

Blue Cross and Blue Shield of Texas*
Summary of Benefits Prepared for Bishop C.I.S.D.

PPO State Plan

BlueChoice BlueChoice Solutions

TYPE OF SERVICE	NETWORK	OUT-OF-NETWORK
GENERAL PROVISIONS		
Calendar Year Deductible (Applies to Non-Inpatient Hospital Services)	None	\$500 Indiv/\$1,500 Family
4 th Quarter Carryover Applies	N/A	N/A
Deductible Credit from Prior Carrier	N/A	N/A
Coshare Stoploss Maximum	\$1,000 Indiv/None Family per cal. yr. <i>Network coshare will only apply toward Network coshare</i>	\$3,000 Indiv/None Family per cal. Yr. <i>Out-of-Network coshare will also apply toward Network coshare</i>
Coshare Stoploss Credit from Prior Carrier	Yes	Yes
Lifetime Maximum per Participant	\$2,000,000	
INPATIENT HOSPITAL SERVICES (must be preauthorized)	80% after \$100 (\$500 maximum copay per adm. co pay per day, \$1,500 maximum copay per plan yr. limit)	60% after \$100 (\$500 maximum copay per adm. co pay per day, \$1,500 maximum copay per plan yr. limit)
Per Admission Deductible	N/A	N/A
Penalty for Failure to Preauthorize	None	N/A
EMERGENCY ROOM/TREATMENT ROOM		
Accident & Medical Emergency Situation within 48 Hours	80% after \$100 copay, waived if admitted	60% after cal. yr. deductible
Facility Charges	80%	60%
Physician Charges	80%	60%
Non-Emergency Situations	80% after \$100 copay, waived if admitted	60% after cal. yr. deductible
Facility Charges	80%	60% after cal. yr. deductible
Physician Charges	80%	60% after cal. yr. deductible
MEDICAL-SURGICAL SERVICES		
Services Performed in Physician Office (non-surgical), Including Lab & X-ray	100% after \$20 copay for primary \$30 copay for specialist Per visit	60% after cal. yr. deductible
Services Performed in a Contracted Urgent Care Center (non-surgical)	100% after \$100 copay per visit	60% after cal. yr. deductible
Immunizations (birth to the day of the 6 th birthdate)	100% (Covered under Preventive Care)	60% (Covered under Preventive Care)
Physician Surgical Services in any Setting	80%	60% after cal. yr. deductible
Lab & X-Ray in Other Outpatient Facilities (excluding Certain Diagnostic Procedures):	80%	60% after cal. yr. deductible
• Certain Diagnostic Procedures: Bone Scan, Cardiac Stress Test, CT Scan (with or without contrast), Ultrasound, MRI, Myelogram, PET Scan	80%	60% after cal. yr. deductible
Home Infusion Therapy (must be preauthorized)	80%	60% after cal. yr. deductible
In-Vitro Fertilization	Declined	60% after cal. yr. deductible
Chiropractic Care – Office Services	80%	60% after cal. yr. deductible
	\$1,500 cal. yr. max.	
	<i>All Other Physical Medicine Services rendered by any other eligible Provider will be allowed on the same basis as any other sickness.</i>	
Speech and Hearing Services with Hearing Aids	Covered as any other sickness \$1,000 Maximum benefit per 36-month period for Hearing Aids	Covered as any other sickness
All Other Outpatient Services and Supplies	80%	60% after cal. yr. deductible

Specialists: internal medicine, family/general practice, OB/GYN and pediatrician.

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PREVENTIVE CARE Routine Physicals, Well Baby Care, Immunizations (after 6 th birthdate), Vision & Hearing Exams	100% after \$20 copay for primary \$30 copay for specialist Per visit	60% after cal. yr. deductible
EXTENDED CARE SERVICES (must be preauthorized) Home Health Care Calendar Year Maximum Skilled Nursing Facility Hospice Care	80% \$10,000 per cal. yr. \$10,000 per cal. yr. \$20,000 lifetime max. <i>Benefits used in Network or Out-of-Network apply towards satisfying both maximums.</i>	60% after cal. yr. deductible
MENTAL HEALTH/CHEMICAL DEPENDENCY (must be preauthorized) Inpatient Services Hospital Services (Facility) Physician Services Calendar Year Limitations Outpatient Services Services Performed in Physician Office (non-surgical) Emergency Room/Treatment Room/Facility Charges (non-emergency only) Professional Provider Visits Allowed Chemical Dependency Maximum for each Covered Individual	80% 80% 30 inpatient days/30 physician visits <i>Days and visits used in Network or Out-of-Network apply towards satisfying both maximums.</i>	60% after per adm. deductible 60% after cal. yr. deductible
	100% after \$20 copay for primary \$30 copay for specialist Per visit 80% after \$100 copay, waived if admitted 80% 30 outpatient visits per cal. yr. Two separate series of treatments	60% after cal. yr. deductible 60% after cal. yr. deductible, waived if admitted 60% after cal. yr. deductible
SERIOUS MENTAL ILLNESS (For Public Entities) (must be preauthorized)	Covered as any other sickness	

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TYPE OF SERVICE	PARTICIPATING PHARMACY	NON-PARTICIPATING PHARMACY (member files claim)
<p>PRESCRIPTION DRUG PROGRAM—Prescription deductible per individual applies to first prescription(s) filled in the plan year.</p> <p>Retail Prescription (all copays are per 30-day supply and will not apply to coshare stoploss maximum)</p> <p>Non-Preferred Brand Name</p> <p>Preferred Brand Name</p> <p>Generic</p>	<p>\$50 Plan Year prescription deductible until met by any combination of Network and Non-Network purchases, plus copay(s)</p> <p>\$10 copay</p> <p>\$25 copay</p> <p>\$40 copay</p>	<p>\$10 copay</p> <p>\$25 copay</p> <p>\$40 copay (Patient also pays amount over network cost)</p>
<p>Mail Service Prescription (all copays are per 90-day supply and will not apply to coshare stoploss maximum)</p> <p>Non-Preferred Brand Name</p> <p>Preferred Brand Name</p> <p>Generic</p>		<p>Yes</p> <p>\$20 copay</p> <p>\$62.50 copay</p> <p>\$100 copay</p>
<p>* DELETE THE LANGUAGE THAT DOES NOT APPLY:</p> <p>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 copay. If "Brand Medically Necessary" is indicated on the prescription, the member will pay the preferred or non-preferred brand name copay.</p> <p>**4th quarter carryover does not apply to prescription drug deductible. Copay amounts and pricing differences, if applicable, apply after Pharmacy Deductible has been met.</p> <p>Diabetes Supplies are available under the Prescription Drug Program portion of your plan. All provisions of this portion of the Plan will apply including Copayment Amounts and any pricing differences that may apply to the items dispensed.</p>		

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EMPLOYEE INFORMATION

- This is a general Summary of your benefit design. Please refer to your benefit booklet for other details and for limitations and exclusions.
- The following benefits apply to dependent coverage:
 - Dependent children are covered to age 25.
 - 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.
- Provider charges are paid according to BCBSTX determined Allowable Amount and negotiated prices.
- Preexisting conditions are defined in the benefit booklet and are excluded for 12 months. Appropriate credit will be given for time served under another health benefit plan as defined under the law.
- Replacement of Medical Coverage: In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 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.
- Please notify your service representative if you have or acquire employees or dependents outside of Texas and/or in state(s) with no network, limited network or in locations in states where there is not a network service area.

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