

PPO Insured Standard with Network Deductible and Split Copay



BENEFIT HIGHLIGHTS Prepared for
City of West University Place
Effective Date: 10/01/15

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 Calendar Year Deductible <i>Applies to all Eligible Expenses unless otherwise indicated</i>	None \$750 Individual / \$1,500 Family	None \$5,000 Individual / \$10,000 Family
Three-month Deductible carryover applies Deductible credit from prior carrier (applied on initial group enrollment only)	No Yes	No Yes
Out-of-Pocket Maximum "Standard" for effective/renewal dates in 2014/2015		
	\$3,000 Individual / \$6,000 Family	\$10,000 Individual / \$20,000 Family
Deductibles applies to Out-of-Pocket Copayment applies to Out-of-Pocket	Yes – no option Yes – no option	Yes** Yes**
** Copayment amounts and per admission deductibles are applied but will continue to be required after the benefit percentage increases to 100%.	<i>Network Deductible & Out-of-Pocket will only apply toward Network Deductible & Out-of-Pocket Maximum</i>	<i>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</i>
Credit for Out-of-Pocket Maximum from prior carrier (applied on initial group enrollment only)	Yes	Yes
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>	\$30 Primary Care Copayment \$50 Specialty Care Copayment	
Urgent Care center visit <i>Refer to Urgent Care section for more information</i>	\$50 Copayment Amount	
Outpatient Hospital Emergency Room/Treatment Room visit <i>Refer to Emergency Room/Treatment Room section for more information</i>	\$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>		
All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units	80% of Allowable Amount after Deductible	50% of Allowable Amount after Deductible
Penalty for failure to preauthorize services	None	\$250
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)	100% of Allowable Amount after \$30 Primary Care Copayment**	50% 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	50% of Allowable Amount after Deductible
-Lab & x-ray in other outpatient facilities (excluding Certain Diagnostic	100% of Allowable Amount	50% of Allowable Amount after

PPO Insured Standard with Network Deductible and Split Copay



BENEFIT HIGHLIGHTS *Prepared for*
City of West University Place
Effective Date: 10/01/15

BlueChoice Network

Procedures) -Physician surgical services performed in any setting	80% of Allowable Amount after Deductible	Deductible 50% of Allowable Amount after Deductible
--	---	---

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

Medical / Surgical Expenses, cont.	In-Network Benefits	Out-of-Network Benefits
-Physician inpatient hospital visits	80% 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	80% of Allowable Amount after Deductible	50% of Allowable Amount after Deductible
-Home Infusion Therapy (<i>Services must be preauthorized</i>)	80% of Allowable Amount after Deductible	50% of Allowable Amount after Deductible
-All other outpatient services and supplies	80% of Allowable Amount after Deductible	50% of Allowable Amount after Deductible
In Vitro Fertilization Services	Not Covered	

Extended Care Expenses	In-Network Benefits	Out-of-Network Benefits
Extended Care Expenses All services must be preauthorized Skilled Nursing Facility Home Health Care Hospice Care	100% of Allowable Amount	50% of Allowable Amount after Deductible Limited to 25 day maximum each Year* Limited to 60 visit maximum each Year* Unlimited

Special Provisions Expenses	In-Network Benefits	Out-of-Network Benefits
Serious Mental Illness/Mental Health Care/ Treatment of Chemical Dependency Inpatient Services Inpatient Chemical Dependency treatment must be provided in a Chemical Dependency/Residential Treatment Center (RTC)	80% of Allowable Amount after Deductible	50% of Allowable Amount after Deductible
-Hospital services (facility)	80% of Allowable Amount after Deductible	50% of Allowable Amount after Deductible
-Physician services	80% of Allowable Amount after Deductible	50% of Allowable Amount after Deductible
Penalty for failure to preauthorize services Preauthorization required for inpatient, residential treatment centers (RTC), partial hospital program admissions, and certain outpatient professional services	None	\$250
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	50% of Allowable Amount after Deductible
-All outpatient services and psychological testing	80% of Allowable Amount after Deductible	50% of Allowable Amount after Deductible

Emergency Room/Treatment Room	In-Network Benefits	Out-of-Network Benefits
Accidental Injury & Emergency Care -Facility charges	80% of Allowable Amount after \$200 Copayment Amount (Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply) 80% of Allowable Amount after Deductible	
-Physician charges	80% of Allowable Amount after \$200 Copayment Amount (Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply)	
Non-Emergency Care -Facility charges	50% of Allowable Amount after \$200 Copayment Amount & Deductible (Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply)	
-Physician charges	80% of Allowable Amount after Deductible	50% of Allowable Amount after Deductible

PPO Insured Standard with Network Deductible and Split Copay



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

50% of Allowable Amount after Deductible

Certain Diagnostic Procedures: Bone Scan, Cardiac Stress Test, CT Scan (with or without contrast), MRI, Myelogram, PET Scan, surgical procedures and all other services and supplies

80% 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

Special Provisions Expenses, cont.

In-Network
Benefits

Out-of-Network
Benefits

Ground and Air Ambulance Services

80% 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

50% of Allowable Amount after Deductible

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

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

Covered same as any other sickness

Covered same as any other sickness

Hearing Aids

80% of Allowable Amount after Deductible

50% of Allowable Amount after Deductible

Hearing Aid Maximum

Hearing aids are subject to 1 per ear per 36 month period

Organ and Tissue Transplant Services

Covered same as any other sickness
Refer to benefit booklet for details

Covered same as any other sickness
Refer to benefit booklet for details

Physical Medicine Services

Physical Medicine Services (includes, but is not limited to physical, occupational, and manipulative therapy)
Maximum

80% of Allowable Amount after Deductible

50% of Allowable Amount after Deductible

Limited to 35 visits each Year*

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

PPO Insured Standard with Network Deductible and Split Copay



Pharmacy Benefits	Participating Pharmacy*	Non-Participating Pharmacy (member files claim)
-------------------	-------------------------	--

Drug List**	Preferred Drug List 1	
Prescription Drug Deductible***	None	
Prescription Drug Out-of-Pocket Maximum	<i>Separate Prescription Drug Out-of-Pocket Maximum applies to Retail & Mail Service Pharmacy: Individual: \$ 1,000 / Family: \$ 2,000</i>	
Vaccinations obtained through Pharmacies****	Yes, flu vaccinations covered as follows:	
	Select pharmacies participating in Flu Network – 100%	50% of Allowable Amount minus Copayment Amount
	All other in-network pharmacies – appropriate tier copay applies	
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	\$10 Copayment Amount	50% of Allowable Amount minus Copayment Amount
Preferred Brand Name Drug	\$30 Copayment Amount	50% of Allowable Amount minus Copayment Amount
Non-Preferred Brand Name	\$60 Copayment Amount	50% of Allowable Amount minus Copayment Amount
Specialty Drugs†	<i>Members will be required to obtain specialty medications through Prime Therapeutics Specialty Pharmacy LLC (Prime Specialty Pharmacy). Members who obtain covered specialty medication through any contracting pharmacy other than Prime Specialty Pharmacy will be subject to a reduction in benefits.</i>	
Mail Order Program (Copayment amounts are based on a 90-day supply. With appropriate prescription order, up to a 90-day supply is available. Copayment amounts apply to Out-of-Pocket Maximum.)	Yes	
Generic Drug	\$20 Copayment Amount	
Preferred Brand Name Drug	\$60 Copayment Amount	
Non-Preferred Brand Name Drug	\$120 Copayment Amount	

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.

All medications with over-the-counter (OTC) equivalents are excluded from coverage except for Omeprazole 20 mg.

** To locate a 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 preferred drug list is available at: bcbstx.com/member/rx_drugs.html*

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

***** Select pharmacies participating in the Flu Network are contracted to provide vaccination services. Flu vaccinations at all other in-network and out-of-network pharmacies are payable at the non-participating Flu Network pharmacy benefit level. Each pharmacy may have age, scheduling, or other requirements that will apply. You are encouraged to contact the store in advance. Childhood immunizations subject to state regulations are not available under this pharmacy benefit. Refer to your BCBSTX medical coverage for benefits available for childhood immunizations.*

†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.