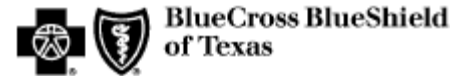


# PPO Insured Standard with Network Deductible and Split Copay



**BENEFIT HIGHLIGHTS** *Prepared for*  
Gebo Distributing Company  
Effective Date: 1/1/17 BA#

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.  **Partial matrix page attached**

<b>Overall Payment Provisions</b>	<b>In-Network Benefits</b>	<b>Out-of-Network Benefits</b>
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**Deductibles**

Per-admission Deductible Calendar Year Deductible <i>Applies to all Eligible Expenses, unless otherwise indicated, except Inpatient Hospital Expenses</i> Three-month Deductible carryover applies Deductible credit from prior carrier (applied on initial group enrollment only)	NONE \$2,500 Individual / \$5,000 Family  No Yes No	NONE \$5,000 Individual / \$10,000 Family  No Yes No
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**Out-of-Pocket Maximum**

Deductible applies to Out-of-Pocket Copayment applies to Out-of-Pocket  ** Copayment amounts and per admission deductibles are applied but will continue to be required after the benefit percentage increases to 100%.  Credit for Out-of-Pocket Maximum from prior carrier (applied on initial group enrollment only)	\$6,000 Individual / \$12,000 Family  Yes – no option Yes – no option  Network Deductible & Out-of-Pocket <b>will only</b> apply toward Network Deductible & Out-of-Pocket Maximum  Yes No	\$15,000 Individual / \$30,000 Family  Yes** Yes**  Out-of-Network Deductible & Out-of-Network Out-of-Pocket <b>will only</b> apply toward Out-of-Network Deductible & Out-of-Network Out-of-Pocket Maximum  No
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**Copayment Amounts Required**

Physician office visit/consultation: <b>Primary Care Copayment Amount</b> 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 <b>Specialty Care Copayment Amount</b> for office visit/consultation when services rendered by a Specialty Care Provider <i>Refer to Medical/Surgical Expenses section for more information</i> Urgent Care center visit <i>Refer to Urgent Care section for more information</i>	\$35 Primary Care Copayment  \$55 Specialty Care Copayment  \$50 Copayment Amount	Unlimited
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**Maximum Lifetime Benefits Per Participant**

**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 Penalty for failure to preauthorize services	70% of Allowable Amount after Deductible  None	50% of Allowable Amount after Deductible  \$250
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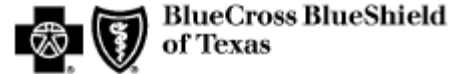
**Medical/Surgical Expenses**

**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	100% of Allowable Amount after \$35 Primary Care Copayment**  100% of Allowable Amount after \$55 Specialty Care Copayment  100% of Allowable Amount  70% of Allowable Amount after Deductible	50% of Allowable Amount after Deductible  50% of Allowable Amount after Deductible  50% of Allowable Amount after Deductible  50% of Allowable Amount after Deductible
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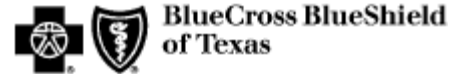
\*\* Primary Care/Specialty Care copayments are defined in the Overall Payment Provisions section in this document.

# PPO Insured Standard with Network Deductible and Split Copay



Medical / Surgical Expenses, cont.	In-Network Benefits	Out-of-Network Benefits
-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 after Deductible	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
<b>Virtual Visit MDLIVE (standard offering)</b> <b>Note:</b> Must mirror PCP office visit benefit Medical & Behavioral Health <b>Medical</b>  <b>Note:</b> Behavioral Health benefit must mirror benefit under Mental Health and Substance Use Disorder <b>Behavioral Health</b>  <b>Note:</b> Behavioral Health Virtual Visit applies to MHP	100% of Allowable Amount after \$35 Copayment Amount  100% of Allowable Amount after \$35 Copayment Amount	50% of Allowable Amount after Deductible  50% of Allowable Amount after Deductible
In Vitro Fertilization Services	Decline	
<b>Extended Care Expenses</b>		
<b>Extended Care Expenses</b> 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 30 day maximum each Year* Limited to 60 visit maximum each Year* Unlimited
<b>Special Provisions Expenses</b>		
<b>Mental Health (Serious Mental Illness (SMI) included) and Chemical Dependency (Substance Use Disorder)</b>		
<b>Inpatient Services</b> Inpatient Chemical Dependency treatment must be provided in a Chemical Dependency/Residential Treatment Center (RTC)		
-Hospital services (facility)	70% of Allowable Amount after Deductible	50% of Allowable Amount after Deductible
-Physician services	70% of Allowable Amount after Deductible	50% of Allowable Amount after Deductible
<b>Penalty for failure to preauthorize services</b> Preauthorization required for inpatient, residential treatment centers (RTC), partial hospital program admissions, and certain outpatient professional services	None	\$250
<b>Outpatient Services</b> -Services performed during office visit/consultation when rendered by a Primary Care Provider (does not include psychological testing)	100% of Allowable Amount after \$35 Primary Care Copayment Amount	50% of Allowable Amount after Deductible
-All outpatient services and psychological testing	70% of Allowable Amount after Deductible	50% of Allowable Amount after Deductible
<b>Emergency Room/Treatment Room</b>		
<b>Accidental Injury &amp; Emergency Care</b>		
-Facility charges	70% of Allowable Amount after deductible	
-Physician charges	70% of Allowable Amount after Deductible	
<b>Non-Emergency Care</b>		
-Facility charges	70% of Allowable Amount after Deductible	50% of Allowable Amount after Deductible

## PPO Insured Standard with Network Deductible and Split Copay



-Physician charges	70% of Allowable Amount after Deductible	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)	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	70% of Allowable Amount after Deductible	50% of Allowable Amount after Deductible

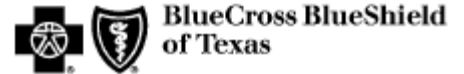
\* Benefits used In-Network and Out-of-Network will apply toward satisfying any Annual Maximum benefits indicated

<b>Special Provisions Expenses, cont.</b>	<b>In-Network Benefits</b>	<b>Out-of-Network Benefits</b>
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<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	100% of Allowable Amount	50% of Allowable Amount after Deductible
Immunizations for Dependent children through the date of the child's 6 <sup>th</sup> birthday	100% of Allowable Amount	100% of Allowable Amount
<b>Speech and Hearing Services</b>		
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	70% of Allowable Amount after Deductible	50% of Allowable Amount after Deductible
<b>Hearing Aid Maximum</b>	Hearing aids are subject to 1 per ear per 36 month period	
<b>Organ and Tissue Transplant Services</b>	Covered same as any other sickness Refer to benefit booklet for details	Covered same as any other sickness Refer to benefit booklet for details
<b>Physical Medicine Services</b>		
Physical Medicine Services (includes, but is not limited to physical, occupational, and manipulative therapy)	70% of Allowable Amount after Deductible	50% of Allowable Amount after Deductible
<b>Maximum</b>	Limited to 35 visits each Year*	

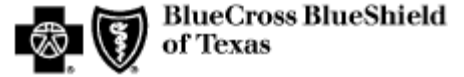
\* Benefits used In-Network and Out-of-Network will apply toward satisfying any Annual Maximum benefits indicated

# PPO Insured Standard with Network Deductible and Split Copay



Pharmacy Benefits	Participating Pharmacy*	Non-Participating Pharmacy (member files claim)
Drug List**	<input checked="" type="checkbox"/> Enhanced (Previously drug list 2) <input type="checkbox"/> Performance (all standard UM must apply)  <b>Note:</b> For non-grandfathered insured business, enhanced is standard. Non-grandfathered insured business may optionally select Performance.	
Compound Drugs	Not Covered	
Non-sedating antihistamine (NSA) drugs and combination medications containing a non-sedating antihistamine and decongestant	Exclude Prescription Strength NSA's	
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	
Prescription Drug Deductible***	<input checked="" type="checkbox"/> None  <input type="checkbox"/> All benefits, including prescription drug benefits (retail and mail service) apply to Deductible shown on page 1. Deductible will apply to the Out-of-Pocket Maximum.  <input type="checkbox"/> Separate Prescription Drug Deductible applies to Retail & Mail Service Pharmacy: Individual: \$ / Family: \$ . Deductible will apply to the Out-of-Pocket Maximum.	
Prescription Drug Out-of-Pocket Maximum	<input type="checkbox"/> All benefits, including prescription drug benefits (retail and mail service) apply to the Out-of-Pocket Maximum shown on page 1.  <input type="checkbox"/> Separate Prescription Drug Out-of-Pocket Maximum applies to Retail & Mail Service Pharmacy: Individual: \$ / Family: \$	
Vaccinations obtained through Pharmacies****	Yes, all ACA vaccines, including flu covered at pharmacies participating in Prime's Vaccination Network only: Zero Copayment  <b>Deductible does not apply (No OON Benefits)</b>	
<b>Retail Pharmacy</b> (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  Preferred Brand Name Drug  Non-Preferred Brand Name	\$15 Copayment Amount  \$40 Copayment Amount  \$70 Copayment Amount	50% of Allowable Amount minus Copayment Amount  50% of Allowable Amount minus Copayment Amount  50% of Allowable Amount minus Copayment Amount
Specialty Drugs†	Mandatory Specialty applies: Available at in-network benefit level through Prime Specialty Pharmacy only. All other pharmacies will be payable at the non-participating pharmacy benefit level.	
<b>Mail Order Program</b> (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.) Generic Drug Preferred Brand Name Drug Non-Preferred Brand Name Drug	Yes  \$45 Copayment Amount \$120 Copayment Amount \$210 Copayment Amount	

## PPO Insured Standard with Network Deductible and Split Copay



**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.

\* 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 standard and generics plus drug list is available at: [bcbstx.com/member/rx\\_drugs.html](http://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 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.

**Note:** To confirm standard benefits, refer to the Pharmacy page on Product Central on FYIBlue.