PPO Insured/Cost Standard with Network Deductible and Split Copay

BlueCross BlueShield of Texas

BENEFIT HIGHLIGHTS *Prepared for*
Moody Gardens, Inc.
Funding: Fully Insured
Effective Date: 07/01/2020
BA# 0001

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.*

Overall Payment Provisions	In-Network Benefits	Out-of-Network Benefits
Deductibles		
Calendar Year Deductible *Applies to all Eligible Expenses, unless otherwise indicated, except Inpatient Hospital Expenses*	*$1,500 Individual / $3,000 Family*	*$ 2,000 Individual / $ 4,000 Family*
Three-month Deductible carryover applies***	*Yes*	*Yes*
Out-of-Pocket Maximum		
Standard (2014 forward)	*$5,250 Individual / $10,500 Family*	*$10,000 Individual / $20,000 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*
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*	*$50 Specialty Care Copayment*	
Urgent Care center visit *Refer to Urgent Care section for more information*	*$75 Copayment Amount*	
Outpatient Hospital Emergency Room/Treatment Room visit *Refer to Emergency Room/Treatment Room section for more information*	*$200 Copayment Amount*	*$200 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	*80% of Allowable Amount after Deductible*	*50% of Allowable Amount after Deductible*
Penalty for failure to preauthorize services	*None*	*$250*
For Inpatient Facility Services, Blue Cross Blue Shield of TX or the Host Blue's Participating Provider is required to obtain preauthorization. If preauthorization is not obtained, the Participating Provider will be sanctioned based on Blue Cross Blue Shield of TX or the Host Blue's contractual agreement with the Provider, therefore the member will be held harmless for the Provider sanction		

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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 $50 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	*80% 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

Medical / Surgical Expenses,	***In-Network Benefits***	***Out-of-Network Benefits***
-Physician inpatient hospital visits	*80% 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	*80% of Allowable Amount after Deductible*	*50% of Allowable Amount after Deductible*
-Home Infusion Therapy *(Services must be preauthorized)*	*80% of Allowable Amount after Deductible*	*50% of Allowable Amount after Deductible*
-All other outpatient services and supplies	*80% 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	*Not Covered*	

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 100 day maximum each Year**	
Home Health Care	*Limited to 120 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	*80% of Allowable Amount after Deductible*	*50% of Allowable Amount after Deductible*
-Physician services	*80% 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	*80% of Allowable Amount after Deductible*	*50% of Allowable Amount after Deductible*
Emergency Room/Treatment Room		
Accidental Injury & Emergency Care -Facility charges	*80% of Allowable Amount after $200 Copayment Amount (Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply)*	
-Physician charges	*80% of Allowable Amount after Deductible*	
Non-Emergency Care -Facility charges	*80% of Allowable Amount after $200 Copayment Amount (Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply)*	*50% of Allowable Amount after $200 Copayment Amount & Deductible (Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply)*
-Physician charges	*80% 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 $75 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	*80% 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	*80% 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	*80% 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)	*80% of Allowable Amount after Deductible*	*50% of Allowable Amount after Deductible*
Maximum	*Limited to 35 visits each 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**	*Enhanced*	
Compound Drugs	*Not Covered*	

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Pharmacy Benefits Cont….		
Non-sedating antihistamine (NSA) drugs and combination medications containing a non-sedating antihistamine and decongestant	*Exclude Prescription Strength NSA's*	
Proton Pump Inhibitors NOTE: For the Performance drug list, coverage will be based on the drug list. Customization is not allowed.	*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*	
Prescription Drug Out-of-Pocket Maximum	*Separate Prescription Drug Out-of-Pocket Maximum applies to Retail & Mail Service Pharmacy: Individual: $ 1,000 / Family: $ 2,000*	
Vaccinations obtained through Pharmacies** **	*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.)		
3 Tier Generic Drug Preferred Name Brand Non-Preferred Brand Name	*$15 Copay* *$30 Copay* *$50 Copay*	*80%: of Allowable Amount minus deductible* *80%: of Allowable Amount minus deductible* *80%: of Allowable Amount minus deductible*
Specialty Drugs†	*Mandatory Specialty applies (standard): Only available at in-network benefit level through specialty pharmacy network provider. All other pharmacies will be payable at the non-participating pharmacy benefit level.*	
Mail Order Program (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.)	*Yes*	
3 Tier Generic Drug Preferred Brand Name Drug Non-Preferred Brand Name Drug	*Copay $15* *Copay $30* *Copay $50*	
MAC 3 - Generic Incentive (Standard)- *Members electing to purchase brand name drugs when a generic equivalent is available, will be required to pay the difference between the cost of the generic and brand name drug, plus the applicable copay.* ** 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 drug lists are 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.* ***Benefit does not include childhood immunizations, subject to state regulations.***	*†For more information on the specialty drug program, call (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.*	