ASO CDHP with Embedded Deductible

BlueCross BlueShield of Texas

BENEFIT HIGHLIGHTS *Prepared for* Amarillo Independent School District
Effective Date: 07/01/17
BA# 0002

BlueChoice Network

***This is a general summary of your benefits**. Please refer to your Summary of Benefits and Coverage (SBC), or you may request a copy of the policy or plan document for additional details and a description of the plan requirements and benefit design. This plan does not cover all health care expenses. Please carefully review the plan's limitations and exclusions.*

Overall Payment Provisions	In-Network Benefits	Out-of-Network Benefits
Embedded Deductible		
☒ Plan Year Deductible	*$3,000 Individual / $6,000 Family*	*$6,000 Individual / $12,000 Family*
Applies to all Eligible Expenses (unless otherwise indicated)		
Applies to Out-of-Pocket Maximum		
Family coverage: When one family member meets the individual Deductible, benefits become available under the plan for that individual.		
NOTE: The individual Deductible amount must be equal to or greater than the minimum family Deductible amount. This qualification is established by the U. S. Treasury for a plan to be considered a qualified HSA plan.		
Deductible credit from prior carrier (Applied on initial group enrollment only)	*No*	*No*
Out-of-Pocket Maximum		
	$3,000 Individual / $6,000 Family	*$11,000 Individual / $27,000 Family*
Deductible applies to Out-of-Pocket	*Yes – no option*	*Yes***
Copayment applies to Out-of-Pocket	*Yes – no option*	*Yes***
	Network Deductible & Out-of-Pocket will only apply toward Network Deductible & Out-of-Pocket Maximum	*Out-of-Network Deductible & Out-of Network Out-of-Pocket will only apply toward Out-of-Network Deductible & Out-of-Network Out-of-Pocket Maximum*
Credit for Out-of-Pocket Maximum from prior carrier (applied on initial group enrollment only)	*No*	*No*
** Copayment amounts and per are admission deductibles applied but will continue to be required after the benefit percentage increases to 100%.		
Maximum Lifetime Benefits		
Per Participant	*Unlimited*	
Telemedicine		
Teladoc	*$45 Office Consultation. 100% after PYD*	
Inpatient Hospital Expenses		
Inpatient Hospital Expenses		
All services must be preauthorized		
Inpatient Hospital Expenses	*100% of Allowable Amount after Deductible*	*60% of Allowable Amount after Deductible*
Each admission must be preauthorized		
All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units.		
Penalty for failure to preauthorize services	*None*	*$1000*
Medical/Surgical Expenses		
Medical / Surgical Expenses		
-Services performed during the Physician's office visit/consultation, including lab & x-ray	*100% of Allowable Amount after Deductible*	*60% of Allowable Amount after Deductible*
-Lab & x-ray in other outpatient facilities	*100% of Allowable Amount after Deductible*	*60% of Allowable Amount after Deductible*

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-Physician surgical services performed in any setting	*100% of Allowable Amount after Deductible*	*60% of Allowable Amount after Deductible*
-Physician inpatient hospital visits	*100% of Allowable Amount after Deductible*	*60% of Allowable Amount after Deductible*
-Certain Diagnostic Procedures; such as Bone Scan, Cardiac Stress Test, CT Scan (with or without contrast), MRI, Myelogram, PET Scan.	*100% of Allowable Amount after Deductible*	*60% of Allowable Amount after Deductible*
-Home Infusion Therapy *(Services must be preauthorized)*	*100% of Allowable Amount after Deductible*	*60% of Allowable Amount after Deductible*
-All other outpatient services and supplies	*100% of Allowable Amount after Deductible*	*60% of Allowable Amount after Deductible*
In Vitro Fertilization Services	*Decline*	

Extended Care Expenses	**In-Network Benefits**	**Out-of-Network Benefits**
Extended Care Expenses *(must be preauthorized)*	*100% of Allowable Amount after Deductible*	*60% of Allowable Amount after Deductible*
Skilled Nursing Facility	*Limited to 60 day maximum each Year**	
Home Health Care	*Limited to 60 visit maximum each Year**	
Hospice Care	*Unlimited*	

Special Provisions Expenses

Mental Health (Serious Mental Illness (SMI) included) and Chemical Dependency (Substance Use Disorder)		
Inpatient Services		
Inpatient Chemical Dependency treatment must be provided in a Chemical Dependency/Residential Treatment Center (RTC)		
-Hospital services (facility)	*100% of Allowable Amount after Deductible*	*60% of Allowable Amount after Deductible*
-Physician services	*100% of Allowable Amount after Deductible*	*60% of Allowable Amount after Deductible*
Penalty for failure to preauthorize services	*None*	*$1000*
Preauthorization required for inpatient, residential treatment centers (RTC), partial hospital program admissions, and certain outpatient professional services		
Outpatient Services		
-Services performed during Physician office visit/consultation (does not include psychological testing)	*100% of Allowable Amount after Deductible*	*60% of Allowable Amount after Deductible*
-All outpatient services and psychological testing	*100% of Allowable Amount after Deductible*	*60% of Allowable Amount after Deductible*
Emergency Room/Emergency Treatment Room		
Accidental Injury & Emergency Care		
-Facility charges	*100% of Allowable Amount after Deductible*	
- Physician charges	*100% of Allowable Amount after Deductible*	
Non-Emergency Care		
-Facility charges	*100% of Allowable Amount after Deductible*	*60% of Allowable Amount after Deductible*
-Physician charges	*100% of Allowable Amount after Deductible*	*60% of Allowable Amount after Deductible*
Urgent Care Services		
Urgent Care center visit, including lab & x-ray services	*100% of Allowable Amount after Deductible*	*60% of Allowable Amount after Deductible*

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Certain Diagnostic Procedures; such as Bone Scan, Cardiac Stress Test, CT Scan (with or without contrast), MRI, Myelogram, PET Scan, surgical procedures and all other services and supplies.	*100% of Allowable Amount after Deductible*	*60% of Allowable Amount after Deductible*
Ground and Air Ambulance Services		
	100% of Allowable Amount after Deductible	
Preventive Care		
Routine annual physical examinations, well-baby care exams, immunizations 6 years of age & over, and any other preventive health services as determined by USPSTF	*100% of Allowable Amount*	*60% of Allowable Amount*
Immunizations for Dependent children through the date of the child's 6th birthday	*100% of Allowable Amount*	*100% of Allowable Amount*
Special Provisions Expenses, cont.	***In-Network Benefits***	***Out-of-Network Benefits***
Speech and Hearing Services		
Services to restore loss of or correct an impaired speech or hearing function	*Covered same as any other sickness*	*Covered same as any other sickness*
Hearing Aids	*Not Covered*	*Not Covered*
Physical Medicine Services		
Chiropractic Care-Office Services	*100% of Allowable Amount after Deductible*	*60% of Allowable Amount after Deductible*
Maximum	*Limited to 30 visit maximum each Year** *All other Physical Medicine Services rendered by any other 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 Annual Maximum benefits indicated.

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Pharmacy Benefits	Participating Pharmacy*	Non-Participating Pharmacy (member files claim)
Prime Therapeutics		
Drug List**	*Performance*	
Compound Drugs	*Not Covered*	
Non-sedating antihistamine (NSA) drugs and combination medications containing a non-sedating antihistamine and decongestant	*Exclude prescription strength NSA's*	
Proton Pump Inhibitors	*Generics coverage only for Omeprazole*	
Deductible and Out of Pocket Accums–Integrated is the Standard option for HSA.		
Integrated RX Accum The drug deductible and Out-of-Pocket is the same as the medical Deductible and /Out-of-Pocket. All benefits, including prescription drug benefits (retail and mail order) must apply to the plan's overall Deductible and Out-of-Pocket Maximum.		
Vaccinations obtained through Pharmacies***	*Shingles and Meningitis Vaccine covered at 100% of Allowable Amount after the Deductible*	
Retail Pharmacy (Benefit payments are based on a 30-day supply. With appropriate prescription order, up to a 90-day supply is available.)	*100% of Allowable Amount after the Deductible****	
Specialty Drugs†	☒ *Specialty Lock-Out through Prime Specialty Pharmacy applies: No coverage available for specialty drugs when purchased through any other provider*	
Mail Order Program (Benefit payments are based on a 30-day supply. With appropriate prescription order, up to a 90-day supply is available.)	*100% of Allowable Amount after the Deductible****	

MAC 1 - No Penalty – Member pays no more than the applicable Generic, Preferred Drug, or Non-Preferred Drug Copayment. Product selection is permitted, even when generic equivalents are available.

** To locate a preferred/participating pharmacy in your area, go to myprime.com or contact customer service at the phone number on the back of your identification card.*

***The drug lists are available at: bcbstx.com/member/rx_drugs.html*

****Select Participating Pharmacies have been contracted to provide vaccination services. Each pharmacy may have age, scheduling, or other requirements that will apply. Members are encouraged to contact the store in advance.* ***Benefit does not include childhood immunizations, subject to state regulations.***

*****Three-month Deductible carryover does not apply to prescription drug deductible.*

†For more information on the specialty drug program, call Prime Specialty Pharmacy at (877)627-6337.

Diabetes Supplies are available under the Prescription Drug benefits of your plan. Diabetic 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.

Standard UM Programs (prior authorization and step therapy) and exclusions apply, including auto updates and FastPath.

± Please be reminded that Health Savings Accounts (HSA's) have tax and legal ramifications. Blue Cross and Blue Shield of Texas does not provide legal or tax advice, and nothing herein should be construed as legal or tax advice. These materials, and any tax-related statements in them, are not intended or written to be used, and cannot be used or relied on, for the purpose of avoiding tax penalties. Tax-related statements, if any, may have been written in connection with the promotion or marketing of the transaction(s) or matter(s) addressed by these materials. You should seek advice based on your particular circumstances from an independent tax advisor regarding the tax consequences of specific health insurance plans or products.