

## BENEFIT HIGHLIGHTS

**MEDICAL INSURANCE**  
 BlueChoice Network

### OPTION 1: COPAY PLAN (M04)

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 (Network)	Non-PPO (Out-of-Network)
<b>Calendar Year Deductible (Combined)</b>		
Applies to all Eligible Expenses (unless otherwise noted)	\$500 Individual / \$1500 Family	
4 <sup>th</sup> quarter Deductible carryover applies	Yes	
Deductible credit from prior carrier (applied on initial group enrollment only)	Yes	
<b>Copayment Amounts Required</b>		
Physician office visit/consultation	\$20 Copayment Amount	
Urgent Care center visit	\$45 Copayment Amount	
Outpatient Hospital Emergency Room visit	\$100 Copayment Amount	\$100 Copayment Amount
<b>Coinsurance Stop-Loss Amount</b>		
Deductibles are not applied to Coinsurance Stop-Loss Amount. Your benefit booklet will provide more details.	\$2,500 Individual / \$7,500 Family	\$5,000 Individual / \$15,000 Family
	Network Coinsurance Stop-Loss Amount <b>will only</b> apply toward Network Coinsurance Stop-Loss Amount	Out-of-Network Coinsurance Stop-Loss Amount <b>will also</b> apply toward Network Coinsurance Stop-Loss Amount
Credit for Coinsurance Stop-Loss Amount from prior carrier (applied on initial group enrollment only)	Yes	Yes
<b>Maximum Lifetime Benefits</b>		
Per individual	\$5,000,000*	
<b>Inpatient Hospital Expenses</b>		
<b>Inpatient Hospital Expenses (must be preauthorized)</b>		
Inpatient Hospital Expenses	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Penalty for failure to preauthorize	None	\$250
<b>Medical/Surgical Expenses</b>		
<b>Medical / Surgical Expenses</b>		
Physician office visit/consultation, including lab & x-ray	100% of Allowable Amount after \$20 Copayment Amount	70% of Allowable Amount after Calendar Year Deductible
Physician surgical services in any setting	80% of Allowable Amount after Calendar Year Deductible	60% 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	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Home Infusion Therapy (must be preauthorized)	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
In Vitro Fertilization Services	Declined	
All other outpatient services and supplies	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible

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

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Extended Care Expenses	PPO (In-Network)	Non-PPO (Out-of-Network)
<b>Extended Care Expenses</b> (must be preauthorized)	100% of Allowable Amount	70% of Allowable Amount after Calendar Year Deductible
Skilled Nursing Facility	<b>Sample</b>	\$10,000 Calendar Year maximum*
Home Health Care		\$10,000 Calendar Year maximum*
Hospice Care		\$20,000 lifetime maximum*
Special Provisions Expenses		
<b>Treatment of Chemical Dependency</b> (must be preauthorized)	Three separate series of treatments for each covered individual*	
Inpatient treatment must be provided in a Chemical Dependency Treatment Center		
All other outpatient treatment	Covered as any other sickness	Covered as any other sickness
<b>Serious Mental Illness</b> (must be preauthorized)		
<b>Inpatient Services</b>		
Hospital services (facility)	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Physician services	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Calendar Year Maximum	45 inpatient days/45 inpatient Physician visits each Calendar Year*	
<b>Outpatient Services</b>		
Physician office visit/consultation, including lab & x-ray	100% of Allowable Amount after \$20 Copayment Amount	70% of Allowable Amount after Calendar Year Deductible
Other outpatient services, including psychological testing	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Calendar Year Maximum	60 outpatient visits each Calendar Year*	
<b>Mental Health Care</b> (must be preauthorized)		
<b>Inpatient Services</b>		
Hospital services (facility)	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Physician services	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Calendar Year Maximum	30 inpatient days/30 inpatient Physician visits each Calendar Year*	
<b>Outpatient Services</b>		
Physician office visit/consultation, including lab & x-ray	100% of Allowable Amount after \$20 Copayment Amount	70% of Allowable Amount after Calendar Year Deductible
Other outpatient services, including psychological testing	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Calendar Year Maximum	30 visits each Calendar Year*	
<b>Emergency Care/Outpatient Hospital Emergency Room</b>		
<b>Accidental Injury &amp; Medical Emergency Care (within 48 hours)</b>		
Facility charges	80% of Allowable Amount after \$100 Copayment Amount (Copayment Amount waived if admitted)	
Physician charges	80% of Allowable Amount after Calendar Year Deductible	
<b>Non-Emergency Situations (after 48 hours)</b>		
Facility charges	80% of Allowable Amount after \$100 Copayment Amount (Copayment Amount waived if admitted)	60% of Allowable Amount after \$100 Copayment Amount & Calendar Year Deductible (Copayment Amount waived if admitted)
Physician charges	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible

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

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#### Special Provisions Expenses, cont.

	PPO (In-Network)	Non-PPO (Out-of-Network)
<b>Urgent Care Services</b>		
Urgent Care center visit, including all lab & x-ray services, except Certain Diagnostic Procedures	100% of Allowable Amount after \$45 Copayment Amount	70% of Allowable Amount after Calendar Year Deductible
Certain Diagnostic Procedures and all services and supplies	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
<b>Preventive Care</b>		
Routine annual physicals, well-baby care, immunizations (through the 6 <sup>th</sup> birthdate), vision and hearing exams	100% of Allowable Amount after \$20 Copayment Amount	70% of allowable Amount after Calendar Year Deductible
Immunizations (birth through the day of the 6 <sup>th</sup> birthdate)	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	80% of Allowable Amount after Calendar Year Deductible	60% 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*	
<b>Physical Medicine Services</b>		
Physical Medicine Services (includes but is not limited to physical, occupational, and manipulative therapy)	80% of Allowable Amount after Calendar Year Deductible	60% 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, or Calendar Year Maximum amounts indicated

#### Prescription Drug Program

	Participating Pharmacy	Non-Participating Pharmacy (member files claim)
<b>Prescription Drugs</b>		
<b>Retail Prescription**</b> (All Copayment Amounts are per 30-day supply and will not apply to Coinsurance Stop-Loss Amount)		
Generic	\$20 Copayment Amount	80% of Allowable Amount minus Copayment Amount
Preferred Brand Name	\$35 Copayment Amount	80% of Allowable Amount minus Copayment Amount
Non-Preferred Brand Name	\$50 Copayment Amount	80% of Allowable Amount minus Copayment Amount
<b>Mail Service Prescription**</b> (All Copayment Amounts are per 30-day supply and will not apply to Coinsurance Stop-Loss Amount)		
Generic	\$20 Copayment Amount	
Preferred Brand Name	\$35 Copayment Amount	
Non -Preferred Brand Name	\$50 Copayment Amount	

\*\*Generic Incentive-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 for each vaccination received. Additional information is available on our website at [www.bcbstx.com](http://www.bcbstx.com).