PPO ASO BASE Standard with Network Deductible and Split Copay

BlueCross BlueShield of Texas

BENEFIT HIGHLIGHTS *Prepared for* Southwestern University
Group #55863 – Base Plan
Effective Date: 01/01/2017
Benefit Agreement #: 0004

BlueChoice Network

This is a general summary of your benefits. Please refer to your Summary of Benefits and Coverage (SBC), or you may request a copy of the policy or plan document for additional details and a description of the plan requirements and benefit design. This plan does not cover all health care expenses. Please carefully review the plan's limitations and exclusions.

Overall Payment Provisions	In-Network Benefits	Out-of-Network Benefits
Deductibles		
Per-admission Deductible	*$250*	*$500*
☒ Calendar Year Deductible	*$1,500 Individual / $3,000 Family*	*$3,000 Individual / $6,000 Family*
Applies to all Eligible Expenses except Inpatient Hospital Expenses (unless otherwise indicated)		
Three-month Deductible carryover applies	*Yes*	*Yes*
Out-of-Pocket Maximum		
Standard (2014 forward)	*$5,500 Individual / $11,000 Family*	*$11,000 Individual / $22,000 Family*
Deductible applies to Out-of-Pocket	*Yes – no option*	*Yes***
Copayment applies to Out-of-Pocket	*Yes – no option*	*Yes***
** Copayment amounts and per admission deductibles are applied but will continue to be required after the benefit percentage increases to 100%.	*Network Deductible & Out-of-Pocket will only apply toward Network Deductible & Out-of-Pocket Maximum*	*Out-of-Network Deductible & Out-of Network Out-of-Pocket will also apply toward Network Deductible & Out-of-Pocket Maximum*
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	*$40 Primary Care Copayment*	
Specialty Care Copayment Amount for office visit/consultation when services rendered by a Specialty Care Provider	*$50 Specialty Care Copayment*	
Refer to Medical/Surgical Expenses section for more information		
Urgent Care center visit	*$50 Copayment Amount*	
Refer to Urgent Care Services section for more information		
Outpatient Hospital Emergency Room/Treatment Room visit	*$200 Copayment Amount*	*$200 Copayment Amount*
Refer to Emergency Room/Treatment Room section for more information		
Maximum Lifetime Benefits		
Per Participant	*Unlimited*	

Inpatient Hospital Expenses		
Inpatient Hospital Expenses		
All services must be preauthorized		
All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units	*70% of Allowable Amount after per-admission Deductible*	*50% of Allowable Amount after per-admission Deductible*
Penalty for failure to preauthorize services	*None*	*$250*

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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 (does include Certain Diagnostic Procedures and surgical services)	*100% of Allowable Amount after $40 Primary Care Copayment***	*70% of Allowable Amount after Deductible*
Services performed during the office visit/consultation when services rendered by a Specialty Care Provider, including lab & x-ray (does include Certain Diagnostic Procedures and surgical services)	*100% of Allowable Amount after $50 Specialty Care Copayment*	*70% of Allowable Amount after Deductible*
Lab & x-ray in other outpatient facilities (including Certain Diagnostic Procedures)	*100% of Allowable Amount*	*70% of Allowable Amount after Deductible*
-Physician surgical services performed in any setting	*70% of Allowable Amount after Deductible*	*50% of Allowable Amount after Deductible*
-Physician inpatient hospital visits	*70% of Allowable Amount after Deductible*	*50% of Allowable Amount after Deductible*
-Certain Diagnostic Procedures; such as Bone Scan, Cardiac Stress Test, CT -Scan (with or without contrast), MRI, Myelogram, PET Scan (not in office setting)	*70% of Allowable Amount*	*50% of Allowable Amount after Deductible*
-Home Infusion Therapy *(Services must be preauthorized)*	*70% of Allowable Amount after Deductible*	*50% of Allowable Amount after Deductible*
-All other outpatient services and supplies	*70% of Allowable Amount after Deductible*	*50% of Allowable Amount after Deductible*
Virtual Visit MDLIVE (Standard) -Virtual Visit Medical ☐*Yes*/ ☒*No*	*% of Allowable Amount after $ Copayment* *Or* *% of Allowable Amount after Deductible*	
-Virtual Visit Behavioral Health ☐*Yes*/ ☒*No* Note: Behavioral Health Virtual Visit Applies to MHP	*% of Allowable Amount after $ Copayment* *Or* *% of Allowable Amount after Deductible*	
-Telemedicine Vendor (Specific procedures and providers) ☒ Does not apply ☐ TeleDoc ☐ Doctor on Demand	*100% of Amount after $ Deductible* Note: Claims will be paid at billed charge	
In Vitro Fertilization Services	*Declined*	

Extended Care Expenses		
Extended Care Expenses *All services must be preauthorized*		
Skilled Nursing Facility	*100% of Allowable Amount* *Limited to 25 day maximum each Year**	*70% of Allowable Amount after Deductible*
Home Health Care	*Limited to 60 visit maximum each Year**	
Hospice Care	*Unlimited*	

Special Provisions Expenses		
Mental Health (Serious Mental Illness (SMI) included) and Chemical Dependency (Substance Use Disorder)		
Inpatient Services *Inpatient Chemical Dependency treatment must be provided in a Chemical Dependency/Residential Treatment Center (RTC)*		
-Hospital services (facility)	*70% of Allowable Amount after per-admission Deductible* *None*	*50% of Allowable Amount after per-admission Deductible*
Penalty for failure to preauthorize services *Preauthorization required for inpatient, residential treatment centers (RTC), partial hospital program admissions, and certain outpatient professional services*		*$250*

-Physician services	*70% of Allowable Amount after Calendar Year Deductible*	*50% of Allowable Amount after Deductible*
Outpatient Services		
-Services performed during office visit/consultation when rendered by a Primary Care Provider (does not include psychological testing)	*100% of Allowable Amount after $40 Primary Care Copayment Amount*	*70% of Allowable Amount after Deductible*
-All outpatient services and psychological testing	*70% of Allowable Amount after Deductible*	*50% of Allowable Amount after Deductible*

Special Provisions Expenses, cont.	***In-Network Benefits***	***Out-of-network Benefits***
Emergency Room/Treatment Room		
Accidental Injury & Emergency Care		
-Facility charges	*70% of Allowable Amount after $200 Copayment Amount (Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply)*	
-Physician charges	*70% of Allowable Amount*	
Non-Emergency Care		
-Facility charges	*70% of Allowable Amount after $200 Copayment Amount (Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply)*	*50% of Allowable Amount after $200 Copayment Amount & Deductible (Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply)*
-Physician charges	*70% of Allowable Amount*	*50% of Allowable Amount after Deductible*
Urgent Care Services		
Urgent Care center visit, including lab & x-ray services *(does not include Certain Diagnostic Procedures and surgical services)*	*100% of Allowable Amount after $50 Copayment Amount*	*70% of Allowable Amount after Deductible*
Certain Diagnostic Procedures; such as Bone Scan, Cardiac Stress Test, CT -Scan (with or without contrast), MRI, Myelogram, PET Scan, surgical procedures and all other services and supplies.	*70% of Allowable Amount after Deductible*	*50% of Allowable Amount after Deductible*
Ground and Air Ambulance Services		
	70% of Allowable Amount after 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	*100% of Allowable Amount*	*70% of Allowable Amount after Deductible*
Immunizations for Dependent children through the date of the child's 6th birthday	*100% of Allowable Amount*	*70% of Allowable Amount*
Speech and Hearing Services		
Services to restore loss of or correct an impaired speech or hearing function	*Covered same as any other sickness*	*Covered same as any other sickness*
Hearing Aid Maximum	*Hearing aids are subject to 1 per ear per 36 month period*	

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

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Special Provisions Expenses, cont.	In-Network Benefits	Out-of-network Benefits
Physical Medicine Services		
Office Visit Only – Primary Care Provider	*100% of Allowable Amount after $40 Primary Care Copayment***	*70% of Allowable Amount after Deductible*
Office Visit Only – Specialty Care Provider	*100% of Allowable Amount after $50 Specialty Care Copayment***	*70% of Allowable Amount after Deductible*
All other services including Occupational Therapy (outpatient or office setting)	*70% of Allowable Amount after Deductible*	*50% of Allowable Amount after Deductible*
Maximum	*Limited to 35 visits each Year**	
	All other Physical Medicine Services rendered by any other eligible Provider will be allowed on the same basis as any other sickness.	

Pharmacy Benefits	Participating Pharmacy*	Non-Participating Pharmacy (member files claim)
Drug List**	☒ *Basic (Previously drug list 1)*	
Compound Drugs	☒ *Covered*	
Non-sedating antihistamine (NSA) drugs and combination medications containing a non-sedating antihistamine and decongestant	☒ *Cover prescription strength NSAs only*	
Proton Pump Inhibitors	☒ *Generics and Brands coverage*	
Cover prescribed over-the-counter (OTC) medications	☐ *Cover all prescribed ACA and non-ACA OTCs* ☒ *Cover only prescribed ACA OTCs* *NOTE: ACA OTCs (aspirin, vitamin D, folic acid, iron, prenatal and fluoride) are standardly covered for Non-Grandfathered plans due to ACA with no cost share with a prescription from a provider.*	
Cover prescription medications with OTC equivalents (same strength, same active ingredients)	☐ *Yes* ☒ *No* *If no, cover Omeprazole 20 mg* ☒ *Yes* ☐ *No*	
Prescription Drug Deductible***	☒ *None*	
Prescription Drug Out-of-Pocket Maximum	☒ *All benefits, including prescription drug benefits (retail and mail service) apply to the Out-of-Pocket Maximum shown on page 1.*	
Vaccinations obtained through Pharmacies****	☒ *Yes* ☒ *All ACA vaccines, including flu (standard)* ☐ *Only flu vaccines* ☐ *No* *Covered at pharmacies participating in Prime's Vaccination Network only:* ☒ *Zero Copayment* ☐ *Copayment Amount applies: select from drop down* *Deductible does not apply*	*80% of Allowable Amount minus Copayment Amount and deductible*
Retail Pharmacy (Copayment amounts are based on a 30-day supply. With appropriate prescription order, up to a 90-day supply is available. Copayment amounts apply to Out-of-Pocket Maximum.)		
Generic Drug	*$15 Copayment Amount n*	*80% of Allowable Amount minus Copayment Amount*
Preferred Brand Name Drug	*$35 Copayment Amount*	*80% of Allowable Amount minus Copayment Amount*
Non-Preferred Brand Name Drug	*$75 Copayment Amount*	*80% of Allowable Amount minus Copayment Amount*
Specialty	*25% of Allowable Amount to a maximum of $500 per prescription*	

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Specialty Drugs†	☒ *Available at ANY retail pharmacy.*
Mail Order Program (Copayment amounts are based on a 90-day supply. Copayment amounts apply to the Out-of-Pocket Maximum.)	*Yes*
Generic Drug	*$30 Copayment Amount*
Preferred Brand Name Drug	*$70 Copayment Amount*
Non-Preferred Brand Name Drug	*$150 Copayment Amount*

MAC 2 - Rx Enhanced-Members electing to purchase Preferred/Non-Preferred Brand Name Drugs when "Brand Medically Necessary" is not indicated and a Generic equivalent is available, will be required to pay the difference between the cost of the Generic and Preferred/Non-Preferred Brand Name Drug, plus the Preferred Brand Name Copayment Amount. If "Brand Medically Necessary" is indicated on the prescription, the member will pay the Preferred or Non-Preferred Brand Name Copayment Amount.

** To locate a preferred/participating pharmacy in your area, go to myprime.com or contact customer service at the phone number on the back of your identification card.*

***The standard and generics plus drug list is available at: bcbstx.com/member/rx_drugs.html*

**** Three-month Deductible carryover does not apply to prescription drug deductible.*

*****Select Participating Pharmacies have been contracted to provide vaccination services. Each pharmacy may have age, scheduling, or other requirements that will apply. Members are encouraged to contact the store in advance. **Benefit does not include childhood immunizations, subject to state regulations.***

†For more information on the specialty drug program, call Prime Specialty Pharmacy at (877)627-6337.

Diabetes Supplies are available under the Prescription Drug benefits of your plan. Diabetic Supplies include insulin and insulin analog preparations, insulin syringes necessary for self-administration, prescriptive and non-prescriptive oral agents, all required test strips and tablets which test for glucose, ketones, and protein, lancets and lancet devices, biohazard disposable containers, glucagon emergency kits, and other injection aids. All provisions of this portion of the plan will apply including Copayment Amounts and any pricing differences that may apply to the items dispensed.

No Utilization Programs.

Note: To confirm standard benefits, refer to the Pharmacy page on Product Central on FYIBlue.

The following updates will apply at renewal 01/01/2017:

- Pharmacy Network – Broad with CVS
- All ACA vaccines are covered including Flu vaccines

_____ Group Executive Name and Title (Please type or print)	_____ Signature	_____ Date
_____ Agent of Record Name (Please print or type) Brian Karleskint	_____ Signature	_____ Date
_____ BCBSTX Representative Name (Please print or type)	_____ Signature	_____ Date