

BENEFIT HIGHLIGHTS *Prepared for Southwestern University - Basic Plan Effective 01/01/2011*

BlueChoice Network

This is a general summary of your benefits. Please refer to your benefit booklet for additional details and a description of the plan requirements and benefit design. This plan does not cover all health care expenses. Upon receipt of your benefit booklet, carefully review the plan's limitations and exclusions.

Overall Payment Provisions	In-Network Benefits	Out-of-Network Benefits
Deductibles		
Per-admission Deductible Calendar Year Deductible <i>Applies to all Eligible Expenses except Inpatient Hospital Expenses (unless otherwise indicated)</i> Three-month Deductible carryover applies Deductible credit from prior carrier (Applied on initial group enrollment only)	\$250 \$500 Individual / \$1,000 Family <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	\$500 \$1,000 Individual / \$2,000 Family <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
CoShare Stoploss Maximum		
Deductibles are not applied to the CoShare Stoploss Maximum. Copayment Amounts are applied but will continue to be required after the benefit percentages increase to 100%. Your benefit booklet will provide more details. Credit for CoShare Stoploss Maximum from prior carrier (Applied on initial group enrollment only)	\$3,000 Individual / \$6,000 Family <i>Network Deductible & CoShare Stoploss will only apply toward Network Deductible & CoShare Stoploss Maximum</i> <input type="checkbox"/> Yes <input type="checkbox"/> No	\$6,000 Individual / \$12,000 Family <i>Out-of-Network Deductible & CoShare Stoploss will also apply toward Network Deductible & CoShare Stoploss Maximum</i> <input type="checkbox"/> Yes <input type="checkbox"/> No
Copayment Amounts Required		
Physician office visit/consultation: Primary Care Copayment Amount for office visit/consultation when services rendered by a Family Practitioner, OB/GYN, Pediatrician, Behavioral Health Practitioner, or Internist and Physician Assistant or Advanced Practice Nurse who works under the supervision of one of these listed physicians Specialty Care Copayment Amount for office visit/consultation when services rendered by a Specialty Care Provider <i>Refer to Medical/Surgical Expenses section for more information</i> Urgent Care center visit <i>Refer to Urgent Care Services section for more information</i> Outpatient Hospital Emergency Room/Treatment Room visit <i>Refer to Emergency Room/Treatment Room section for more information</i>	\$30 Primary Care Copayment \$40 Specialty Care Copayment \$40 Copayment Amount \$100 Copayment Amount	\$100 Copayment Amount
Maximum Lifetime Benefits		
Per Participant	Unlimited	
Inpatient Hospital Expenses		
Inpatient Hospital Expenses		
<i>All services must be preauthorized</i> All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units Penalty for failure to preauthorize services	70% of Allowable Amount after per-admission Deductible None	50% of Allowable Amount after per-admission Deductible \$250



Medical/Surgical Expenses

In-Network Benefits

Out-of-Network Benefits

Medical / Surgical Expenses

Services performed during the office visit/consultation when rendered by a Primary Care Provider, including lab and x-ray

Services performed during the office visit/consultation when services rendered by a Specialty Care Provider, including lab & x-ray

Lab & x-ray in other outpatient facilities (excluding Certain Diagnostic Procedures)

-Physician surgical services performed in any setting

-Physician inpatient hospital visits

-Certain Diagnostic Procedures; such as Bone Scan, Cardiac Stress Test, CT -Scan (with or without contrast), Ultrasound, MRI, Myelogram, PET Scan.

-Home Infusion Therapy (*Services must be preauthorized*)

-All other outpatient services and supplies

100% of Allowable Amount after \$30 Primary Care Copayment**

100% of Allowable Amount after \$40 Specialty Care Copayment

100% of Allowable Amount

70% of Allowable Amount after Calendar Year Deductible

70% of Allowable Amount after Calendar Year Deductible

70% of Allowable Amount after Calendar Year Deductible

70% of Allowable Amount after Calendar Year Deductible

70% of Allowable Amount after Calendar Year Deductible

70% of Allowable Amount after Calendar Year Deductible

70% of Allowable Amount after Calendar Year Deductible

70% of Allowable Amount after Calendar Year Deductible

50% of Allowable Amount after Calendar Year Deductible

50% of Allowable Amount after Calendar Year Deductible

50% of Allowable Amount after Calendar Year Deductible

50% of Allowable Amount after Calendar Year Deductible

50% of Allowable Amount after Calendar Year Deductible

In Vitro Fertilization Services

Decline

Accept (If accepted, Medical/Surgical Expenses covered same as any other sickness)

Extended Care Expenses

Extended Care Expenses

All services must be preauthorized

Skilled Nursing Facility

Home Health Care

Hospice Care

100% of Allowable Amount

70% of Allowable Amount after Calendar Year Deductible

Limited to 25 day maximum each Calendar Year*

Limited to 60 visit maximum each Calendar Year*

Unlimited

Special Provisions Expenses

Serious Mental Illness

Mental Health Care

Treatment of Chemical Dependency

Inpatient Services (All services must be preauthorized)

-Hospital services (facility)

(*Inpatient Chemical Dependency treatment must be provided in a Chemical Dependency Treatment Center*)

-Physician services

70% of Allowable Amount after per-admission Deductible

50% of Allowable Amount after Calendar Year Deductible

70% of Allowable Amount after Calendar Year Deductible

50% of Allowable Amount after Calendar Year Deductible

Outpatient Services (All services must be preauthorized)

-Services performed during office visit/consultation when rendered by a Primary Care Provider (does not include psychological testing)

-All outpatient services and psychological testing

100% of Allowable Amount after \$30 Primary Care Copayment Amount

70% of Allowable Amount after Calendar Year Deductible

70% of Allowable Amount after Calendar Year Deductible

50% of Allowable Amount after Calendar Year Deductible

* Benefits used In-Network and Out-of-Network will apply toward satisfying any Annual Maximum benefits indicated

** Primary Care/Specialty Care copayments are defined in the Overall Payment Provisions section in this document.

Special Provisions Expenses, cont.

**In-Network
Benefits**

**Out-of-network
Benefits**

Emergency Room/Treatment Room

Accidental Injury & Emergency Care
-Facility charges

-Physician charges

Non-Emergency Care

-Facility charges

-Physician charges

70% of Allowable Amount after \$100 Copayment Amount
(Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply)
70% of Allowable Amount after Calendar Year Deductible

70% of Allowable Amount after \$100
Copayment Amount (Copayment
Amount waived if admitted, Inpatient
Hospital Expenses will apply)

50% of Allowable Amount after \$50
Copayment Amount & Calendar Year
Deductible (Copayment Amount
waived if admitted, Inpatient Hospital
Expenses will apply)

70% of Allowable Amount after Calendar
Year Deductible

50% of Allowable Amount after
Calendar Year Deductible

Urgent Care Services

Urgent Care center visit, including lab & x-ray services (does not include
Certain Diagnostic Procedures and surgical services)

Certain Diagnostic Procedures; such as Bone Scan, Cardiac Stress Test,
CT -Scan (with or without contrast), Ultrasound, MRI, Myelogram, PET
Scan, surgical procedures and all other services and supplies.

100% of Allowable Amount after \$40
Copayment Amount

70% of Allowable Amount after
Calendar Year Deductible

70% of Allowable Amount after Calendar
Year Deductible

50% of Allowable Amount after
Calendar Year Deductible

Ground and Air Ambulance Services

70% of Allowable Amount after Calendar Year Deductible

Preventive Care

Routine annual physical examinations, well-baby care exams,
immunizations 6 years of age & over, and any other preventive health
services as determined by USPSTF

Immunizations for Dependent children through the date of the child's 6th
birthday

100% of Allowable Amount

70% of Allowable Amount after
Calendar Year Deductible

100% of Allowable Amount

100% of Allowable Amount

Speech and Hearing Services

Services to restore loss of or correct an impaired speech or hearing
function

Hearing Aid Maximum

Covered same as any other sickness

Covered same as any other sickness

Hearing aids are subject to a \$1,000 maximum amount each 36-month period*

* Benefits used In-Network and Out-of-Network will apply toward satisfying any Annual Maximum benefits indicated

Special Provisions Expenses, cont.

**In-Network
Benefits**

**Out-of-network
Benefits**

Physical Medicine Services

Chiropractic Care-Office Services

100% of Allowable Amount after \$30
Primary Care Copayment**

70% of Allowable Amount after
Calendar Year Deductible

Office Visit Only – Specialty Care Provider

100% of Allowable Amount after \$40
Specialty Care Copayment

70% of Allowable Amount after
Calendar Year Deductible

All Other Services Including Occupational Therapy
(outpatient or office setting)

70% of Allowable Amount after
Calendar Year Deductible

50% of Allowable Amount after
Calendar Year Deductible

Calendar Year Maximum

Limited to 35 visits each Calendar Year*
All other Physical Medicine Services rendered by any other eligible Provider will
be allowed on the same basis as any other sickness.

* Benefits used In-Network and Out-of-Network will apply toward satisfying any Annual Maximum benefits indicated

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 26.
- 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.

Payments: Network providers agree to accept amounts negotiated with BCBSTX and are paid according to this BCBSTX-determined Allowable Amount. Covered individuals are responsible for any required Deductibles, Coinsurance Amounts, and Copayments. Plan benefits paid to Out-of-Network providers are also based on the BCBSTX-determined Allowable Amount. Covered individuals will be responsible for charges in excess of the Allowable Amount in addition to any applicable Deductibles, Coinsurance Amounts, and Copayments. For cost savings information, refer to the section on ParPlan Providers and the definition of Allowable Amount in the benefit booklet.

Preexisting conditions Provision: Benefits for Eligible Expenses incurred for treatment of a Preexisting Condition will not be available during the twelve-month period following the individual's initial Effective Date, or if a Waiting Period applies, the first day of the Waiting Period. In accordance with state and federal law, certain conditions will not be considered Preexisting Conditions and the Preexisting Condition exclusion will not apply to certain individuals. Details are provided in the benefit booklet.

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.

Members residing in other states may use that state's network through the BlueCard program. To locate a participating provider in your state, please contact 1-800-810-BLUE or visit our web site at www.bcbstx.com to use our Provider Finder® tool.

This benefit plan design includes provisions mandated by the Affordable Care Act of 2010, and is subject to change upon direction by federal and state agencies.