

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

**PPO – Plan 1 High Option Fully Insured**

**BlueChoice**     **BlueChoice Solutions**

<b>TYPE OF SERVICE</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>GENERAL PROVISIONS</b>		
Calendar Year Deductible (Applies to Non-Inpatient Hospital Services)	\$500 Individual/\$1000 Family	\$1000 Individual/\$2000 Family
4 <sup>th</sup> Quarter Carryover Applies	Yes	Yes
Deductible Credit from Prior Carrier	Yes	Yes
Coinsurance Stoploss Maximum	\$1500 Indiv/\$3000 Family per cal. yr.	\$3000 Indiv/\$6000 Family per cal. yr.
Coinsurance Stoploss Credit from Prior Carrier	Yes	Yes
	<i>Network deductible and coinsurance will only apply toward Network deductible and coinsurance</i>	<i>Out-of-Network deductible and coinsurance will also apply toward Network deductible and coinsurance</i>
Lifetime Maximum per Participant		\$2,000,000
<b>INPATIENT HOSPITAL SERVICES (must be Preauthorized)</b>		
Per Admission Deductible	90%	70% after per adm. deductible
Penalty for Failure to Preauthorize	\$150	\$250
	None	\$250
<b>EMERGENCY ROOM/TREATMENT ROOM</b>		
<b>Accident &amp; Medical Emergency Situation within 48 Hours</b>		
Facility Charges	90% after \$50 copay, waived if admitted	
Physician Charges	90% after cal. yr. deductible	
<b>Non-Emergency Situations</b>		
Facility Charges	90% after \$50 copay, waived if admitted	70% after \$50 copay & cal. yr. deductible, waived if admitted
Physician Charges	90% after cal. yr. deductible	70% after cal. yr. deductible
<b>MEDICAL-SURGICAL SERVICES</b>		
Services Performed in Physician Office (non-surgical), Including Lab & X-ray (excluding Certain Diagnostic Procedures)	100% after \$20 copay per visit	70% after cal. yr. deductible
Immunizations (birth to the day of the 6 <sup>th</sup> birthdate)	100%	100%
Physician Surgical Services in any Setting	90% after cal. yr. deductible	70% 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	90% after cal. yr. deductible	70% after cal. yr. deductible
Home Infusion Therapy (must be Preauthorized)	90% after cal. yr. deductible	70% after cal. yr. deductible
In-Vitro Fertilization	Declined	
Physical Medicine Services (Physical, Occupational, and Manipulative Therapy)	90% after cal. yr. deductible	70% after cal. yr. deductible
	\$1,500 cal. yr. max.	
Speech and Hearing Services with Hearing Aids	Covered as any other sickness \$1,000 maximum benefit per 36-month period for Hearing Aids	Covered as any other sickness
All Other Outpatient Services and Supplies	90% after cal. yr. deductible	70% after cal. yr. deductible

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<b>PREVENTIVE CARE</b> Routine Physicals, Well Baby Care, Immunizations (after 6 <sup>th</sup> birthdate), Vision & Hearing Exams	100% after \$20 copay per visit	70% after cal. yr. deductible
<b>EXTENDED CARE SERVICES</b> (must be Preauthorized) Home Health Care Calendar Year Maximum Skilled Nursing Facility Hospice Care	100%  \$10,000 per cal. yr. \$10,000 per cal. yr. \$20,000 lifetime max. <i>Benefits used in Network or Out-of-Network apply towards satisfying both maximums.</i>	70% after cal. yr. deductible
<b>MENTAL HEALTH</b> (must be Preauthorized) <b>Inpatient Services</b> Hospital Services (Facility) Physician Services Calendar Year Limitations  <b>Outpatient Services</b> Services Performed in Physician Office (non-surgical) Emergency Room/Treatment Room/Facility Charges (non-emergency only) Professional Provider Visits Allowed	90% 90% after cal. yr. deductible  100% after \$20 copay 90% after \$50 copay, waived if admitted  90% after cal. yr. deductible	70% after per adm. deductible 70% after cal. yr. deductible  70% after cal. yr. deductible 70% after \$50 copay & cal. yr. deductible, waived if admitted 70% after cal. yr. deductible  30 inpatient days/30 physician visits <i>Days and Visits used in Network or Out-of-Network apply towards satisfying both maximums.</i>  30 visits per cal. yr.
<b>CHEMICAL DEPENDENCY</b> in a Substance Abuse Facility (must be Preauthorized) All Other Outpatient Treatment	Three separate series of treatments for each covered individual/ sickness Covered as any other sickness	Covered as any other sickness
<b>SERIOUS MENTAL ILLNESS (For Public Entities)</b> (must be Preauthorized)	Covered as any other sickness	

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<b>TYPE OF SERVICE</b>	<b>PARTICIPATING PHARMACY</b>	<b>NON-PARTICIPATING PHARMACY (member, files claim)</b>
<p><b>PRESCRIPTION DRUG PROGRAM*</b></p> <p><b>Retail Prescription</b> (all copays are per 30-day supply and will not apply to coinsurance stoploss maximum)</p> <p>Non-Preferred Brand Name</p> <p>Preferred Brand Name</p> <p>Generic</p> <p><b>Mail Service Prescription</b> (all copays are per 90-day supply and will not apply to coinsurance stoploss maximum)</p> <p>Non-Preferred Brand Name</p> <p>Preferred Brand Name</p> <p>Generic</p>	<p>\$50 copay</p> <p>\$25 copay</p> <p>\$10 copay</p> <p>Yes</p> <p>\$100 copay</p> <p>\$50 copay</p> <p>\$20 copay</p>	<p>80% of Allowable Amount minus copay</p> <p>80% of Allowable Amount minus copay</p> <p>80% of Allowable Amount minus copay</p>
<p><i><b>Rx Enhanced</b> - 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.</i></p> <p><i>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.</i></p>		

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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.