

TYPE OF SERVICE – IN NETWORK	STANDARD PLAN	BASIC PLAN
<b>GENERAL PROVISIONS</b> Calendar Year Deductible (Applies to Non-Inpatient Hospital Services)  4 <sup>th</sup> Quarter Carryover Applies Deductible Credit from Prior Carrier Coshare Stoploss Maximum *NOTE *(Does not include deductibles)  <i>Specialty/biotech drugs (see page three)</i> Lifetime Maximum per Participant	\$500 Indiv/\$1,000 Family  Yes Yes \$3,000 Indiv/\$6,000 Family per cal. yr. <i>Network deductible and coshare will only apply toward Network deductible and coshare</i>  \$2,000,000	\$500 Indiv/\$1,000 Family  Yes Yes \$3,000 Indiv/\$6,000 Family per cal. yr. <i>Network deductible and coshare will only apply toward Network deductible and coshare</i>  \$2,000,000
<b>INPATIENT HOSPITAL SERVICES –Semi-Private Room</b> (must be preauthorized) Per Admission Deductible Penalty for Failure to Preauthorize	80% after per adm. deductible  \$250 None	70% after per adm. deductible  \$250 None
<b>EMERGENCY ROOM/TREATMENT ROOM</b> <b>Accident &amp; Medical Emergency Situation within 48 Hours</b> Facility Charges Physician Charges Ambulance  <b>Non-Emergency Situations</b> Facility Charges  Physician Charges	80% after \$75 copay, waived if admitted 80% 80%  80% after \$75 copay, waived if admitted  80% after cal. yr. deductible	70% after \$100 copay, waived if admitted 70% 70%  70% after \$100 copay, waived if admitted  70% after cal. Yr. deductible
<b>Hospital Treatment Room Only</b>	100% after \$30 copay	100% after \$40 copay
<b>Maternity Care</b> <b>Maternity/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 Lab & X-ray outside Physician Office Immunizations (birth to the day of the 6 <sup>th</sup> birth date) Allergy Testing and Injections Physician Surgical Services in any Setting Lab & X-Ray in Other Outpatient Facilities (excluding Certain Diagnostic Procedures) when included with other out patient services Certain Diagnostic Procedures: Bone Scan, Cardiac Stress Test, CT Scan (with or without contrast), Ultrasound, MRI, Myelogram, PET Scan	100% after \$20 copay per visit (Specialist \$30 copay) 80% 100% 80% 80% after cal. yr. deductible 100% 80%	100% after \$30 copay per visit (Specialist \$40 copay) 70% 100% 70% 70% after cal. yr. deductible 100% 70%

\*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.

TYPE OF SERVICE – IN NETWORK	STANDARD PLAN	BASIC PLAN
<b>MEDICAL-SURGICAL SERVICES (Continued)</b> Home Infusion Therapy (must be preauthorized) In-Vitro Fertilization Chiropractic Care – Office Services  Speech and Hearing Services with Hearing Aids  All Other Outpatient Services & Supplies (such as Durable Medical Equipment)	80% after cal. yr. deductible Declined 80% after cal. yr. deductible \$1,000 cal. yr. max.  Covered as any other sickness \$1,000 Maximum benefit per 36-month period for Hearing Aids 80% after cal. yr. deductible	70% after cal. yr. deductible Declined 70% after cal. yr. deductible \$500 cal. yr. max.  Covered as any other sickness \$1,000 Maximum benefit per 36-month period for Hearing Aids 70% after cal. yr. deductible
	<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>	
<b>PREVENTIVE CARE</b>		
Routine Physicals, Well Baby Care, Immunizations (after 6 <sup>th</sup> birthdate), Vision & Hearing Exams  <b>EXTENDED CARE SERVICES</b> (must be preauthorized) Home Health Care Calendar Year Maximum Skilled Nursing Facility Hospice Care	100% after \$20 copay per visit  100% \$10,000 per cal. yr. \$10,000 per cal. yr. \$20,000 lifetime max.	100% after \$30 copay per visit  100% \$10,000 per cal. yr. \$10,000 per cal. yr. \$20,000 lifetime max.
<b>MENTAL HEALTH/CHEMICAL DEPENDENCY</b> (must be preauthorized) <b>Inpatient Services</b> Hospital Services (Facility) Physician Services  <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>	80% after per adm. deductible 80% 30 inpatient days 30 physician visits  100% after \$30 copay 80% after \$75 copay, waived if admitted 80%  50 outpatient visits per cal. yr. Three separate series of treatments in a lifetime	70% after per adm. deductible 70% 30 inpatient days 30 physician visits  100% after \$40 copay 70% after \$100 copay, waived if admitted 70%  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	80% after per adm. deductible 80% 45 inpatient days/45 physician visits  100% after \$30 copay 80% after \$75 copay, waived if admitted 80% 60 visits per cal. yr.	70% after per adm. deductible 70% 45 inpatient days/45 physician visits  100% after \$40 copay 70% after \$100 copay, waived if admitted 70% 60 visits per cal. yr.

*Benefits used in Network or Out-of-Network apply towards satisfying both maximums.*

*Days and visits used in Network or Out-of-Network apply towards satisfying both maximums.*

## 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 MEDICATION PRESCRIPTION DRUG BENEFITS

- **Standard Plan**

Participant pays 25% of the cost of the prescription up to a maximum of \$375 per prescription

\$50,000 calendar year maximum allowable benefit (MAB) per participant

Participants will be responsible for 100% of the prescription cost once the MAB has been reached

- **Basic Plan**

Participant pays 25% of the cost of the prescription up to a maximum of \$500 per prescription

\$50,000 calendar year maximum allowable benefit (MAB) per participant

Participants will be responsible for 100% of the prescription cost once the MAB has been reached