HMO Blue Essentials Access – Fully Insured

BlueCross BlueShield of Texas

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 Copayment applies to Out-of-Pocket	*Yes* *Yes*
Professional Services	
Primary Care Physician ("PCP") Office or Home Visit	Deductible Applies No *$35 Copay*
Participating Specialist Physician ("Specialist") Office or Home Visit	Deductible Applies No *$55 Copay*
Inpatient Hospital Services	
Inpatient Hospital Services	Deductible Applies No *then 30% coinsurance*
Penalty for failure to preauthorize services	*None*
Tubal Ligation	Deductible Applies No *then 30% coinsurance*

Outpatient Facility Services	
Outpatient Surgery	Deductible Applies Yes *then 30% coinsurance*
Radiation Therapy	Deductible Applies Yes *then 30% coinsurance*
Dialysis	Deductible Applies Yes *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 Yes *then 30% coinsurance*
Other Outpatient Lab	Deductible Applies Yes *then 30% coinsurance*
Other X-Ray Services	Deductible Applies Yes *then 30% coinsurance*
Rehabilitation Services	
Rehabilitation Services and Therapies PCP	Deductible Applies No *$35 Copay*
Specialist	Deductible Applies No *$55 Copay*
Inpatient Hospital Services	Deductible Applies Yes *then 30% coinsurance*
Outpatient Facility Services (as applicable)	Deductible Applies Yes *then 30% coinsurance*

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*

Pregnancy Terminations Limited to Medically Necessary therapeutic terminations of pregnancy	
PCP	Deductible Applies No *$35 Copay*
Specialist	Deductible Applies No *$55 Copay*
Inpatient Hospital Services	Deductible Applies Yes *then 30% coinsurance*
Outpatient Surgery Services (as applicable)	Deductible Applies Yes *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 Yes *then 30% coinsurance*
Emergency Care- Physician	Deductible Applies Yes *then 30% coinsurance*
Urgent Care Center, per visit	Deductible Applies No *$50 Copay*
Ambulance Services	
Ambulance Services	Deductible Applies Yes *then 30% coinsurance*
Extended Care Services	
Skilled Nursing Facility Services	Deductible Applies Yes *then 30% coinsurance* Day limit per calendar year *60*

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 • 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 • 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 • Outpatient facility or imaging centers	0 - No Deductible
Family Planning Services: • 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

• Breastfeeding Support and Counseling Services	
Hearing Loss	
• Screening test from birth through 30 days	0 - No Deductible
• Follow-up care from birth through 24 months	0 - No Deductible
Rectal screening for the detection of colorectal cancer for Members age 50 and older:	
• Annual fecal occult blood test, once every twelve months	0 - No Deductible
• Flexible sigmoidoscopy with hemoccult of the stool, limited to 1 every 5 years	0 - No Deductible
• Colonoscopy, limited to 1 every 10 years	0 - No Deductible
Early detection test for cardiovascular disease	Limited to 1 test every 5 years, covered same as any other medical/surgical expense in accordance with state mandate
Early detection test for Ovarian Cancer	Same as PCP Copay or Specialist Copay Limited to 1 test every 12 months
Dental Surgical Procedures	
Dental Surgical Procedures (limited Covered Services)	
PCP	Deductible Applies No *$35 Copay*
Specialist	Deductible Applies No *$55 Copay*
Inpatient Hospital Services (as applicable)	Deductible Applies Yes *then 30% coinsurance*
Outpatient Surgery Services (as applicable)	Deductible Applies Yes *then 30% coinsurance*
Cosmetic, Reconstructive or Plastic Surgery	
Cosmetic, Reconstructive or Plastic Surgery (limited Covered Services)	
PCP	Deductible Applies No *$35 Copay*
Specialist	Deductible Applies No *$55 Copay*
Inpatient Hospital Services, as applicable	Deductible Applies Yes *then 30% coinsurance*
Outpatient Surgery Services (as applicable)	Deductible Applies Yes

	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 $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	Deductible Applies Yes *then 30% coinsurance*

Pharmacy Benefits		
Prescription Drug Benefits (Prime Therapeutics)		
Drug List**	*Enhanced*	
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	*Not covered* *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*	

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*

**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***