

# Blue Edge HSA Plan - Employee Only

Non-Grandfathered



BlueCross BlueShield of Texas

## BENEFIT SUMMARY

Prepared for City of Irving

Funding: ASO

HSA: Hybrid (Aggregate Ded / Embedded OPX)

BlueChoice  
PPO Network

Effective Date: 10/1/2021

**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)
<b>Lifetime Maximum</b>		Unlimited	
<b>Individual/Family Coverage Deductible</b>			
Applies to all Eligible Expenses, unless otherwise indicated.		\$2,450 Individual	\$4,000 Individual
<b>Coinsurance</b>		80%	50%
<b>Individual/Family Medical Coverage Out-of-Pocket Expense (OPX) Limit</b>			
Deductible and Copayment applies to Out-of-Pocket		\$6,550 Individual	\$13,000 Individual
<b>Plan Year or Calendar Year Deductible/OPX</b>		Plan Year	
<b>Deductible/OPX credit from prior carrier</b>		Yes	
Physician Services		PPO (In-Network)	Non-PPO (Out-of-Network)
<b>Physician Office Visits</b>			
<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 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.		80% of Allowable Amount after Deductible  MCNT/USMD: 85% of Allowable Amount after Deductible  CareATC Visit - \$40 Charge	50% of Allowable Amount after Deductible
<b>Preventive Care</b>			
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
<b>Medical / Surgical Services</b>			
Physician inpatient hospital visits or surgical services performed in any setting		80% of Allowable Amount after Deductible	50% of Allowable Amount after Deductible
<b>Virtual Visits – MD Live</b>			
Medical and Behavioral Health		80% of Allowable Amount after Deductible	NA
<b>In-Vitro Fertilization Services</b>		Decline	

\* 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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<b>Hospital Services - Inpatient and Outpatient</b>		<b>PPO (In-Network)</b>	<b>Non-PPO (Out-of-Network)</b>
<b>Penalty for failure to preauthorize services</b>		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			
<b>Hospital Admission Deductible</b>			
Per admission, per individual		None	None
<b>Inpatient Hospital Services</b>			
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 Deductible
<b>Outpatient Hospital Services</b>			
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
<b>Lab/X-Ray in other Outpatient Facilities</b> , excluding Certain Diagnostic Procedures		80% of Allowable Amount after Deductible	50% of Allowable Amount after Deductible
<b>Certain Diagnostic Procedures</b> 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
<b>Extended Care Services</b>		<b>PPO (In-Network)</b>	<b>Non-PPO (Out-of-Network)</b>
<b>Deductible Applies?</b> Yes		80% of Allowable Amount after Deductible	50% of Allowable Amount after Deductible
<b>Skilled Nursing (Minimum 25 visits)</b>		100 visits per benefit period	
<b>Home Health Care (Minimum 60 visits)</b>		100 visits per benefit period	
<b>Hospice Services</b>		Unlimited	
<b>Special Provisions Expenses</b>		<b>PPO (In-Network)</b>	<b>Non-PPO (Out-of-Network)</b>
<b>Mental Health &amp; Chemical Dependency Treatment Services</b>		Same as any other illness	
<b>Penalty for failure to preauthorize services</b>		Same as Inpatient Penalty (None INN / 50% OON)	
<b>Emergency Room/Treatment Room</b>			
<b>Accidental Injury &amp; Emergency Care</b>			
Facility Charges		80% of Allowable Amount after Deductible	
Physician Charges		80% of Allowable Amount after Deductible	
<b>Non-Emergency Care</b>			
Facility Charges		80% of Allowable Amount after Deductible	50% of Allowable Amount after Deductible
Physician Charges		80% of Allowable Amount after Deductible	50% of Allowable Amount after Deductible
<b>Urgent Care Services</b> Urgent Care center visit, including lab & x-ray services (Copayment does not include Certain Diagnostic Procedures and surgical services)		80% of Allowable Amount after Deductible	50% of Allowable Amount after Deductible
<b>Ground and Air Ambulance Services</b>		80% of Allowable Amount after Deductible	
<b>Physical Medicine Services – Occupational, Physical, Speech and Chiropractic</b>			
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 per plan year – Physical Medicine Services 20 visits per plan year – Chiropractic Services		80% of Allowable Amount after Deductible	50% of Allowable Amount after Deductible
		Airrosti: 85% of Allowable Amount after Deductible	
<b>Durable Medical Equipment</b>		80% of Allowable Amount after Deductible	50% of Allowable Amount after Deductible
<b>Speech and Hearing Services</b>			
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
<b>Hearing Aid Maximum</b>		Hearing Aids are limited to 1 per ear every 36 months; coverage through age 18	

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***Organ and Tissue Transplant Services***

*BDC/BDC+ 100% of Allowable Amount after Deductible*

*In network Non BDC/BDC+ 80% of Allowable Amount after  
Deductible*

*Out of Network 50% of Allowable Amount after Deductible*

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## Pharmacy Benefits

<b>Pharmacy Network</b>	Traditional Select
<b>Drug List</b>	Balanced
<b>Prescription Drug Deductible***</b>	All benefits, including prescription drug benefits (retail and mail service) apply to Deductible shown on page 1. Deductible will apply to the Out-of-Pocket Maximum
<b>Prescription Drug Out-of-Pocket Maximum</b>	All benefits, including prescription drug benefits (retail and mail service) apply to the Out-of-Pocket Maximum shown on page 1.
<b>Specialty Drugs</b>	Specialty Lockout with one grace fill.

## Retail Copayment Amounts

<b>Generic Drugs</b>	20% after Deductible
<b>Preferred Brand Name Drugs</b>	20% after Deductible
<b>Non-Preferred Brand Name Drugs</b>	20% after Deductible
<b>Specialty</b>	20% after Deductible

## Mail Order Copayment Amounts

<b>ASO 90-day supply</b>	2x Retail
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<b>MAC level</b>	<b>Rx Enhanced</b> -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.
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\*\*\* 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.