Blue Cross and Blue Shield of Texas*
Summary of Benefits Prepared for Comal Independent School District
Group #06481

PPO – Plan 2 Middle Option Fully Insured

☒ BlueChoice ☐ BlueChoice Solutions

TYPE OF SERVICE	NETWORK	OUT-OF-NETWORK
GENERAL PROVISIONS		
Calendar Year Deductible (Applies to Non-Inpatient Hospital Services)	$1000 Individual/$2000 Family	$2000 Individual/$4000 Family
4th Quarter Carryover Applies	Yes	Yes
Deductible Credit from Prior Carrier	Yes	Yes
Coinsurance Stoploss Maximum	$2500 Indiv/$5000 Family per cal. yr.	$5000 Indiv/$10000 Family per cal. yr.
Coinsurance Stoploss Credit from Prior Carrier	Yes	Yes
	Network deductible and coinsurance will only apply toward Network deductible and coinsurance	*Out-of-Network deductible and coinsurance will also apply toward Network deductible and coinsurance*
Lifetime Maximum per Participant	$2,000,000	
INPATIENT HOSPITAL SERVICES (must be Preauthorized)	80%	60% after per adm. deductible
Per Admission Deductible	$150	$250
Penalty for Failure to Preauthorize	None	$250
EMERGENCY ROOM/TREATMENT ROOM		
Accident & Medical Emergency Situation within 48 Hours		
Facility Charges	80% after $100 copay, waived if admitted	
Physician Charges	80% after cal. yr. deductible	
Non-Emergency Situations		
Facility Charges	80% after $100 copay, waived if admitted	60% after $100 copay & cal. yr. deductible, waived if admitted
Physician Charges	80% after cal. yr. deductible	60% after cal. yr. deductible
MEDICAL-SURGICAL SERVICES		
Services Performed in Physician Office (non-surgical), Including Lab & X-ray (excluding Certain Diagnostic Procedures)	100% after $25 copay per visit	70% after cal. yr. deductible
Immunizations (birth to the day of the 6th birthdate)	100%	100%
Physician Surgical Services in any Setting	80% after cal. yr. deductible	60% after cal. yr. deductible
Lab & X-Ray in Other Outpatient Facilities (excluding Certain Diagnostic Procedures):	100%	70% after cal. yr. deductible
• Certain Diagnostic Procedures: Bone Scan, Cardiac Stress Test, CT Scan (with or without contrast), Ultrasound, MRI, Myelogram, PET Scan	80% after cal. yr. deductible	60% after cal. yr. deductible
Home Infusion Therapy (must be Preauthorized)	80% after cal. yr. deductible	60% after cal. yr. deductible
In-Vitro Fertilization	Declined	
Physical Medicine Services (Physical, Occupational, and Manipulative Therapy)	80% after cal. yr. deductible	60% after cal. yr. deductible
	$1,500 cal. yr. max.	
Speech and Hearing Services with Hearing Aids	Covered as any other sickness	Covered as any other sickness
	$1,000 maximum benefit per 36-month period for Hearing Aids	
All Other Outpatient Services and Supplies	80% after cal. yr. deductible	60% after cal. yr. deductible

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TYPE OF SERVICE	NETWORK	OUT-OF-NETWORK
PREVENTIVE CARE		
Routine Physicals, Well Baby Care, Immunizations (after 6th birthdate), Vision & Hearing Exams	100% after $25 copay per visit	70% after cal. yr. deductible
EXTENDED CARE SERVICES (must be Preauthorized)	100%	70% after cal. yr. deductible
Home Health Care		
Calendar Year Maximum	$10,000 per cal. yr.	
Skilled Nursing Facility	$10,000 per cal. yr.	
Hospice Care	$20,000 lifetime max.	
	Benefits used in Network or Out-of-Network apply towards satisfying both maximums.	
MENTAL HEALTH (must be Preauthorized)		
Inpatient Services		
Hospital Services (Facility)	80%	60% after per adm. deductible
Physician Services	80% after cal. yr. deductible	60% after cal. yr. deductible
Calendar Year Limitations	30 inpatient days/30 physician visits	
	Days and Visits used in Network or Out-of-Network apply towards satisfying both maximums.	
Outpatient Services		
Services Performed in Physician Office (non-surgical)	100% after $25 copay	70% after cal. yr. deductible
Emergency Room/Treatment Room/Facility Charges (non-emergency only)	80% after $100 copay, waived if admitted	60% after $100 copay & cal. yr. deductible, waived if admitted
Professional Provider	80% after cal. yr. deductible	60% after cal. yr. deductible
Visits Allowed	30 visits per cal. yr.	
CHEMICAL DEPENDENCY in a Substance Abuse Facility (must be Preauthorized)	Three separate series of treatments for each covered individual/Covered as any other sickness	
All Other Outpatient Treatment	Covered as any other sickness	
SERIOUS MENTAL ILLNESS (For Public Entities) (must be Preauthorized)	Covered as any other sickness	

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TYPE OF SERVICE	PARTICIPATING PHARMACY	NON-PARTICIPATING PHARMACY (member files claim)
PRESCRIPTION DRUG PROGRAM*	$50 combined Retail & Mail Service Pharmacy Deductible** per Calendar Year	
Retail Prescription (all copays are per 30-day supply and will not apply to coinsurance stoploss maximum)		
Non-Preferred Brand Name	$50 copay	80% of Allowable Amount minus copay
Preferred Brand Name	$25 copay	80% of Allowable Amount minus copay
Generic	$10 copay	80% of Allowable Amount minus copay
Mail Service Prescription (all copays are per 90-day supply and will not apply to coinsurance stoploss maximum)	Yes	
Non-Preferred Brand Name	$100 copay	
Preferred Brand Name	$50 copay	
Generic	$20 copay	

Rx Enhanced *- Members electing to purchase preferred/non-preferred 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 preferred/non-preferred brand name drug, plus the preferred brand name copay. If "Brand Medically Necessary" is indicated on the prescription, the member will pay the preferred or non-preferred brand name copay.*

Diabetes Supplies are available under the Prescription Drug Program portion of your plan. Diabetes 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.

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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 covered for maternity benefits.
  - Dependent children are covered to age 25. Disabled dependent children can be covered beyond age 25.
  - 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.
- Provider charges are paid according to BCBSTX determined Allowable Amount and negotiated prices.
- Preexisting conditions are defined in the benefit booklet and are excluded for 12 months. Appropriate credit will be given for time served under another health benefit plan as defined under the law.
- Replacement of Medical Coverage: In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Texas State law, 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.
  - Traditional benefits are not provided under this Plan unless you have employees or dependents residing in State(s) with no network or in locations in states where there is not a network services area. State(s) with no network: Montana. States with limited service: Kansas: Statewide network, except Johnson and Wyandotte counties; Oklahoma: Metropolitan areas of Oklahoma City, Tulsa, Lawton, Edmond, Shawnee, Hugo, Tahlequah, Cushing, Poteau, Pryor and some other communities; Virginia: Statewide network, except Amherst, Appomattox, Campbell, Culpepper counties and the City of Lynchburg; Wisconsin: Statewide, except some rural areas; Wyoming: Laramie County only. Please notify your service representative if you acquire employees or their dependents in these locations after the effective date of the Plan.

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