

PPO ASO BASE Standard with Network Deductible and Split Copay



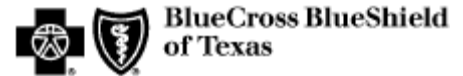
BENEFIT HIGHLIGHTS *Prepared for Southwestern University Group #55863 – Base Plan*
Effective Date: 01/01/2017
Benefit Agreement #: 0004

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 <input checked="" type="checkbox"/> Calendar Year Deductible <i>Applies to all Eligible Expenses except Inpatient Hospital Expenses (unless otherwise indicated)</i> Three-month Deductible carryover applies		\$250 \$1,500 Individual / \$3,000 Family Yes	\$500 \$3,000 Individual / \$6,000 Family Yes
Out-of-Pocket Maximum <i>Standard (2014 forward)</i>		\$5,500 Individual / \$11,000 Family	\$11,000 Individual / \$22,000 Family
Deductible applies to Out-of-Pocket Copayment applies to Out-of-Pocket ** Copayment amounts and per admission deductibles are applied but will continue to be required after the benefit percentage increases to 100%.		Yes – no option Yes – no option <i>Network Deductible & Out-of-Pocket will only apply toward Network Deductible & Out-of-Pocket Maximum</i>	Yes** Yes** <i>Out-of-Network Deductible & Out-of-Network Out-of-Pocket will also apply toward Network Deductible & Out-of-Pocket Maximum</i>
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>		\$40 Primary Care Copayment \$50 Specialty Care Copayment \$50 Copayment Amount \$200 Copayment Amount	\$200 Copayment Amount
Maximum Lifetime Benefits Per Participant		Unlimited	
Inpatient Hospital Expenses			
Inpatient Hospital Expenses <i>All services must be preauthorized</i> <i>All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units</i> Penalty for failure to preauthorize services		70% of Allowable Amount after per-admission Deductible None	50% of Allowable Amount after per-admission Deductible \$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)

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)

Lab & x-ray in other outpatient facilities (including 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), MRI, Myelogram, PET Scan (not in office setting)

-Home Infusion Therapy (Services must be preauthorized)

-All other outpatient services and supplies

100% of Allowable Amount after \$40 Primary Care Copayment**

100% of Allowable Amount after \$50 Specialty Care Copayment

100% of Allowable Amount

70% of Allowable Amount after Deductible

70% of Allowable Amount after Deductible

70% of Allowable Amount

70% of Allowable Amount after Deductible

70% of Allowable Amount after Deductible

70% of Allowable Amount after Deductible

70% of Allowable Amount after Deductible

70% of Allowable Amount after Deductible

50% of Allowable Amount after Deductible

50% of Allowable Amount after Deductible

50% of Allowable Amount after Deductible

50% 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

% of Allowable Amount after \$ Copayment
Or
% of Allowable Amount after Deductible

Note: Behavioral Health Virtual Visit Applies to MHP

-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

Home Health Care

Hospice Care

100% of Allowable Amount

70% of Allowable Amount after Deductible

Limited to 25 day maximum each Year*

Limited to 60 visit maximum each Year*

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

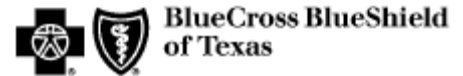
50% of Allowable Amount after per-admission Deductible

Penalty for failure to preauthorize services

Preauthorization required for inpatient, residential treatment centers (RTC), partial hospital program admissions, and certain outpatient professional services

\$250

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----- -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

-Physician charges

Non-Emergency Care

-Facility charges

-Physician charges

70% of Allowable Amount after \$200 Copayment Amount
(Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply)
70% of Allowable Amount

70% of Allowable Amount after \$200 Copayment Amount (Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply)

70% of Allowable Amount

50% of Allowable Amount after \$200 Copayment Amount & Deductible
(Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply)

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)

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.

100% of Allowable Amount after \$50 Copayment Amount

70% of Allowable Amount after Deductible

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

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

100% of Allowable Amount

100% of Allowable Amount

70% of Allowable Amount after Deductible

70% of Allowable Amount

Speech and Hearing Services

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

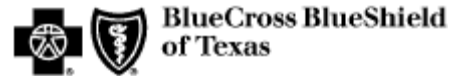
Hearing Aid Maximum

Covered same as any other sickness
Hearing aids are subject to 1

Covered same as any other sickness
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

Office Visit Only – Specialty Care Provider

All other services including Occupational Therapy (outpatient or office setting)

Maximum

100% of Allowable Amount after \$40 Primary Care Copayment**

100% of Allowable Amount after \$50 Specialty Care Copayment**

70% of Allowable Amount after Deductible

70% of Allowable Amount after Deductible

70% of Allowable Amount after Deductible

50% of Allowable Amount after Deductible

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

80% of Allowable Amount minus Copayment Amount and deductible

Deductible does not apply

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

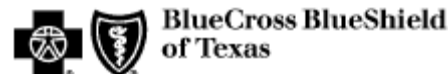
\$75 Copayment Amount

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[†]	<input checked="" type="checkbox"/> 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.) Generic Drug Preferred Brand Name Drug Non-Preferred Brand Name Drug	Yes \$30 Copayment Amount \$70 Copayment Amount \$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