Base PPO ASO Standard with Network Deductible and Split Copay

BlueCross BlueShield of Texas

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 *Applies to all Eligible Expenses except Inpatient Hospital Expenses (unless otherwise indicated)*	*$1,500 Individual / $3,000 Family*	*$3,000 Individual / $6,000 Family*
Three-month Deductible carryover applies	*Yes*	☒*Yes*/☐*No*
Out-of-Pocket Maximum		
	$5,500 Individual / $11,000 Family	*$11,000 Individual / $22,000 Family*
Deductible applies to Out-of-Pocket	*Yes*	*Yes***
Copayment applies to Out-of-Pocket	*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	*$40 Primary Care Copayment*	
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*	*$50 Specialty Care Copayment*	
Urgent Care center visit *Refer to Urgent Care Services section for more information*	*$50 Copayment Amount*	
Outpatient Hospital Emergency Room/Treatment Room visit *Refer to Emergency Room/Treatment Room section for more information*	*$200 Copayment Amount*	*$200 Copayment Amount*
Virtual Visit MDLIVE (Standard) Medical *& Behavioral Health*	100% *of Allowable Amount after $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*

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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 not 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 not 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 (excluding 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.	*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*
Extended Care Expenses		
Extended Care Expenses		
All services must be preauthorized		
Skilled Nursing Facility	*100% of Allowable Amount*	*70% of Allowable Amount after Deductible*
Home Health Care	*Limited to 25 day maximum each Year**	
Hospice Care	*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*
Penalty for failure to preauthorize services	*None*	*$250*
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 $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*

* 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.

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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 after Deductible*	
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 after Deductible*	*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*	

Special Provisions Expenses, cont.	In-Network Benefits	Out-of-network Benefits
Physical Medicine Services		
Chiropractic Care – Office 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 Primary 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.	

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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	$35 Copayment Amount	80% of Allowable Amount minus Copayment Amount
Non-Preferred Brand Name	$75 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	$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 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 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*

*****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.

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