Texas Association of Counties Health and Employee Benefits Pool

BENEFIT HIGHLIGHTS

Plan 1300-NGS

(Non-Grandfathered ACA Plan)

BlueChoice Network

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
Deductibles		
Per-admission Deductible	*$0*	*$0*
Deductible *Applies to all Eligible Expenses except Inpatient Hospital Expenses (unless otherwise indicated)*	*$1,500 Individual / $4,500 Family*	*$4,500 Individual / $13,500 Family*
CoShare Stoploss Maximum		
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.	*$3,500 Individual / $8,700 Family* *Network Deductible & CoShare Stoploss Maximum **will only** apply toward Network Deductible & CoShare Stoploss Maximum*	*$7,000 Individual / $21,000 Family* *Out-of-Network Deductible & CoShare Stoploss Maximum **do not** apply toward Network Deductible & CoShare Stoploss Maximum*
Credit for Coshare Stoploss Maximum from prior carrier (Applied on initial group enrollment only)	*Yes*	*Yes*
Copayment Amounts Required		
Physician office visit/consultation *Refer to Medical/Surgical Expenses section for more information*	*$30 Copayment Amount*	*N/A-Refer to Medical/Surgical Expense section for benefits*
Specialty Care Copayment Amount for office visit/consultation when services rendered by a Specialty Care Provider	*$40 Copayment Amount*	*70% of Allowable Amount after Plan Year Deductible*
Urgent Care	*$30 / $40 Copayment Amount*	*70% of Allowable Amount*
Outpatient Hospital Emergency Room/Treatment Room *Refer to Emergency Room/Treatment Room section for more information*	*$150 Copayment Amount*	*$150 Copayment Amount*
Maximum Lifetime Benefits		
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	*80% of Allowable Amount*	*60% of Allowable Amount*
Penalty for failure to preauthorize services	*None*	*$250*

BlueCross BlueShield of Texas

Initials _____ Date _____

Medical/Surgical Expenses	In-Network Benefits	Out-of-Network Benefits
Medical / Surgical Expenses		
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 Plan Year Deductible*
Lab & x-ray in other outpatient facilities (excluding Certain Diagnostic Procedures)	*100% of Allowable Amount*	*70% of Allowable Amount after Plan Year Deductible*
Allergy Injections	*100% of Allowable Amount*	*70% of Allowable Amount after Plan Year Deductible*
Colonoscopy (All places of treatment and diagnoses)	*100% of Allowable Amount*	*70% of Allowable Amount after Plan Year Deductible*
Physician surgical services performed in any setting	*80% of Allowable Amount after Plan Year Deductible*	*60% of Allowable Amount after Plan 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 Plan Year Deductible*	*60% of Allowable Amount after Plan Year Deductible*
Home Infusion Therapy *(Services must be preauthorized)*	*80% of Allowable Amount after Plan Year Deductible*	*60% of Allowable Amount after Plan Year Deductible*
Organ Transplants	*80% of Allowable Amount after Plan Year Deductible*	*60% of Allowable Amount after Plan Year Deductible*
All other outpatient services and supplies	*80% of Allowable Amount after Plan Year Deductible*	*60% of Allowable Amount after Plan Year Deductible*
In Vitro Fertilization Services	*Declined*	

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

Special Provisions Expenses		
Serious Mental Illness *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 Plan Year Deductible*	*60% of Allowable Amount after Plan Year Deductible*
Outpatient Services		
-Services performed during Physician office visit/consultation (does not include psychological testing)	*100% of Allowable Amount after $30 Copayment*	*60% of Allowable Amount after Plan Year Deductible*
-All outpatient services and psychological testing	*80% of Allowable Amount after Plan Year Deductible*	*60% of Allowable Amount after Plan Year Deductible*

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

Initials _____ Date _____

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 Plan Year Deductible*	*60% of Allowable Amount after Plan Year Deductible*
Plan Year Maximum	*30 inpatient days/30 inpatient Physician visits each Plan Year**	*30 inpatient days/30 inpatient Physician visits each Plan 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 Plan 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 & Plan Year Deductible (Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply)*
-Other Outpatient Services and psychological testing	*80% of Allowable Amount after Plan Year Deductible*	*60% of Allowable Amount after Plan Year Deductible*
Plan Year Maximum	*30 outpatient visits each Plan 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 Plan 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 & Plan Year Deductible (Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply)*
-Physician charges	*80% of Allowable Amount after Plan Year Deductible*	*60% of Allowable Amount after Plan Year Deductible*
Ground and Air Ambulance Services	*80% of Allowable Amount after Plan Year Deductible*	

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

Initials _____ Date _____

Special Provisions Expenses, cont.	In-Network Benefits	Out-of-network Benefits
Preventive Care		
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 Plan Year Deductible*
Immunizations for Dependent children through the date of the child's 6th birthday	*100% of Allowable Amount*	*100% of Allowable Amount*
Speech and Hearing Services		
Services to restore loss of or correct an impaired speech or hearing function without hearing aids	*80% of Allowable Amount after Plan Year Deductible*	*60% of Allowable Amount after Plan Year Deductible*
Physical Medicine Services		
Chiropractic Care-Office Services	*80% of Allowable Amount after Plan Year Deductible*	*60% of Allowable Amount after Plan Year Deductible*
Plan Year Maximum	*35 visit maximum each Plan Year**	
	All other Physical Medicine Services rendered by any other eligible Provider will be allowed on the same basis as any other sickness.	

* Benefits used In-Network and Out-of-Network will apply toward satisfying any day, visit, 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, the 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.

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 _____