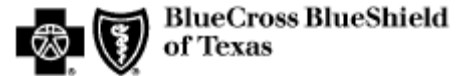


## Buy-up PPO ASO Standard with Network Deductible and Split Copay



*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  
Calendar Year Deductible  
Applies to all Eligible Expenses except Inpatient Hospital Expenses (unless otherwise indicated)  
Three-month Deductible carryover applies

\$250  
\$500 Individual /  
\$1,000 Family

\$500  
\$1,000 Individual /  
\$2,000 Family

Yes

Yes

#### Out-of-Pocket Maximum

\$3,500 Individual /  
\$7,000 Family

\$7,000 Individual /  
\$14,000 Family

Deductible applies to Out-of-Pocket  
Copayment applies to Out-of-Pocket

Yes  
Yes

Yes\*\*  
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 only** apply toward Out-of-Network Deductible & Out-of-Network 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  
**Specialty Care Copayment Amount** for office visit/consultation when services rendered by a Specialty Care Provider  
Refer to Medical/Surgical Expenses section for more information  
Urgent Care center visit  
Refer to Urgent Care Services section for more information  
Outpatient Hospital Emergency Room/Treatment Room visit  
Refer to Emergency Room/Treatment Room section for more information

\$30 Primary Care Copayment

\$40 Specialty Care Copayment

\$40 Copayment Amount

\$100 Copayment Amount

\$100 Copayment Amount

Virtual Visit MDLIVE (Standard)

-Virtual Visit

Medical & Behavioral Health

\$20 Copayment

N/A

#### 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

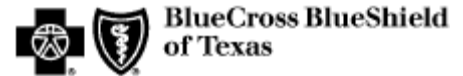
50% of Allowable Amount after per-admission Deductible

Penalty for failure to preauthorize services

None

\$250

# PPO ASO Standard with Network Deductible and Split Copay



## Medical/Surgical Expenses

### Medical / Surgical Expenses

Services performed during the office visit/consultation when rendered by a Primary Care Provider, including lab and x-ray (does not 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 not include Certain Diagnostic Procedures and surgical services)

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), MRI, Myelogram, PET Scan.

-Home Infusion Therapy (Services must be preauthorized)

-All other outpatient services and supplies

### In-Network Benefits

### Out-of-Network Benefits

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

70% of Allowable Amount after Deductible

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

70% of Allowable Amount after Deductible

100% of Allowable Amount

70% of Allowable Amount after Deductible

70% of Allowable Amount after Deductible

50% of Allowable Amount after Deductible

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50% of Allowable Amount after Deductible

## 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

50% of Allowable Amount after per-admission Deductible

None

\$250

#### Penalty for failure to preauthorize services

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

-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 \$30 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

\* 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

### Out-of-network

# PPO ASO Standard with Network Deductible and Split Copay



	Benefits	Benefits
<b>Emergency Room/Treatment Room</b> Accidental Injury & Emergency Care -Facility charges  -Physician charges <b>Non-Emergency Care</b> -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 Deductible  70% of Allowable Amount after \$100 Copayment Amount (Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply)  70% of Allowable Amount after Deductible	50% of Allowable Amount after \$100 Copayment Amount & Deductible (Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply)  50% of Allowable Amount after Deductible
<b>Urgent Care Services</b> 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 \$40 Copayment Amount  70% of Allowable Amount after Deductible	70% of Allowable Amount after Deductible  50% of Allowable Amount after Deductible
<b>Ground and Air Ambulance Services</b>	70% of Allowable Amount after Deductible	
<b>Preventive Care</b> 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 6 <sup>th</sup> birthday	100% of Allowable Amount  100% of Allowable Amount	70% of Allowable Amount after Deductible  70% of Allowable Amount
<b>Speech and Hearing Services</b> 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 per ear per 36 month period	Covered same as any other sickness
Special Provisions Expenses, cont.	In-Network Benefits	Out-of-network Benefits
<b>Physical Medicine Services</b> Chiropractic Care – Office 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 \$30 Primary Care Copayment 100% of Allowable Amount after \$40 Primary Care Copayment 70% 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.	70% of Allowable Amount after Deductible 70% of Allowable Amount after Deductible 50% of Allowable Amount after Deductible

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

# PPO ASO Standard with Network Deductible and Split Copay



## Pharmacy Benefits

### Participating Pharmacy\*

### Non-Participating Pharmacy (member files claim)

Drug List**	Basic	
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 only prescribed ACA OTCs NOTE: ACA OTCs (aspirin, vitamin D, folic acid, iron, prenatal and fluoride)	
Cover prescription medications with OTC equivalents (same strength, same active ingredients)	No, except for Omeprazole 20 mg	
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****	All ACA vaccines, including flu  Covered at pharmacies participating in Prime's Vaccination Network only:  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	80% of Allowable Amount minus Copayment Amount
Preferred Brand Name Drug	\$25 Copayment Amount	80% of Allowable Amount minus Copayment Amount
Non-Preferred Brand Name	\$50 Copayment Amount	80% of Allowable Amount minus Copayment Amount
Specialty	25% of allowable amount to a maximum of \$500 per prescription	25% of allowable amount to a maximum of \$500 per prescription
Specialty Drugs†	Available at ANY retail pharmacy	
Mail Order Program (Copayment amounts are based on a 90-day supply, with appropriate prescription order. Copayment amounts apply to the Out-of-Pocket Maximum.) Generic Drug Preferred Brand Name Drug Non-Preferred Brand Name Drug	\$30 Copayment Amount \$50 Copayment Amount \$100 Copayment Amount	

**MAC 2 - Rx Enhanced**-Members electing to purchase 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 Brand Name Drug, plus the applicable Copayment Amount. If "Brand Medically Necessary" is indicated on the prescription, the member will pay the Brand Name Copayment Amount.

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

\*\*The drug lists are available at: [bcbstx.com/member/rx\\_drugs.html](http://bcbstx.com/member/rx_drugs.html)

\*\*\*\*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.

Standard UM Programs (prior authorization and step therapy) and exclusions apply, including auto updates and FastPath.