

HMO Blue Essentials Access – Fully Insured



BENEFIT HIGHLIGHTS *Prepared For* Gebo Distributing Company
 Effective Date: 1/1/17

HMO Blue Essentials Network

This is a general summary of your benefits. Please refer to your Summary of Benefits and Coverage (SBC) 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.

Deductible per Calendar Year

Per Individual Member	\$2,500
Per Family	\$5,000
Deductible credit from prior carrier (Applied on initial group enrollment only)	No

Out-of-Pocket Maximums Per Calendar Year

Per Individual Member	\$6,000
Per Family	\$12,000
Credit for Out-of-Pocket Maximum from prior carrier (applied on initial group enrollment only)	No
Deductible applies to Out-of-Pocket	Yes
Copayment applies to Out-of-Pocket	Yes

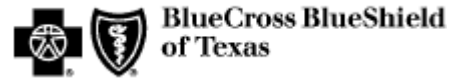
Professional Services

Primary Care Physician ("PCP") Office or Home Visit	Deductible Applies <u>No</u> \$35 Copay
Participating Specialist Physician ("Specialist") Office or Home Visit	Deductible Applies <u>No</u> \$55 Copay

Inpatient Hospital Services

Inpatient Hospital Services	Deductible Applies <u>No</u> then 30% coinsurance
Penalty for failure to preauthorize services	None
Tubal Ligation	Deductible Applies <u>No</u> then 30% coinsurance

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Outpatient Facility Services

Outpatient Surgery	Deductible Applies <u>Yes</u> then 30% coinsurance
Radiation Therapy	Deductible Applies <u>Yes</u> then 30% coinsurance
Dialysis	Deductible Applies <u>Yes</u> then 30% coinsurance

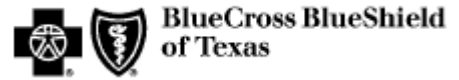
Outpatient Diagnostic Laboratory and X-Ray Services

Arteriograms, Computerized Tomography (CT Scan), Magnetic Resonance Imaging (MRI), Electroencephalogram (EEG), Myelogram, Positron Emission Tomography (PET Scan)	Deductible Applies <u>Yes</u> then 30% coinsurance
Other Outpatient Lab	Deductible Applies <u>Yes</u> then 30% coinsurance
Other X-Ray Services	Deductible Applies <u>Yes</u> then 30% coinsurance

Rehabilitation Services

Rehabilitation Services and Therapies	
PCP	Deductible Applies <u>No</u> \$35 Copay
Specialist	Deductible Applies <u>No</u> \$55 Copay
Inpatient Hospital Services	Deductible Applies <u>Yes</u> then 30% coinsurance
Outpatient Facility Services (as applicable)	Deductible Applies <u>Yes</u> then 30% coinsurance

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Maternity Care and Family Planning Services

Maternity Care

Prenatal and Postnatal Visit
PCP

Deductible Applies No
\$35 Copay

Specialist

Deductible Applies No
\$55 Copay

Inpatient Hospital Services, for each admission

Deductible Applies Yes
then 30% coinsurance

Voluntary sterilization

Vasectomy
PCP

Deductible Applies No
\$35 Copay

Specialist

Deductible Applies No
\$55 Copay

Outpatient Surgery Services (as applicable)

Deductible Applies Yes
then 30% coinsurance

Infertility Services

Diagnostic counseling, consultations, planning and treatment services
PCP

Deductible Applies No
\$35 Copay

Specialist

Deductible Applies No
\$55 Copay

Artificial insemination, for each procedure and all services related to
procedure (cost of sperm not covered)-(Optional)
PCP

Deductible Applies No
\$35 Copay

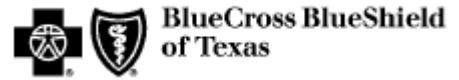
Specialist

Deductible Applies No
\$55 Copay

Outpatient Surgery Services (as applicable)

Deductible Applies Yes
then 30% coinsurance

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Pregnancy Terminations Limited to Medically Necessary therapeutic terminations of pregnancy PCP Specialist Inpatient Hospital Services Outpatient Surgery Services (as applicable)	Deductible Applies <u>No</u> \$35 Copay Deductible Applies <u>No</u> \$55 Copay Deductible Applies <u>Yes</u> then 30% coinsurance Deductible Applies <u>Yes</u> then 30% coinsurance
Behavioral Health Services	
Outpatient Mental Health Care	Covered / Same as any other illness
Mental Health (Serious Mental Illness (SMI) included)	Covered / Same as any other illness
Chemical Dependency (Substance Use Disorder) Services	Covered / Same as any other illness
Emergency Care Services	
Emergency Care- Facility	Deductible Applies <u>Yes</u> then 30% coinsurance
Emergency Care- Physician	Deductible Applies <u>Yes</u> then 30% coinsurance
Urgent Care Center, per visit	Deductible Applies <u>No</u> \$50 Copay
Ambulance Services	
Ambulance Services	Deductible Applies <u>Yes</u> then 30% coinsurance
Extended Care Services	
Skilled Nursing Facility Services	Deductible Applies <u>Yes</u> then 30% coinsurance Day limit per calendar year <u>60</u>

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Hospice Care

Deductible Applies Yes
then 30% coinsurance

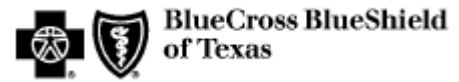
Home Health Care

Deductible Applies Yes
then 30% coinsurance

Health Maintenance and Preventive Services

Well child care through age 17	0 - No Deductible
Periodic health assessments for Members age 18 and older	0 - No Deductible
Immunizations <ul style="list-style-type: none"> • Childhood immunizations required by law for Members up to age 6 • Immunizations for Members age 6 and older 	0 - No Deductible 0 - No Deductible
Eye and ear screenings for Members through age 17 , once every twelve months	same as PCP copay or Specialist copay
Eye and ear screening for Members age 18 and older , once every two years	same as PCP copay or Specialist copay
Preventive Lab & X-Ray Services <ul style="list-style-type: none"> • Outpatient Lab, includes independent lab • X-Ray services, includes routine EKG 	0 - No Deductible 0 - No Deductible
Exam for prostate cancer, once every twelve months	0 - No Deductible
Bone mass measurement for osteoporosis	0 - No Deductible
Well-woman exam , once every twelve months, includes, but not limited to, exam for cervical cancer (Pap smear)	0 - No Deductible
Screening mammogram for female Members age 35 and over and for female Members with other risk factors, once every twelve months <ul style="list-style-type: none"> • Outpatient facility or imaging centers 	0 - No Deductible
Family Planning Services: <ul style="list-style-type: none"> • Diagnostic counseling, consultations and planning services • Insertion or removal of intrauterine device (IUD), including cost of device • Diaphragm or cervical cap fitting, including cost of device • Insertion or removal of birth control device implanted under the skin, including cost of device • Injectable contraceptive drugs, including cost of drug • Contraceptive Services Supplies: Certain FDA approved contraceptive methods for women, female sterilization procedures and devices included on the Contraceptive Drug & Devices list 	0 - No Deductible

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<ul style="list-style-type: none"> Breastfeeding Support and Counseling Services <p>Hearing Loss</p> <ul style="list-style-type: none"> Screening test from birth through 30 days Follow-up care from birth through 24 months 	<p>0 - No Deductible</p> <p>0 - No Deductible</p>
<p>Rectal screening for the detection of colorectal cancer for Members age 50 and older:</p> <ul style="list-style-type: none"> Annual fecal occult blood test, once every twelve months Flexible sigmoidoscopy with hemoccult of the stool, limited to 1 every 5 years Colonoscopy, limited to 1 every 10 years 	<p>0 - No Deductible</p> <p>0 - No Deductible</p> <p>0 - No Deductible</p>
<p>Early detection test for cardiovascular disease</p>	<p>Limited to 1 test every 5 years, covered same as any other medical/surgical expense in accordance with state mandate</p>
<p>Early detection test for Ovarian Cancer</p>	<p>Same as PCP Copay or Specialist Copay Limited to 1 test every 12 months</p>

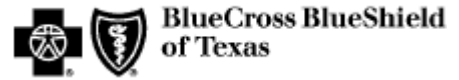
Dental Surgical Procedures

<p>Dental Surgical Procedures (limited Covered Services)</p> <p>PCP</p>	<p>Deductible Applies <u>No</u> \$35 Copay</p>
<p>Specialist</p>	<p>Deductible Applies <u>No</u> \$55 Copay</p>
<p>Inpatient Hospital Services (as applicable)</p>	<p>Deductible Applies <u>Yes</u> then 30% coinsurance</p>
<p>Outpatient Surgery Services (as applicable)</p>	<p>Deductible Applies <u>Yes</u> then 30% coinsurance</p>

Cosmetic, Reconstructive or Plastic Surgery

<p>Cosmetic, Reconstructive or Plastic Surgery (limited Covered Services)</p> <p>PCP</p>	<p>Deductible Applies <u>No</u> \$35 Copay</p>
<p>Specialist</p>	<p>Deductible Applies <u>No</u> \$55 Copay</p>
<p>Inpatient Hospital Services, as applicable</p>	<p>Deductible Applies <u>Yes</u> then 30% coinsurance</p>
<p>Outpatient Surgery Services (as applicable)</p>	<p>Deductible Applies <u>Yes</u></p>

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then 30% coinsurance

Allergy Care

Testing and Evaluation

Deductible Applies Yes
then 30% coinsurance

Injections

Deductible Applies Yes
then 30% coinsurance

Serum

Deductible Applies Yes
then 30% coinsurance

Diabetes Care

Diabetes Self-Management Training
PCP

Deductible Applies No
\$35 Copay

Specialist

Deductible Applies No
\$55 Copay

Diabetes Equipment

Deductible Applies Yes
then 30% coinsurance

Diabetes Supplies

Deductible Applies Yes
then 30% coinsurance

Prosthetic Appliances and Orthotic Devices

Prosthetic Appliances and Orthotic Devices

Deductible Applies Yes
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\$300 maximum benefit for purchase of one (1) wig needed as a result of current chemotherapy or radiation treatment for cancer; limited to initial breast prostheses and two (2) surgical brassieres after mastectomy

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Pharmacy Benefits		
Prescription Drug Benefits (Prime Therapeutics)		
Drug List**	<i>Enhanced</i>	
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.	
Compound Drugs	Not Covered	
Non-sedating antihistamine (NSA) drugs and combination medications containing a non-sedating antihistamine and decongestant	Exclude prescription strength NSAs (2015 Standard)	
Proton Pump Inhibitors	Generics coverage only	
Prescribed over-the-counter (OTC) medications	<i>Not covered</i> Exclude prescription orders for which there is an OTC product available with the same active ingredient(s) in the same strength (standard exclusion). Cover Omeprazole 20 mg Yes	
Vaccinations obtained through Pharmacies****	Yes All ACA vaccines, including flu (standard) Covered at pharmacies participating in Prime's Vaccination Network only: 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 the Out-of-Pocket Maximum.)		
Preferred Generic	Copay \$15	
Non-Preferred Generic	Copay \$40	
Preferred Brand Name	Copay \$70	
Non-Preferred Brand Name	20% per prescription	
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 the Out-of-Pocket Maximum.)		
Preferred Generic	Copay \$45	
Non-Preferred Generic	Copay \$120	
Preferred Brand Name	Copay \$210	
<p>Rx Enhanced (MAC II) - If the Allowable Amount of the drug is less than the Copayment, member pays the lower cost. Member pays no more than the applicable Preferred Drug or Non-Preferred Drug Copayment if the Prescription Order includes a valid dispensing directive prohibiting substitution of a generic equivalent (brand necessary or brand medically necessary) or if there is no generic equivalent. If member receives a name brand drug when product selection is permitted and when a generic equivalent is available, the Copayment will be the total of the Generic Drug Copayment plus the difference between the cost of the Generic Drug equivalent and the cost of the name brand drug</p> <p>*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.</p> <p>**The standard and generics plus drug list is available at: bcbstx.com/member/rx_drugs.html</p> <p>*** Three-month Deductible carryover does not apply to prescription drug deductible.</p> <p>****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</p>		