PPO Insured Standard with Network Deductible and Split Copay

BlueCross BlueShield of Texas

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***

Overall Payment Provisions	In-Network Benefits	Out-of-Network Benefits
Deductibles		
Per-admission Deductible	*NONE*	*NONE*
Calendar Year Deductible *Applies to all Eligible Expenses, unless otherwise indicated, except Inpatient Hospital Expenses*	*$2,500 Individual / $5,000 Family*	*$5,000 Individual / $10,000 Family*
Three-month Deductible carryover applies	*No*	*No*
Deductible credit from prior carrier (applied on initial group enrollment only)	*Yes No*	*Yes No*
Out-of-Pocket Maximum		
	$6,000 Individual / $12,000 Family	*$15,000 Individual / $30,000 Family*
Deductible applies to Out-of-Pocket	*Yes – no option*	*Yes***
Copayment applies to Out-of-Pocket	*Yes – no option*	*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*
Credit for Out-of-Pocket Maximum from prior carrier (applied on initial group enrollment only)	*Yes No*	*No*
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	*$35 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*	*$55 Specialty Care Copayment*	
Urgent Care center visit *Refer to Urgent Care section for more information*	*$50 Copayment Amount*	
***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 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 $35 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 $55 Specialty Care Copayment*	*50% of Allowable Amount after Deductible*
-Lab & x-ray in other outpatient facilities (excluding Certain Diagnostic Procedures)	*100% of Allowable Amount*	*50% of Allowable Amount after Deductible*
-Physician surgical services performed in any setting	*70% of Allowable Amount after Deductible*	*50% of Allowable Amount after Deductible*

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

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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*
Virtual Visit MDLIVE (standard offering) **Note:** Must mirror PCP office visit benefit Medical & Behavioral Health **Medical**	*100% of Allowable Amount after $35 Copayment Amount*	*50% of Allowable Amount after Deductible*
Note: Behavioral Health benefit must mirror benefit under Mental Health and Substance Use Disorder **Behavioral Health**	*100% of Allowable Amount after $35 Copayment Amount*	*50% of Allowable Amount after Deductible*
Note: Behavioral Health Virtual Visit applies to MHP		
In Vitro Fertilization Services	*Decline*	

Extended Care Expenses		
Extended Care Expenses *All services must be preauthorized*	*100% of Allowable Amount*	*50% of Allowable Amount after Deductible*
Skilled Nursing Facility	*Limited to 30 day maximum each Year**	
Home Health Care	*Limited to 60 visit maximum each Year**	
Hospice Care	*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 Deductible*	*50% of Allowable Amount after Deductible*
-Physician services	*70% 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 $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*
Emergency Room/Treatment Room		
Accidental Injury & Emergency Care -Facility charges	*70% of Allowable Amount after deductible*	
-Physician charges	*70% of Allowable Amount after Deductible*	
Non-Emergency Care -Facility charges	*70% of Allowable Amount after Deductible*	*50% of Allowable Amount after Deductible*

-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*	*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

Special Provisions Expenses, cont.	***In-Network Benefits***	***Out-of-Network Benefits***
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*	*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	*70% 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)	*70% of Allowable Amount after Deductible*	*50% of Allowable Amount after Deductible*
Maximum	*Limited to 35 visits each Year**	

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Pharmacy Benefits	Participating Pharmacy*	Non-Participating Pharmacy (member files claim)
Drug List**	☒ Enhanced (Previously drug list 2) ☐ Performance (all standard UM must apply) **Note:** 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***	☒ None ☐ 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. ☐ 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	☐ All benefits, including prescription drug benefits (retail and mail service) apply to the Out-of-Pocket Maximum shown on page 1. ☐ 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 ***Deductible does not apply*** ***(No OON Benefits)***	
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	50% of Allowable Amount minus Copayment Amount
Preferred Brand Name Drug	$40 Copayment Amount	50% of Allowable Amount minus Copayment Amount
Non-Preferred Brand Name	$70 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.	
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	$45 Copayment Amount	
Preferred Brand Name Drug	$120 Copayment Amount	
Non-Preferred Brand Name Drug	$210 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.*

** 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 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.*