



# TEXAS ASSOCIATION of COUNTIES HEALTH AND EMPLOYEE BENEFITS POOL

## BENEFIT HIGHLIGHTS Plan 1300 NGS

## BlueChoice Network

(Non-Grandfathered ACA Plan)

This is a general summary of your benefits. Please refer to your benefit booklet for additional details and a description of the plan requirements and benefit design. This plan does not cover all health care expenses. Upon receipt of your benefit booklet, carefully review the plan's limitations and exclusions.

Overall Payment Provisions	In-Network Benefits	Out-of-Network Benefits
<p><b>Deductibles</b></p> <p>Per-admission Deductible Deductible <i>Applies to all Eligible Expenses except Inpatient Hospital Expenses (unless otherwise indicated)</i></p> <p>Three-month Deductible carryover applies Deductible credit from prior carrier (Applied on initial group enrollment only)</p>	<p>\$0 \$1,500 Individual / \$4,500 Family</p> <p>Yes Yes</p>	<p>\$0 \$4,500 Individual / \$13,500 Family</p> <p>Yes Yes</p>
<p><b>CoShare Stoploss Maximum</b></p> <p>Deductibles are not applied to CoShare Stoploss Maximum. Copayment Amounts will apply and will not be required after CoShare Stoploss Maximum has been satisfied. Your benefit booklet will provide more details.</p> <p>Credit for Coshare Stoploss Maximum from prior carrier (Applied on initial group enrollment only)</p>	<p>\$3,500 Individual / \$8,200 Family</p> <p><i>Network Deductible &amp; CoShare Stoploss Maximum will only apply toward Network Deductible &amp; CoShare Stoploss Maximum</i></p> <p>Yes</p>	<p>\$7,000 Individual / \$21,000 Family</p> <p><i>Out-of-Network Deductible &amp; CoShare Stoploss Maximum will also apply toward Network Deductible &amp; CoShare Stoploss Maximum</i></p> <p>Yes</p>
<p><b>Copayment Amounts Required</b></p> <p>Physician office visit/consultation <i>Refer to Medical/Surgical Expenses section for more information</i></p> <p><b>Specialty Care Copayment Amount</b> for office visit/consultation when services rendered by a Specialty Care Provider</p> <p>Outpatient Hospital Emergency Room/Treatment Room <i>Refer to Emergency Room/Treatment Room section for more information</i></p>	<p>\$30 Copayment Amount</p> <p>\$40 Copayment Amount</p> <p>\$150 Copayment Amount</p>	<p><i>N/A-Refer to Medical/Surgical Expense section for benefits</i></p> <p><i>60% of Allowable Amount after Calendar Year Deductible</i></p> <p>\$150 Copayment Amount</p>
<p><b>Maximum Lifetime Benefits</b></p> <p>Per Participant</p>	<p>Unlimited</p>	
<p><b>Inpatient Hospital Expenses</b></p>		
<p><b>Inpatient Hospital Expenses</b></p> <p><i>All services must be preauthorized</i> <i>All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units</i></p> <p>Penalty for failure to preauthorize services</p>	<p>80% of Allowable Amount</p> <p>None</p>	<p>60% of Allowable Amount</p> <p>\$250</p>



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<b>Medical/Surgical Expenses</b>	<b>In-Network Benefits</b>	<b>Out-of-Network Benefits</b>
<b>Medical / Surgical Expenses</b> Services performed during the Physician's office visit/consultation, including lab & x-ray (does not include Certain Diagnostic Procedures and surgical services)	100% of Allowable Amount after \$30 Copayment	70% of Allowable Amount after Calendar Year Deductible
Lab & x-ray in other outpatient facilities (excluding Certain Diagnostic Procedures)	100% of Allowable Amount	70% of Allowable Amount after Calendar Year Deductible
Allergy Injections	100% of Allowable Amount	70% of Allowable Amount after Calendar Year Deductible
Colonoscopy (All places of treatment and diagnoses)	100% of Allowable Amount	70% of Allowable Amount after Calendar Year Deductible
Physician surgical services performed in any setting	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Certain Diagnostic Procedures; such as Bone Scan, Cardiac Stress Test, CT -Scan (with or without contrast), Ultrasound, MRI, Myelogram, PET Scan.	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Home Infusion Therapy (Services must be preauthorized)	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Organ Transplants	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
All other outpatient services and supplies	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
In Vitro Fertilization Services	Declined	

<b>Extended Care Expenses</b>		
<b>Extended Care Expenses</b> All services must be preauthorized	100% of Allowable Amount	70% of Allowable Amount after Calendar Year Deductible
Skilled Nursing Facility Home Health Care Hospice Care	25 day maximum each Calendar Year* 60 visit maximum each Calendar Year* Unlimited	

<b>Special Provisions Expenses</b>		
<b>Serious Mental Illness</b> All services must be preauthorized		
<b>Inpatient Services</b>		
-Hospital services (facility)	80% of Allowable Amount	60% of Allowable Amount
-Physician services	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
<b>Outpatient Services</b>		
-Services performed during Physician office visit/consultation (does not include psychological testing)	100% of Allowable Amount after \$30 Copayment	60% of Allowable Amount after Calendar Year Deductible
-All outpatient services and psychological testing	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible

\* Benefits used In-Network and Out-of-Network will apply toward satisfying any day, visit, Calendar Year, Plan Year, Annual Maximum, series of treatments benefits indicated

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## Special Provisions Expenses, cont.

### In-Network Benefits

### Out-of-network Benefits

### Mental Health Care/Chemical Dependency

All services must be preauthorized

#### Inpatient Services

-Hospital services (facility)

80% of Allowable Amount

60% of Allowable Amount

-Physician services

80% of Allowable Amount after  
Calendar Year Deductible

60% of Allowable Amount after  
Calendar Year Deductible

#### Calendar Year Maximum

30 inpatient days/30 inpatient Physician  
visits each Calendar Year\*

30 inpatient days/30 inpatient  
Physician visits each Calendar Year\*

#### Outpatient Services

-Services performed during Physician office visit/consultation  
(does not include psychological testing)

100% of Allowable Amount after \$30  
Copayment Amount

70% of Allowable Amount after  
Calendar Year Deductible

-Emergency Room/Treatment Room

80% of Allowable Amount after  
\$150 Copayment Amount  
  
(Copayment Amount waived if admitted,  
Inpatient Hospital Expenses will apply)

60% of Allowable Amount after \$150  
Copayment Amount & Calendar Year  
Deductible  
  
(Copayment Amount waived if  
admitted, Inpatient Hospital Expenses  
will apply)

-Other Outpatient Services and psychological testing

80% of Allowable Amount after  
Calendar Year Deductible

60% of Allowable Amount after  
Calendar Year Deductible

#### Calendar Year Maximum

30 outpatient visits each Calendar Year\*

#### Chemical Dependency Maximum

(Inpatient treatment must be provided in a Chemical Dependency  
Treatment Center)

Limited to three separate series of treatments for each covered individual per  
lifetime \*

### Emergency Room/Treatment Room

#### Accidental Injury & Emergency Care

-Facility charges (outpatient Hospital emergency treatment room  
charges)

80% of Allowable Amount after \$150 Copayment Amount  
(Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply)

-Physician charges

80% of Allowable Amount after Calendar Year Deductible

#### Non-Emergency Care

-Facility charges (outpatient Hospital emergency treatment room  
charges)

80% of Allowable Amount after \$150  
Copayment Amount  
(Copayment Amount waived if admitted,  
Inpatient Hospital Expenses will apply)

60% of Allowable Amount after \$150  
Copayment Amount & Calendar Year  
Deductible  
(Copayment Amount waived if  
admitted, Inpatient Hospital Expenses  
will apply)

-Physician charges

80% of Allowable Amount after  
Calendar Year Deductible

60% of Allowable Amount after  
Calendar Year Deductible

### Ground and Air Ambulance Services

80% of Allowable Amount after Calendar Year Deductible

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<b>Special Provisions Expenses, cont.</b>	<b>In-Network Benefits</b>	<b>Out-of-network Benefits</b>
<b>Preventive Care</b>		
Routine annual physical examinations, well-baby care exams, immunizations 6 years of age & over, vision exams, hearing exams, and any other preventive health services as determined by USPSTF	100% of Allowable Amount	70% of Allowable Amount after Calendar Year Deductible
Immunizations for Dependent children through the date of the child's 6 <sup>th</sup> birthday	100% of Allowable Amount	100% of Allowable Amount
<b>Speech and Hearing Services</b>		
Services to restore loss of or correct an impaired speech or hearing function without hearing aids	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
<b>Physical Medicine Services</b>		
Chiropractic Care-Office Services	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Calendar Year Maximum	35 visit maximum each Calendar Year*	
	<i>All other Physical Medicine Services rendered by any other eligible Provider will be allowed on the same basis as any other sickness.</i>	

\* Benefits used In-Network and Out-of-Network will apply toward satisfying any day, visit, Calendar Year, Plan Year, Annual Maximum, series of treatments benefits indicated

## 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.

The following benefits apply to dependent coverage:

- Dependent children are covered to age 26.
- 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.

**Payments:** Network providers agree to accept amounts negotiated with BCBSTX and are paid according to this BCBSTX-determined Allowable Amount. Covered individuals are responsible for any required Deductibles, Coinsurance Amounts, and Copayments. Plan benefits paid to Out-of-Network providers are based on the BCBSTX-determined Allowable Amount, except in the event of Emergency Care received in an outpatient hospital emergency treatment room within 48 hours of the incident. For all other services received by an Out-of-Network Provider, he covered individual will be responsible for charges in excess of the Allowable Amount in addition to any applicable Deductibles, Coinsurance Amounts, and Copayments. For cost savings information, refer to the section on ParPlan Providers and the definition of Allowable Amount in the benefit booklet.

**Preexisting conditions Provision:** Benefits for Eligible Expenses incurred for treatment of a Preexisting Condition will not be available during the twelve-month period following the individual's initial Effective Date, or if a Waiting Period applies, the first day of the Waiting Period. In accordance with state and federal law, certain conditions will not be considered Preexisting Conditions and the Preexisting Condition exclusion will not apply to certain individuals. Details are provided in the benefit booklet.

**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.

Initials \_\_\_\_\_ Date \_\_\_\_\_