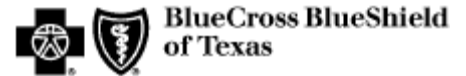


# PPO Insured/Cost Standard with Network Deductible and Split Copay



**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
<b>Deductibles</b> Calendar Year Deductible <i>Applies to all Eligible Expenses, unless otherwise indicated, except Inpatient Hospital Expenses</i> Three-month Deductible carryover applies***	\$1,500 Individual / \$3,000 Family  Yes	\$ 2,000 Individual / \$ 4,000 Family  Yes
<b>Out-of-Pocket Maximum</b> <i>Standard (2014 forward)</i>	\$5,250 Individual / \$10,500 Family	\$10,000 Individual / \$20,000 Family
Deductible applies to Out-of-Pocket Copayment applies to Out-of-Pocket  <b>** Copayment amounts and per admission deductibles are applied but will continue to be required after the benefit percentage increases to 100%.</b>	Yes – no option Yes – no option  <i>Network Deductible &amp; Out-of-Pocket will only apply toward Network Deductible &amp; Out-of-Pocket Maximum</i>	Yes** Yes**  <i>Out-of-Network Deductible &amp; Out-of-Network Out-of-Pocket will only apply toward Out-of-Network Deductible &amp; Out-of-Network Out-of-Pocket Maximum</i>
<b>Copayment Amounts Required</b> Physician office visit/consultation: <b>Primary Care Copayment Amount</b> 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 <b>Specialty Care Copayment Amount</b> for office visit/consultation when services rendered by a Specialty Care Provider <i>Refer to Medical/Surgical Expenses section for more information</i> Urgent Care center visit <i>Refer to Urgent Care section for more information</i> Outpatient Hospital Emergency Room/Treatment Room visit <i>Refer to Emergency Room/Treatment Room section for more information</i>	\$35 Primary Care Copayment  \$50 Specialty Care Copayment  \$75 Copayment Amount  \$200 Copayment Amount	     \$200 Copayment Amount
<b>Maximum Lifetime Benefits</b> 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*

Penalty for failure to preauthorize services

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

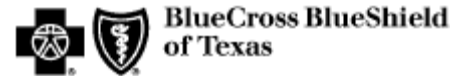
80% of Allowable Amount after Deductible

None

50% of Allowable Amount after Deductible

\$250

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**Moody Gardens, Inc.**  
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**BlueChoice Network**

## 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 -Home Infusion Therapy ( <i>Services must be preauthorized</i> )	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
<b>Virtual Visit MDLIVE (standard offering)</b> <b>Note:</b> Must mirror PCP office visit benefit Medical & Behavioral Health <b>Medical</b>  <b>Note:</b> Behavioral Health benefit must mirror benefit under Mental Health and Substance Use Disorder <b>Behavioral Health</b>  <b>Note:</b> Behavioral Health Virtual Visit applies to MHP	100% of Allowable Amount after \$35 Copayment Amount   100% of Allowable Amount after \$35 Copayment Amount	50% of Allowable Amount after Deductible   50% of Allowable Amount after Deductible
In Vitro Fertilization Services	Not Covered	

## Extended Care Expenses

### Extended Care Expenses

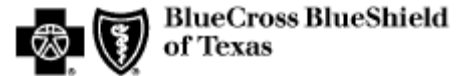
All services must be preauthorized Skilled Nursing Facility Home Health Care Hospice Care	100% of Allowable Amount   Limited to 100 day maximum each Year* Limited to 120 visit maximum each Year*	50% of Allowable Amount after Deductible   Unlimited
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## Special Provisions Expenses

### Mental Health (Serious Mental Illness (SMI) included) and Chemical Dependency (Substance Use Disorder)

<b>Inpatient Services</b> 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

# PPO Insured/Cost Standard with Network Deductible and Split Copay



<p><b>Penalty for failure to preauthorize services</b> Preauthorization required for inpatient, residential treatment centers (RTC), partial hospital program admissions, and certain outpatient professional services</p> <p><b>Outpatient Services</b> -Services performed during office visit/consultation when rendered by a Primary Care Provider (does not include psychological testing) -All outpatient services and psychological testing</p>	<p>None</p> <p>100% of Allowable Amount after \$35 Primary Care Copayment Amount</p> <p>80% of Allowable Amount after Deductible</p>	<p>\$250</p> <p>50% of Allowable Amount after Deductible</p> <p>50% of Allowable Amount after Deductible</p>
<p><b>Emergency Room/Treatment Room</b></p>		
<p><b>Accidental Injury &amp; Emergency Care</b> -Facility charges</p> <p>-Physician charges</p> <p><b>Non-Emergency Care</b> -Facility charges</p> <p>-Physician charges</p>	<p>80% of Allowable Amount after \$200 Copayment Amount (Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply)</p> <p>80% of Allowable Amount after Deductible</p> <p>80% of Allowable Amount after \$200 Copayment Amount (Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply)</p> <p>80% of Allowable Amount after Deductible</p>	<p>50% of Allowable Amount after \$200 Copayment Amount &amp; Deductible (Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply)</p> <p>50% of Allowable Amount after Deductible</p>
<p><b>Urgent Care Services</b> Urgent Care center visit, including lab &amp; x-ray services (does not include Certain Diagnostic Procedures and surgical services) 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</p>	<p>100% of Allowable Amount after \$75 Copayment Amount</p> <p>80% of Allowable Amount after Deductible</p>	<p>50% of Allowable Amount after Deductible</p> <p>50% of Allowable Amount after Deductible</p>

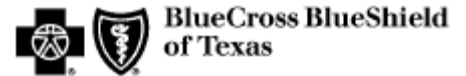
\* Benefits used In-Network and Out-of-Network will apply toward satisfying any Annual Maximum benefits indicated

Special Provisions Expenses, cont.	In-Network Benefits	Out-of-Network Benefits
<p><b>Ground and Air Ambulance Services</b></p>	80% of Allowable Amount after Deductible	
<p><b>Preventive Care</b> Routine annual physical examinations, well-baby care exams, immunizations 6 years of age &amp; over, and any other preventive health services as determined by USPSTF</p> <p>Immunizations for Dependent children through the date of the child's 6<sup>th</sup> birthday</p>	<p>100% of Allowable Amount</p> <p>100% of Allowable Amount</p>	<p>50% of Allowable Amount after Deductible</p> <p>100% of Allowable Amount</p>
<p><b>Speech and Hearing Services</b> Services to restore loss of or correct an impaired speech or hearing function Hearing Aids</p> <p><b>Hearing Aid Maximum</b></p>	<p>Covered same as any other sickness</p> <p>80% of Allowable Amount after Deductible</p> <p>Hearing aids are subject to 1 per ear per 36 month period</p>	<p>Covered same as any other sickness</p> <p>50% of Allowable Amount after Deductible</p>
<p><b>Organ and Tissue Transplant Services</b></p>	<p>Covered same as any other sickness Refer to benefit booklet for details</p>	<p>Covered same as any other sickness Refer to benefit booklet for details</p>
<p><b>Physical Medicine Services</b> Physical Medicine Services (includes, but is not limited to physical, occupational, and manipulative therapy) <b>Maximum</b></p>	<p>80% of Allowable Amount after Deductible</p> <p>Limited to 35 visits each Year*</p>	<p>50% of Allowable Amount after Deductible</p>

\* 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)
<p><b>Drug List**</b></p>	<p>Enhanced</p>	
<p><b>Compound Drugs</b></p>	<p>Not Covered</p>	

# PPO Insured/Cost Standard with Network Deductible and Split Copay



<b>Pharmacy Benefits Cont...</b>							
<b>Non-sedating antihistamine (NSA) drugs</b> and combination medications containing a non-sedating antihistamine and decongestant	Exclude Prescription Strength NSA's						
<b>Proton Pump Inhibitors</b> NOTE: For the Performance drug list, coverage will be based on the drug list. Customization is not allowed.	Generics coverage only						
<b>Prescribed over-the-counter (OTC) medications</b>	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						
<b>Prescription Drug Deductible***</b>	None						
<b>Prescription Drug Out-of-Pocket Maximum</b>	Separate Prescription Drug Out-of-Pocket Maximum applies to Retail & Mail Service Pharmacy: Individual: \$ 1,000 / Family: \$ 2,000						
<b>Vaccinations obtained through Pharmacies****</b>	ACA vaccines, including flu covered at pharmacies participating in Prime's Vaccination Network only: Zero Copayment <b>Deductible does not apply (No OON Benefits)</b>						
<b>Retail Pharmacy</b> (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.)							
<b>3 Tier</b> Generic Drug  Preferred Name Brand Non-Preferred Brand Name	<table border="0"> <tr> <td style="padding-right: 20px;">\$15 Copay</td> <td>80%: of Allowable Amount minus deductible</td> </tr> <tr> <td style="padding-right: 20px;">\$30 Copay</td> <td>80%: of Allowable Amount minus deductible</td> </tr> <tr> <td style="padding-right: 20px;">\$50 Copay</td> <td>80%: of Allowable Amount minus deductible</td> </tr> </table>	\$15 Copay	80%: of Allowable Amount minus deductible	\$30 Copay	80%: of Allowable Amount minus deductible	\$50 Copay	80%: of Allowable Amount minus deductible
\$15 Copay	80%: of Allowable Amount minus deductible						
\$30 Copay	80%: of Allowable Amount minus deductible						
\$50 Copay	80%: of Allowable Amount minus deductible						
<b>Specialty Drugs†</b>	Mandatory Specialty applies (standard): <b>Only</b> available at in-network benefit level through specialty pharmacy network provider. All other pharmacies will be payable at the non-participating pharmacy benefit level.						
<b>Mail Order Program</b> (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						
<b>3 Tier</b> Generic Drug Preferred Brand Name Drug Non-Preferred Brand Name Drug	<table border="0"> <tr> <td>Copay \$15</td> </tr> <tr> <td>Copay \$30</td> </tr> <tr> <td>Copay \$50</td> </tr> </table>	Copay \$15	Copay \$30	Copay \$50			
Copay \$15							
Copay \$30							
Copay \$50							
<b>MAC 3 - Generic Incentive (Standard)-</b> 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 <a href="http://myprime.com">myprime.com</a> or contact customer service at the phone number on the back of your identification card.  **The drug lists are available at: <a href="http://bcbstx.com/member/rx_drugs.html">bcbstx.com/member/rx_drugs.html</a>  *** 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. <b>Benefit does not include childhood immunizations, subject to state regulations.</b>	†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.  <b>Note:</b> To confirm standard benefits, refer to the Pharmacy page on Product Central on FYIBlue.						

