BestChoice Benefits – S30

BlueCross BlueShield of Texas

BENEFIT HIGHLIGHTS

BlueChoice Network

This is a general summary of your benefits. Please refer to your benefit booklet for additional details and a description of the plan requirements and benefit design. This plan does not cover all health care expenses. Upon receipt of your benefit booklet, carefully review the plan's limitations and exclusions.

Overall Payment Provisions	PPO (In-Network)	Non-PPO (Out-of-Network)
Calendar Year Deductible		
Applies to all Eligible Expenses (unless otherwise indicated) 4th quarter Deductible carryover does not apply Deductible credit from prior carrier (applied on initial group enrollment only)	*$5,000 Individual / $15,000 Family*	
Copayment Amounts Required		
Physician office visit/consultation	*$30 Copayment Amount*	
Urgent Care center visit	*$55 Copayment Amount*	
Outpatient Hospital Emergency Room visit	*$100 Copayment Amount*	*$100 Copayment Amount*
Coinsurance Stop-Loss Amount		
Deductibles are not applied to the Coinsurance Stop-Loss Amount. Copayment Amounts are applied but will continue to be required after the benefit percentages increase to 100%. Your benefit booklet will provide more details.	*$0 Individual / $0 Family* *Network Coinsurance Stop-Loss Amount **will only** apply toward Network Coinsurance Stop-Loss Amount*	*$10,000 Individual / $30,000 Family* *Out-of-Network Coinsurance Stop-Loss Amount **will also** apply toward Network Coinsurance Stop-Loss Amount*
No credit given for Coinsurance Stop-Loss Amount from prior carrier		
Maximum Lifetime Benefits		
Per individual	*$5,000,000**	
Inpatient Hospital Expenses		
Inpatient Hospital Expenses *(must be preauthorized)*		
Inpatient Hospital Expenses (including Maternity Care)	*100% of Allowable Amount after Calendar Year Deductible*	*70% of Allowable Amount after Calendar Year Deductible*
Penalty for failure to preauthorize	*None*	*$250*
Medical/Surgical Expenses		
Medical / Surgical Expenses		
Physician office visit/consultation, including lab & x-ray	*100% of Allowable Amount after $30 Copayment Amount*	*70% of Allowable Amount after Calendar Year Deductible*
Physician surgical services in any setting and Maternity Care	*100% of Allowable Amount after Calendar Year Deductible*	*70% of Allowable Amount after Calendar Year Deductible*
Lab & x-ray in other outpatient facilities (excluding Certain Diagnostic Procedures)	*100% of Allowable Amount*	*70% of Allowable Amount after Calendar Year Deductible*
Certain Diagnostic Procedures: Bone Scan, Cardiac Stress Test, CT Scan (with or without contrast), Ultrasound, MRI, Myelogram, PET Scan.	*100% of Allowable Amount after Calendar Year Deductible*	*70% of Allowable Amount after Calendar Year Deductible*
Home Infusion Therapy (must be preauthorized)	*100% of Allowable Amount after Calendar Year Deductible*	*70% of Allowable Amount after Calendar Year Deductible*
In Vitro Fertilization Services	*Declined*	
All other outpatient services and supplies	*100% of Allowable Amount after Calendar Year Deductible*	*70% of Allowable Amount after Calendar Year Deductible*

* Benefits used In-Network and Out-of-Network will apply toward satisfying any day, visit, Calendar Year, or Lifetime Maximum amounts indicated

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Extended Care Expenses	PPO (In-Network)	Non-PPO (Out-of-Network)
Extended Care Expenses *(must be preauthorized)*	*100% of Allowable Amount*	*70% of Allowable Amount*
Skilled Nursing Facility	*$10,000 Calendar Year maximum**	
Home Health Care	*$10,000 Calendar Year maximum**	
Hospice Care	*$20,000 lifetime maximum**	

Special Provisions Expenses

Treatment of Chemical Dependency *(must be preauthorized)*		
Inpatient treatment must be provided in a Chemical Dependency Treatment Center	*Three separate series of treatments for each covered individual** *Covered as any other physical sickness*	
All other outpatient treatment	*Covered as any other sickness*	*Covered as any other sickness*
Serious Mental Illness / Mental Health Care *(must be preauthorized)*		
Inpatient Services		
Hospital services (facility)	*100% of Allowable Amount after Calendar Year Deductible*	*70% of Allowable Amount after Calendar Year Deductible*
Physician services	*100% of Allowable Amount after Calendar year Deductible*	*70% of Allowable Amount after Calendar Year Deductible*
Outpatient Services		
Physician office visit/consultation, including lab & x-ray	*100% of Allowable Amount after $30 Copayment Amount*	*70% of Allowable Amount after Calendar Year Deductible*
Other outpatient services, including psychological testing	*100% of Allowable Amount after Calendar Year Deductible*	*70% of Allowable Amount after Calendar Year Deductible*
Calendar Year Maximum	*$5,000**	
Lifetime Maximum	*$10,000**	
Emergency Care/Outpatient Hospital Emergency Room		
Accidental Injury & Medical Emergency Care (within 48 hours)		
Facility charges	*100% of Allowable Amount after $100 Copayment Amount (Copayment Amount waived if admitted)*	
Physician charges	*100% of Allowable Amount after Calendar Year Deductible*	
Non-Emergency Situations (after 48 hours)		
Facility charges	*100% of Allowable Amount after $100 Copayment Amount (Copayment Amount waived if admitted)*	*70% of Allowable Amount after $100 Copayment Amount & Calendar Year Deductible (Copayment Amount waived if admitted)*
Physician charges	*100% of Allowable Amount after Calendar Year Deductible*	*70% of Allowable Amount after Calendar Year Deductible*
Urgent Care Services		
Urgent Care center visit, including lab & x-ray services (does not include Certain Diagnostic Procedures)	*100% of Allowable Amount after $55 Copayment Amount*	*70% of Allowable Amount after Calendar Year Deductible*
Certain Diagnostic Procedures and all other Medically Necessary services and supplies	*100% of Allowable Amount after Calendar Year Deductible*	*70% of Allowable Amount after Calendar Year Deductible*
Preventive Care		
Routine annual physicals, well-baby exam, annual vision and hearing exams, immunizations (any Deductibles will not be applicable to immunizations of a Dependent child age seven years of age or younger)	*100% of Allowable Amount after $30 Copayment Amount*	*70% of Allowable Amount after Calendar Year Deductible*

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Special Provisions Expenses, cont.	PPO (In-Network)	Non-PPO (Out-of-Network)
Speech and Hearing Services		
Services to restore loss of or correct an impaired speech or hearing function with hearing aids	*Covered same as any other sickness*	*Covered same as any other sickness*
Hearing Aids	*100% of Allowable Amount after Calendar Year Deductible*	*70% of Allowable Amount after Calendar Year Deductible*
Hearing Aids Maximum Benefit	*Hearing aids are subject to a $1,000 maximum amount each 36-month period**	
Physical Medicine Services		
Physical Medicine Services (includes but is not limit to physical, occupational, and manipulative therapy)	*100% of Allowable Amount after Calendar Year Deductible*	*70% of Allowable Amount after Calendar Year Deductible*
Calendar Year Maximum	*$1,500 maximum benefit each Calendar Year**	

* Benefits used In-Network and Out-of-Network will apply toward satisfying any day, visit, Calendar Year, or Lifetime Maximum amounts indicated

Prescription Drug Program	Participating Pharmacy	Non-Participating Pharmacy (member files claim)
Prescription Drugs*		
Retail Prescription (All Copayment Amounts are per 30-day supply and will not apply to Coinsurance Stop-Loss Amount)		
Generic	*$10 Copayment Amount*	*80% of Allowable Amount minus Copayment Amount*
Preferred Brand Name	*$40 Copayment Amount*	*80% of Allowable Amount minus Copayment Amount*
Non-Preferred Brand Name	*$60 Copayment Amount*	*80% of Allowable Amount minus Copayment Amount*
Mail Service Prescription (All Copayment Amounts are per 30-day supply and will not apply to Coinsurance Stop-Loss Amount)		
Generic	*$10 Copayment Amount*	
Preferred Brand Name	*$40 Copayment Amount*	
Non-Preferred Brand Name	*$60 Copayment Amount*	

** Members electing to purchase Preferred/Non-Preferred Brand Name Drugs when 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.*

Diabetes Supplies are available under the Prescription Drug Program portion of your plan. Diabetes 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.

Flu vaccinations are available through certain pharmacies for BCBSTX members. You will be charged $15.00 Copayment Amount for each vaccination received. Additional information is available on our website at www.bcbstx.com.

EMPLOYEE INFORMATION

The following benefits apply to dependent coverage:

- Dependent children are covered for maternity benefits.
- Automatic coverage for newborns for the first 31 days following birth. Infants not enrolled for coverage within the first 31 days after birth will not be eligible for coverage until the following open enrollment period or special enrollment event.

Payments: Network providers agree to accept amounts negotiated with BCBSTX and are paid according to this BCBSTX-determined Allowable Amount. Covered individuals are responsible for any required Deductibles, Coinsurance Amounts, and Copayments. Plan benefits paid to Out-of-Network providers are based on the BCBSTX-determined Allowable Amount. These providers may balance bill covered individuals for charges in excess of the BCBSTX Allowable Amount. The covered individual will be responsible for charges in excess of the Allowable Amount in addition to any applicable Deductibles, Coinsurance Amounts, and Copayments. For cost savings information, refer to the section on ParPlan Providers and the definition of Allowable Amount in the benefit booklet.

Preexisting conditions are defined in the benefit booklet and are excluded for 12 months. Appropriate credit will be given for time served under Creditable Coverage as defined under the law and shown in your benefit booklet.

Replacement of Medical Coverage: In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Texas State law, the following provisions apply to each eligible participant who has health coverage under the employer's plan immediately prior to the effective date of the health contract between the employer and BCBSTX (the contract date):

- Benefits for eligible expenses incurred for any service or supplies prior to the contract date, are not covered under the contract.
- Eligible expenses for services or supplies incurred on or after the effective date will be considered for benefits subject to all applicable contract provisions.

Members residing in other states may use that state's network through the BlueCard program. To locate a participating provider in your state, please contact 1-800-810-BLUE or visit our web site at www.bcbstx.com to use our Provider Finder® tool. n addition to the benefits stated herein, benefits for covered persons who reside outside of Texas will conform to all extraterritorial requirements of those states

Coverage is contingent upon the following:

- The employer must maintain enrollment of at least 75% of eligible employees and pay at least 50% of the employee only cost.
- The replacement of coverage stipulation in the contract.