admitted	
Physician Charges	80%	
Ambulance	80%	
Non-Emergency Situations		
Facility Charges	80% after \$75 copay, waived if admitted	60% after \$50 copay & cal. yr. deductible, waived if admitted
Physician Charges	80% after cal. yr. deductible	60% after cal. yr. deductible
Hospital Treatment Room Only	100% after \$30 copay	70% after cal. yr. deductible
Maternity Care/Complications of Pregnancy for Dependent Daughters	Covered as any other sickness	Covered as any other sickness
MEDICAL-SURGICAL SERVICES		
Services Performed in Physician Office (non-surgical), Including Lab & X-ray	100% after \$20 copay per visit (Specialist \$30 copay)	70% after cal. yr. deductible
Lab X-ray outside Physician Office	80%	60% after cal. yr. deductible
Immunizations (birth to the day of the 6 th birth date)	100%	100%
Allergy Testing and Injections	80%	60% after cal. yr. deductible
Physician Surgical Services in any Setting	80% after cal. yr. deductible	60% 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"> • Certain Diagnostic Procedures: Bone Scan, Cardiac Stress Test, CT Scan (with or without contrast), Ultrasound, MRI, Myelogram, PET Scan 	80%	60% 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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MEDICAL-SURGICAL SERVICES (Continued) Home Infusion Therapy (must be preauthorized) In-Vitro Fertilization Chiropractic Care – Office Services Speech and Hearing Services with Hearing Aids All Other Outpatient Services and Supplies (such as Durable Medical Equipment)	80% after cal. yr. deductible	60% after cal. yr. deductible
	80% after cal. yr. deductible	60% after cal. yr. deductible
	Declined \$1,000 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>	
	Covered as any other sickness \$1,000 Maximum benefit per 36-month period for Hearing Aids	Covered as any other sickness
	80% after cal. yr. deductible	60% after cal. yr. deductible
PREVENTIVE CARE Routine Physicals, Well Baby Care, Immunizations (after 6 th birthdate), Vision & Hearing Exams	100% after \$20 copay per visit	70% after cal. yr. deductible
EXTENDED CARE SERVICES (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>		
MENTAL HEALTH/CHEMICAL DEPENDENCY (must be preauthorized) Inpatient Services Hospital Services (Facility) Physician Services	80% after per adm. deductible 80% 30 inpatient days 30 physician visits	60% after per adm. deductible 60% 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>	
Outpatient Services Services Performed in Physician Office (non-surgical) Emergency Room/Treatment Room/Facility Charges Professional Provider To include Marriage Counseling Visits Allowed Chemical Dependency Maximum for each Covered Individual	100% after \$30 copay 80% after \$75 copay, waived if admitted 80%	70% after cal. yr. deductible 60% after \$75 copay & cal. yr. deductible, waived if admitted 60% after cal. yr. deductible
	50 outpatient visits per cal. yr. Three separate series of treatments in a lifetime	
SERIOUS MENTAL ILLNESS (must be preauthorized) Inpatient Services Hospital Services (Facility) Physician Services Calendar Year Limitations Outpatient Services Services Performed in Physician Office (non-surgical) Emergency Room/Treatment Room/Facility Charges Professional Provider Number of Outpatient Visits	80% after per adm. deductible 80% 45 inpatient days/45 physician visits	60% after per adm. deductible 60% after cal. yr. deductible
	100% after \$30 copay 80% after \$75 copay, waived if admitted 80%	70% after cal. yr. deductible 60% after \$75 copay & cal. yr. deductible waived if admitted 60% 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 \$375 per prescription. \$50,000 calendar year benefit max per person.*