

SCHEDULE OF COVERAGE

Benefits described in this booklet apply only if also listed here.

Coverage Code - B09, B10

Dept. - 0000-0006

Group No. – 67099

TYPE OF SERVICE	NETWORK	OUT-OF-NETWORK
GENERAL PROVISIONS		
Calendar Year Deductible (CYD) (Applies to Non-Inpatient Hospital Services)	\$250 Indiv/\$500 Family	\$250 Indiv/\$500 Family
4 th Quarter Carryover Applies	Yes	Yes
Deductible Credit from Prior Carrier	N/A	N/A
Coshare Stoploss Maximum	\$1,500 Indiv/\$3,000 Family per cal. yr.	\$2,000 Indiv/\$4,000 Family per cal. yr.
	In-Network deductible and coshare will only apply toward Network deductible and coshare	Out-of-Network deductible and coshare will also apply toward Network deductible and coshare
Coshare Stoploss Credit from Prior Carrier	N/A	N/A
Lifetime Maximum per Participant	\$1,000,000	
INPATIENT HOSPITAL SERVICES (must be precertified)	90% after CYD	80% after CYD
Per Individual Per Year Deductible	\$100	\$100
Penalty for Failure to Precertify	None	\$250
EMERGENCY ROOM/TREATMENT ROOM		
Accident & Medical Emergency Situation within 48 Hours		
Facility Charges	90% after \$50 copay, waived if admitted	
Physician Charges	90% after CYD	
Non-Emergency Situations		
Facility Charges	90% after \$50 copay, waived if admitted	80% after CYD
Physician Charges	90% after CYD	80% after CYD
MEDICAL-SURGICAL SERVICES		
Services Performed in Physician Office (non-surgical), Including Lab & X-ray	100% after \$25 copay per visit	80% after CYD
Immunizations (birth to the day of the 6 th birthdate)	100%	100%
Physician Surgical Services in any In-Patient	90% after CYD	80% after CYD
Physician Surgical Services in any Out-Patient	90%	80%
Lab & X-Ray in Other Outpatient Facilities (excluding Certain Diagnostic Procedures):	90%	80%
<ul style="list-style-type: none"> • Certain Diagnostic Procedures: Bone Scan, Cardiac Stress Test, CT Scan (with or without contrast), Ultrasound, MRI, Myelogram, PET Scan 		
Home Infusion Therapy (must be precertified)	90% after CYD	80% after CYD
In-Vitro Fertilization	Declined	
Chiropractic Care – Office Services	90% after CYD	80% after CYD
	\$1,500 cal. yr. max.	\$1,500 cal. yr. max.
	All Other Physical Medicine Services rendered by any other eligible Provider will be allowed on the same basis as any other sickness.	
Speech and Hearing Services without Hearing Aids	Covered as any other sickness	Covered as any other sickness
All Other Outpatient Services and Supplies	90% after CYD	80% after CYD
PREVENTIVE CARE		
Routine Physicals, Well Baby Care, Immunizations (after 6 th birthdate), Vision & Hearing Exams	100% after \$25 copay per visit	80% deductible waived

TYPE OF SERVICE	NETWORK	OUT-OF-NETWORK
EXTENDED CARE SERVICES (must be precertified)	100%	80% after CYD
Home Health Care	NO LIMIT (EXCEPT LIFETIME MAXIMUM)	NO LIMIT (EXCEPT LIFETIME MAXIMUM)
Skilled Nursing Facility	\$10,000 per cal. yr.	\$7,000 per cal. yr.
Hospice Care	NO LIMIT (EXCEPT LIFETIME MAXIMUM)	NO LIMIT (EXCEPT LIFETIME MAXIMUM)
	Benefits used in Network or Out-of-Network apply towards satisfying both maximums.	
MENTAL HEALTH/CHEMICAL DEPENDENCY (must be precertified)		
Inpatient Services		
Hospital Services (Facility)	90% after CYD	80% after CYD
Physician Services	90% after CYD	80% after CYD
Calendar Year Limitations	45 inpatient days/45 physician visits	
	Days and visits used in Network or Out-of-Network apply towards satisfying both maximums.	
Outpatient Services		
Office Visit/Consultation	100% after \$25 copay	80% after CYD
Emergency Room/Treatment Room/Facility Charges	90% after \$50 copay, waived if admitted	80% after CYD
Professional Provider Visits Allowed	90% after CYD	80% after CYD
	60 outpatient visits per cal. yr.	
Chemical Dependency Maximum for each Covered Individual	NO LIMIT (EXCEPT LIFETIME MAXIMUM)	NO LIMIT (EXCEPT LIFETIME MAXIMUM)
SERIOUS MENTAL ILLNESS (must be precertified)	Covered as any other sickness	
PRESCRIPTION DRUGS	NOT COVERED	

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.
- Employees and eligible dependents who reside outside the service area will receive the Traditional Benefits and are responsible for the precertification process, and in some cases, may be responsible for filing the claim.
- The following benefits apply to dependent coverage:
 - Dependent children are covered to age 25. Grandchildren are not covered for health.
 - 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.
 - Dependent daughters are not covered for maternity – ONLY COMPLICATIONS.
- Provider charges are paid according to BCBSTX determined Allowable Amount and negotiated prices.
- 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.

NO WAITING PERIOD FOR PRE-EXISTING CONDITIONS.

Coverage Code – B1B, B2P

Dept. - 0000-0006

Group No. – 67099

TYPE OF SERVICE	TRADITIONAL BENEFITS
GENERAL PROVISIONS	
Calendar Year Deductible (CYD) (Applies to Non-Inpatient Hospital Services)	\$250 Indiv/\$500 Family
4 th Quarter Carryover Applies	Yes
Deductible Credit from Prior Carrier	N/A
Coshare Stoploss Maximum	\$1,500 Indiv/\$3,000 Family per calendar year
Coshare Stoploss Credit from Prior Carrier	N/A
Lifetime Maximum per Participant	\$1,000,000
INPATIENT HOSPITAL SERVICES (must be precertified)	90% after CYD
Per Individual Per Year Deductible	\$100
Penalty for Failure to Precertify	\$250
EMERGENCY ROOM/TREATMENT ROOM	
Accident & Medical Emergency Situation within 48 Hours	
Facility Charges	90% after CYD
Physician Charges	90% after CYD
Non-Emergency Situations	
Facility Charges	90% after CYD
Physician Charges	90% after CYD
MEDICAL-SURGICAL SERVICES	
Physical Surgical Services In-Patient Setting	90% after CYD
Physical Surgical Services Out-Patient Setting	90% after CYD
Immunizations (birth to the day of the 6 th birthdate)	100%
Home Infusion Therapy (must be precertified)	90% after CYD
Invitro Fertilization Services	Declined
Chiropractic Care – Office Services	90% after CYD, \$1,500 cal. yr. maximum
	All Other Physical Medicine Services rendered by any other eligible Provider will be allowed on the same basis as any other sickness.
Speech and Hearing Services without Hearing Aids	Covered as any other sickness
PREVENTIVE CARE	
Routine Physicals, Well Baby Care, Immunizations (after 6 th birthdate), Vision & Hearing Exams	90%
Maximum Benefit	\$300 per 2-year period per participant
EXTENDED CARE SERVICES (must be precertified)	100%
Home Health Care	NO LIMIT (EXCEPT LIFETIME MAXIMUM)
Skilled Nursing Facility	\$10,000 PER CALENDAR YEAR
Hospice Care	NO LIMIT (EXCEPT LIFETIME MAXIMUM)
MENTAL HEALTH/CHEMICAL DEPENDENCY	
Inpatient Services (must be precertified)	90% after CYD/45 days per cal. yr.
Hospital Services (Facility)	90% after PCYD/45 days per cal. yr.
Physician Services	90%, after CYD /45 visits per cal. yr.
Outpatient Services	
Office Visit/Consultation	90% after CYD
Professional Provider/Facility	90% after CYD
Number of Outpatient Visits	60 visits per cal. yr.
Chemical Dependency Maximum for each Covered Individual	NO LIMIT (EXCEPT LIFETIME MAXIMUM)
SERIOUS MENTAL ILLNESS (For Public Entities) (must be precertified)	Covered as any other sickness
PRESCRIPTION DRUGS	NOT COVERED

