

Blue Choice Plan

Non-Grandfathered



BlueCross BlueShield of Texas

BENEFIT SUMMARY

Prepared for City of Irving

Funding: ASO

Effective Date: 10/1/2021

BlueChoice
PPO Network

This is a general summary of our proposed 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		PPO (In-Network)	Non-PPO (Out-of-Network)
Lifetime Maximum		Unlimited	
Individual/Family Coverage Deductible			
	Applies to all Eligible Expenses, unless otherwise indicated.	\$1,000 Individual \$3,000 Family	\$2,000 Individual \$6,000 Family
Coinsurance		80%	50%
Individual/Family Medical Coverage Out-of-Pocket Expense (OPX) Limit			
	Deductible and Copayment applies to Out-of-Pocket	\$4,500 Individual \$13,500 Family	\$7,500 Individual \$22,500 Family
Plan Year or Calendar Year Deductible/OPX		Plan Year	
Deductible/OPX credit from prior carrier		Yes	
4th Quarter Carryover		No	
Physician Services		PPO (In-Network)	Non-PPO (Out-of-Network)
Physician Office Visits			
	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 Specialty Care Copayment Amount for office visit/consultation when services rendered by a Specialty Care Provider Including lab and x-ray (does not include Certain Diagnostic Procedures and surgical services). Copayment applies for each visit to the physician's office. Surgeries, therapies, and certain diagnostic procedures performed in a physician's office may be subject to the Deductible and/or coinsurance.	\$25 PCP Copay* \$40 Specialist Copay* \$25 MCNT/USMD PCP Copay* \$40 MCNT/USMD Specialist Copay* \$0 CareATC Copay	50% of Allowable Amount after Deductible 50% 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
Medical / Surgical Services			
	Physician inpatient hospital visits or surgical services performed in any setting	80% of Allowable Amount after Deductible	50% of Allowable Amount after Deductible
Virtual Visits – MD Live			
	Medical and Behavioral Health	\$25 Copay	NA
In-Vitro Fertilization Services		Decline	

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Hospital Services - Inpatient and Outpatient	PPO (In-Network)	Non-PPO (Out-of-Network)
Penalty for failure to preauthorize services	None	50%
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		
Hospital Admission Deductible		
Per admission, per individual	None	\$250
Inpatient Hospital Services		
All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units Room allowances based on the hospital's most common semi-private room rates.	80% of Allowable Amount after Deductible	50% of Allowable Amount after Per-Admission deductible and Plan Year Deductible

Hospital Services - Inpatient & Outpatient	PPO (In-Network)	Non-PPO (Out-of-Network)
Outpatient Hospital Services		
Coverage for services performed in an outpatient facility or ambulatory surgical center. All other outpatient services and supplies Home Infusion Therapy (Services must be preauthorized)	80% of Allowable Amount after Deductible	50% of Allowable Amount after Deductible
Lab/X-Ray in other Outpatient Facilities , excluding Certain Diagnostic Procedures	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

Extended Care Services	PPO (In-Network)	Non-PPO (Out-of-Network)
Deductible Applies? Yes	80% of Allowable Amount after Deductible	50% of Allowable Amount after Deductible
Skilled Nursing (Minimum 25 visits)	100 visits per benefit period	
Home Health Care (Minimum 60 visits)	100 visits per benefit period	
Hospice Services	Unlimited	

Special Provisions Expenses	PPO (In-Network)	Non-PPO (Out-of-Network)
Mental Health & Chemical Dependency Treatment Services	Same as any other illness	
Penalty for failure to preauthorize services	Same as Inpatient Penalty (None INN / 50% OON)	
Emergency Room/Treatment Room		
Accidental Injury & Emergency Care		
Facility Charges	80% of Allowable Amount	
Physician Charges	80% of Allowable Amount	
Non-Emergency Care		
Facility Charges	80% of Allowable Amount	50% of Allowable Amount after Deductible
Physician Charges	80% of Allowable Amount	50% of Allowable Amount after Deductible
Urgent Care Services Urgent Care center visit, including lab & x-ray services (Copayment does not include Certain Diagnostic Procedures and surgical services)	80% of Allowable Amount	50% of Allowable Amount after Deductible
Ground and Air Ambulance Services	80% of Allowable Amount after Deductible	
Physical Medicine Services – Occupational, Physical, Speech and Chiropractic		
Physical Medicine Services (includes, but is not limited to physical, occupational, and manipulative therapy) Coverage for services provided by a physician or therapist. Includes Physical, Occupational, Speech and Chiropractic Services. 60 visits for Physical Medicine Services 20 visits for Chiropractic Services	100% of Allowable Amount after \$25 PCP / \$40 Specialist / \$25 Airrosti Copayment	50% of Allowable Amount after Deductible
Durable Medical Equipment	80% of Allowable Amount after Deductible	50% of Allowable Amount after Deductible

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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 Aid Maximum	Hearing Aids are limited to 1 per ear every 36 months; Coverage through age 18	
<i>Organ and Tissue Transplant Services</i>		BDC/BDC+ 100% of Allowable Amount, Deductible waived In network Non BDC/BDC+ 80% of Allowable Amount after Deductible Out of Network 50% of Allowable Amount after Per-Admission deductible and Plan Year Deductible	

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

** Primary Care/Specialty Care Copayments are defined in the Overall Payment Provisions section in this document.

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Pharmacy Benefits

Pharmacy Network	Traditional Select
Drug List	Balanced
Prescription Drug Deductible***	None
Prescription Drug Out-of-Pocket Maximum	All benefits, including prescription drug benefits (retail and mail service) apply to the Out-of-Pocket Maximum shown on page 1.
Specialty Drugs	Specialty Lockout with one grace fill.

Retail Copayment Amounts

Generic Drugs	\$0 Copayment
Preferred Brand Name Drugs	\$40 Copayment
Non-Preferred Brand Name Drugs	\$60 Copayment
Specialty Drugs	\$100 Copayment

Mail Order Copayment Amounts

ASO 90-day supply	2x Retail
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MAC level

Rx Enhanced-Members electing to purchase 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 Brand Name Drug, plus the applicable Copayment Amount. If "Brand Medically Necessary" is indicated on the prescription, the member will pay the Brand Name Copayment Amount.

*** 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.

Standard UM Programs (prior authorization and step therapy) and exclusions apply, including auto updates and FastPath.

This benefit summary is a Non-Grandfathered health plan. This is not a contract. This benefit summary does not contain a complete list of benefits available to you, nor does it contain a listing of exclusions, limitations and conditions that apply to the benefits shown. Full information can be found in the Certificate of Benefits.