BlueEdge ASO HDHP – Embedded Deductible – Integrated Rx

BlueCross BlueShield of Texas

BENEFIT HIGHLIGHTS *Prepared for* **BlueChoice Network**
Southwestern University - 01/01/2015

***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.

Overall Payment Provisions	In-Network Benefits	Out-of-Network Benefits
Calendar Year Embedded Deductible		
Applies to all Eligible Expenses (unless otherwise indicated) Applies to Out-of-Pocket Maximum *Family coverage: When one family member meets the individual Deductible, benefits become available under the plan for that individual.* *NOTE: The individual Deductible amount must be equal to or greater than the minimum family Deductible amount. This qualification is established by the U. S. Treasury for a plan to be considered a qualified HSA plan.*	*$3,000 Individual / $6,000 Family*	*$6,000 Individual / $12,000 Family*
Out-of-Pocket Maximum	*$5,000 Individual / $10,000 Family*	*$10,000 Individual / $20,000 Family*
Deductibles apply to Out-of-Pocket	*Yes* *Network Deductible & Out-of-Pocket **will only** apply toward Network Deductible & Out-of-Pocket Maximum*	*Yes* *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*
Maximum Lifetime Benefits		
Per Participant	*Unlimited*	
Inpatient Hospital Expenses		
Inpatient Hospital Expenses		
All services must be preauthorized		
Inpatient Hospital Expenses *Each admission must be preauthorized* *All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units.*	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
Penalty for failure to preauthorize services	*None*	*$250*
Medical/Surgical Expenses		
Medical / Surgical Expenses		
-Services performed during the Physician's office visit/consultation, including lab & x-ray	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
-Lab & x-ray in other outpatient facilities	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
-Physician surgical services performed in any setting	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
-Physician inpatient hospital visits	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
-Certain Diagnostic Procedures; such as Bone Scan, Cardiac Stress Test, CT Scan (with or without contrast), MRI, Myelogram, PET Scan.	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
-Home Infusion Therapy *(Services must be preauthorized)*	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
-All other outpatient services and supplies	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
In Vitro Fertilization Services	*Decline*	

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Extended Care Expenses	In-Network Benefits	Out-of-Network Benefits
Extended Care Expenses *(must be preauthorized)*		
	80% of Allowable Amount after Calendar Year Deductible	*60% of Allowable Amount after Calendar Year Deductible*
Skilled Nursing Facility	*Limited to 25 day maximum each Calendar Year**	
Home Health Care	*Limited to 60 visit maximum each Calendar Year**	
Hospice Care	*Unlimited*	

Special Provisions Expenses		
Serious Mental Illness ***Mental Health Care*** ***Treatment of Chemical Dependency***		
Inpatient Services (All services must be preauthorized)		
-Hospital services (facility) *(Inpatient Chemical Dependency treatment must be provided in a Chemical Dependency Treatment Center)*	*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*
Penalty for failure to preauthorize services	*None*	*$250*
Outpatient Services (Certain services must be preauthorized; refer to benefit booklet for more details)	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
-Services performed during Physician office visit/consultation (does not include psychological testing)		
-All outpatient services and psychological testing	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
Emergency Room/Emergency Treatment Room		
Accidental Injury & Emergency Care		
-Facility charges	*80% of Allowable Amount after Calendar Year Deductible*	
- Physician charges	*80% of Allowable Amount after Calendar Year Deductible*	
Non-Emergency Care		
-Facility charges	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
-Physician charges	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
Urgent Care Services		
Urgent Care center visit, including lab & x-ray services	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
Certain Diagnostic Procedures; such as Bone Scan, Cardiac Stress Test, CT Scan (with or without contrast), MRI, Myelogram, PET Scan, surgical procedures and all other services and supplies.	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
Ground and Air Ambulance Services		
	80% of Allowable Amount after Calendar Year 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*	*70% of Allowable Amount*
Immunizations for Dependent children through the date of the child's 6th birthday	*100% of Allowable Amount*	*100% of Allowable Amount*

* 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
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	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
Hearing Aid Maximum	*Hearing aids are subject to 1 per ear per 36 month period*	
Physical Medicine Services		
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	*Limited to 35 visit maximum each Calendar Year**	

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

Pharmacy Benefits	Participating Pharmacy*	Non-Participating Pharmacy (member files claim)
Drug List**	*Preferred Drug List 1*	
Vaccinations obtained through Pharmacies***	*Yes* *Flu vaccinations covered as follows:* *Select pharmacies participating in Flu Network – 100%* *All other pharmacies – apply appropriate tier copay*	
Retail Pharmacy (Benefit payments are based on a 30-day supply. With appropriate prescription order, up to a 90-day supply is available.)	*80% of Allowable Amount after the Calendar Year Deductible****	
Mail Order Program (Benefit payments are based on a 30-day supply. With appropriate prescription order, up to a 90-day supply is available.)	*80% of Allowable Amount after the Calendar Year Deductible****	

No Penalty – Member pays no more than the applicable Generic, Preferred Drug, or Non-Preferred Drug Copayment. Product selection is permitted, even when generic equivalents are available.

** To locate a 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 preferred drug list is available at:* bcbstx.com/member/rx_drugs.html

****Select pharmacies participating in the Flu Network are contracted to provide vaccination services. Flu vaccinations at all other in-network and out-of-network pharmacies are payable at the applicable tier copay. Each pharmacy may have age, scheduling, or other requirements that will apply. You are encouraged to contact the store in advance. Childhood immunizations subject to state regulations are not available under this pharmacy benefit. Refer to your BCBSTX medical coverage for benefits available for childhood immunizations.*

***** Three-month Deductible carryover does not apply to prescription drug deductible.*

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.

All medications with over-the-counter (OTC) equivalents are excluded from coverage except for Omeprazole 20 mg.

EMPLOYEE INFORMATION

- The following applies to dependent coverage:
  - Dependent children are covered to age 26. Disabled dependent children can be covered beyond age 26.
  - 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 also based on the BCBSTX-determined Allowable Amount. Covered individuals 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.

- 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.
- Deductible: The benefits of the Plan will be available after satisfaction of the applicable Deductible. The Deductible may be increased in the future in direct proportion to the increase as determined from the cost-of-living adjustments based on the Consumer Price Index (CPI-U). The Deductibles are explained as follows:
  1. The Individual Deductible amount as shown on this Benefits Highlights under "Calendar Year Deductible," will apply to all combined Inpatient Hospital Expenses, Medical-Surgical Expenses, Extended Care Expenses, and Special Provisions Expenses you incur during a Calendar Year and must be satisfied by each Participant under your coverage each Calendar Year before any benefits are available under the Plan. This Deductible, unless otherwise indicated, will be applied to all Eligible Expenses before benefits are available under the Plan.
  2. The family Deductible amount as shown on this Benefits Highlight under "Calendar Year Deductible," will apply to all combined Inpatient Hospital Expenses, Medical-Surgical Expenses, Extended Care Expenses, and Special Provisions Expenses each Participant incurs during each Calendar Year and must be satisfied by each Participant under your coverage each Calendar Year before any benefits are available under the Plan. If you have several covered Dependents, all charges used to apply toward a "per individual" Deductible amount will be applied toward the "per family" Deductible amount. When the family Deductible is reached, no further individual Deductibles will have to be satisfied for the remainder of that Calendar Year. No Participant will contribute more than the individual Deductible amount to the "per family" Deductible amount.

- Out-of-Pocket Maximum: Most of your Eligible Expense payment obligations are applied to the Out-of-Pocket Maximum. The Out-of-Pocket Maximum may be increased in the future in direct proportion to the increase as determined from the cost-of-living adjustments based on the Consumer Price Index (CPI-U).
  1. The Out-of-Pocket Maximum **will not** include:
     - Services, supplies, or charges limited or excluded by the Plan;
     - Expenses not covered because of a benefit maximum has been reached;
     - Any Eligible Expense paid by the Primary Plan when BCBSTX is the Secondary Plan for purposes of coordination of benefits;
     - Penalties for failing to obtain preauthorization;
  2. When the Out-of-Pocket Maximum for the In-Network or Out-of-Network Benefits level for a Participant in a Calendar Year equals the "per individual" "Out-of-Pocket Maximum" shown on this Benefits Highlights for that level, the benefit percentage automatically increases to 100% for purposes of determining the benefits available for additional Eligible Expenses incurred by that Participant during the remainder of that Calendar Year for that level.
  3. When the "Out-of-Pocket Maximum" amount for the In-Network or Out-of-Network Benefits level for all Participants under your coverage in a Calendar Year equals the "per family" "Out-of-Pocket Maximum" amount shown on this Benefits Highlights for that level, the benefit percentage automatically increases to 100% for purposes of determining the benefits available for additional Eligible Expenses incurred by all family Participants during the remainder of that Calendar Year for that level. No Participant will be required to contribute more than the individual Out-of-Pocket Maximum to the family Out-of-Pocket Maximum.

- Members residing in states other than Texas may use that stat's network through the BlueCard Program. To locate a participating provider in your state, please contact 1-800-810-BLUE or visit our website at bcbstx.com to use our Provider Finder® tool.

This benefit plan design includes provisions mandated by the Affordable Care Act of 2010, and is subject to change upon direction by federal and state agencies.

± Please be reminded that Health Savings Accounts (HSA's) have tax and legal ramifications. Blue Cross and Blue Shield of Texas does not provide legal or tax advice, and nothing herein should be construed as legal or tax advice. These materials, and any tax-related statements in them, are not intended or written to be used, and cannot be used or relied on, for the purpose of avoiding tax penalties. Tax-related statements, if any, may have been written in connection with the promotion or marketing of the transaction(s) or matter(s) addressed by these materials. You should seek advice based on your particular circumstances from an independent tax advisor regarding the tax consequences of specific health insurance plans or products.

Group Executive Name and Title (Please type or print)	Signature	Date
Agent of Record Name (Please print or type)	Signature	Date
BCBSTX Representative Name (Please print or type)	Signature	Date