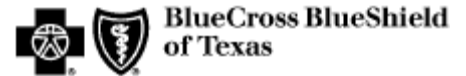


PPO ASO Standard with Network Deductible and Split Copay



BENEFIT HIGHLIGHTS *Prepared for* Amarillo Independent School District

BlueChoice Network

Effective Date: 07/01/17

Benefit Agreement #: 0001

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
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Deductibles

Per-admission Deductible <input checked="" type="checkbox"/> Plan Year Deductible <i>Applies to all Eligible Expenses except Inpatient Hospital Expenses (unless otherwise indicated)</i> Three-month Deductible carryover applies Deductible credit from prior carrier (Applied on initial group enrollment only)	None \$3,000 Individual / \$9,000 Family	None \$6,000 Individual / \$18,000 Family
	No	No
	No	No

Out-of-Pocket Maximum

	\$6,500 Individual / \$12,700 Family	\$11,000 Individual / \$33,000 Family
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Deductible applies to Out-of-Pocket Copayment applies to Out-of-Pocket ** Copayment amounts and per admission deductibles are applied but will continue to be required after the benefit percentage increases to 100%. Credit for Out-of-Pocket Maximum from prior carrier (applied on initial group enrollment only)	Yes – no option Yes – no option Network Deductible & Out-of-Pocket will only apply toward Network Deductible & Out-of-Pocket Maximum No	Yes** Yes** 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 No
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Copayment Amounts Required

Telemedicine Teladoc Physician office visit/consultation: Primary Care Copayment Amount for office visit/consultation when services rendered by a Family Practitioner, OB/GYN, Pediatrician, Behavioral Health Practitioner, or Internist and Physician Assistant or Advanced Practice Nurse who works under the supervision of one of these listed physicians Specialty Care Copayment Amount for office visit/consultation when services rendered by a Specialty Care Provider <i>Refer to Medical/Surgical Expenses section for more information</i> Urgent Care center visit <i>Refer to Urgent Care Services section for more information</i> Outpatient Hospital Emergency Room/Treatment Room visit <i>Refer to Emergency Room/Treatment Room section for more information</i>	\$10 Copayment \$35 Primary Care Copayment \$50 Specialty Care Copayment \$75 Copayment Amount 80% after Deductible	60% after Deductible
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Maximum Lifetime Benefits

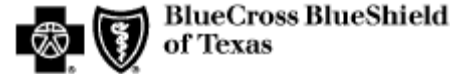
Per Participant	Unlimited
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Inpatient Hospital Expenses

Inpatient Hospital Expenses

All services must be preauthorized All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units Penalty for failure to preauthorize services	80% of Allowable Amount after per-admission Deductible (if applicable) None	60% of Allowable Amount after per-admission Deductible (if applicable) \$1000
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Medical/Surgical Expenses

Medical / Surgical Expenses

	In-Network Benefits	Out-of-Network Benefits
Services performed during the office visit/consultation when rendered by a Primary Care Provider, including lab and x-ray (does not include Certain Diagnostic Procedures and surgical services)	100% of Allowable Amount after \$35 Primary Care Copayment**	60% of Allowable Amount after Deductible
Services performed during the office visit/consultation when services rendered by a Specialty Care Provider, including lab & x-ray (does not include Certain Diagnostic Procedures and surgical services)	100% of Allowable Amount after \$50 Specialty Care Copayment	60% of Allowable Amount after Deductible
Lab & x-ray in other outpatient facilities (excluding Certain Diagnostic Procedures)	100% of Allowable Amount	60% of Allowable Amount after Deductible
-Physician surgical services performed in any setting	80% of Allowable Amount after Deductible	60% of Allowable Amount after Deductible
-Physician inpatient hospital visits	80% 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.	80% of Allowable Amount after Deductible	60% of Allowable Amount after Deductible
-Home Infusion Therapy (Services must be preauthorized)	80% of Allowable Amount after Deductible	60% of Allowable Amount after Deductible
-All other outpatient services and supplies	80% of Allowable Amount after Deductible	60% of Allowable Amount after Deductible
In Vitro Fertilization Services	Decline	

Extended Care Expenses

Extended Care Expenses

All services must be preauthorized

<p>Skilled Nursing Facility Home Health Care Hospice Care</p>	<p>100% of Allowable Amount</p> <p>Limited to 60 day maximum each Year* Limited to 60 visit maximum each Year*</p>	<p>60% of Allowable Amount after Deductible</p> <p>Unlimited</p>
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Special Provisions Expenses

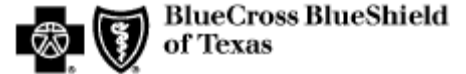
Mental Health (Serious Mental Illness (SMI) included) and Chemical Dependency (Substance Use Disorder)

<p>Inpatient Services Inpatient Chemical Dependency treatment must be provided in a Chemical Dependency/Residential Treatment Center (RTC)</p> <p>-Hospital services (facility)</p> <p>Penalty for failure to preauthorize services Preauthorization required for inpatient, residential treatment centers (RTC), partial hospital program admissions, and certain outpatient professional services</p> <p>-Physician services</p> <p>Outpatient Services -Services performed during office visit/consultation when rendered by a Primary Care Provider (does not include psychological testing)</p> <p>-All outpatient services and psychological testing</p>	<p>80% of Allowable Amount after per-admission Deductible (if applicable)</p> <p style="color: #0056b3;">None</p> <p>80% of Allowable Amount after Calendar Year Deductible</p> <p>100% of Allowable Amount after \$35 Primary Care Copayment Amount</p> <p>80% of Allowable Amount after Deductible</p>	<p>60% of Allowable Amount after per-admission Deductible (if applicable)</p> <p style="color: #0056b3;">\$1000</p> <p>60% of Allowable Amount after Deductible</p> <p>60% of Allowable Amount after Deductible</p> <p>60% of Allowable Amount after Deductible</p>
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* Benefits used In-Network and Out-of-Network will apply toward satisfying any Annual Maximum benefits indicated

** Primary Care/Specialty Care copayments are defined in the Overall Payment Provisions section in this document.

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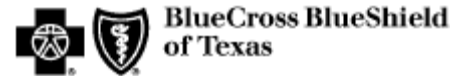
Special Provisions Expenses, cont.	In-Network Benefits	Out-of-network Benefits
Emergency Room/Treatment Room		
Accidental Injury & Emergency Care -Facility charges	80% of Allowable Amount after Deductible	
-Physician charges	80% of Allowable Amount after Deductible	
Non-Emergency Care -Facility charges	80% of Allowable Amount after Deductible	60% of Allowable Amount after Deductible
-Physician charges	80% of Allowable Amount after Deductible	60% of Allowable Amount after Deductible
Urgent Care Services		
Urgent Care center visit, including lab & x-ray services (does not include Certain Diagnostic Procedures and surgical services)	100% of Allowable Amount after \$75 Copayment Amount	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, surgical procedures and all other services and supplies.	80% of Allowable Amount after Deductible	60% of Allowable Amount after Deductible
Ground and Air Ambulance Services		
	80% 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 after Deductible
Immunizations for Dependent children through the date of the child's 6 th 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	Covered same as any other sickness	Covered same as any other sickness
Hearing Aid	Not Covered	

Special Provisions Expenses, cont.	In-Network Benefits	Out-of-network Benefits
Physical Medicine Services		
Chiropractic Care-Office Services	80% of Allowable Amount after Deductible	60% of Allowable Amount after Deductible
Maximum	Limited to 30 visits each 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 Annual Maximum benefits indicated

Pharmacy Benefits	Participating Pharmacy*	Non-Participating Pharmacy (member files claim)
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 NSAs	
Proton Pump Inhibitors	Generics coverage only for Omeprazole	
Prescription Drug Deductible***	None	

PPO ASO Standard with Network Deductible and Split Copay



Prescription Drug Out-of-Pocket Maximum	<i>All benefits, including prescription drug benefits (retail and mail service) apply to the Out-of-Pocket Maximum shown on page 1.</i>	
Vaccinations obtained through Pharmacies****	<i>Shingles and Meningitis Vaccines covered at \$30 Copayment Amount</i>	
Retail Pharmacy (Copayment amounts are based on a 30-day supply. With appropriate prescription order, up to a 90-day supply is available. Copayment amounts apply to Out-of-Pocket Maximum.)		
Generic Drug	<i>\$15 Copayment Amount</i>	<i>80% of Allowable Amount minus Copayment Amount</i>
Preferred Brand Name Drug	<i>\$60 Copayment Amount</i>	<i>80% of Allowable Amount minus Copayment Amount</i>
Non-Preferred Brand Name Drug	<i>\$90 Copayment Amount</i>	<i>80% of Allowable Amount minus Copayment Amount</i>
Preferred Specialty Drug	<i>\$150 Copayment Amount</i>	<i>80% of Allowable Amount minus Copayment Amount</i>
Non-Preferred Specialty Drug	<i>\$250 Copayment Amount</i>	<i>80% of Allowable Amount minus Copayment Amount</i>
Specialty Drugs†	<i>Specialty Lock-Out through Prime Specialty Pharmacy applies: No coverage available for specialty drugs when purchased through any other provider.</i>	
Mail Order Program (Copayment amounts are based on a 90-day supply. With appropriate prescription order, up to a 90-day supply is available. Copayment amounts apply to the Out-of-Pocket Maximum.)	Yes	
Generic Drug	<i>\$30 Copayment Amount</i>	
Preferred Brand Name Drug	<i>\$135 Copayment Amount</i>	
Non-Preferred Brand Name Drug	<i>\$205 Copayment Amount</i>	
<p>MAC 3 - Generic Incentive (Standard)-Members who purchase Preferred/Non-Preferred Brand Name Drugs when a Generic equivalent exists, 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 Copayment Amount.</p> <p>* 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.</p> <p>**The drug lists are available at: bcbstx.com/member/rx_drugs.html</p> <p>*** Three-month Deductible carryover does not apply to prescription drug deductible.</p> <p>****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.</p> <p>†For more information on the specialty drug program, call Prime Specialty Pharmacy at (877)627-6337.</p> <p>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.</p> <p>Standard UM Programs (prior authorization and step therapy) and exclusions apply, including auto updates and FastPath.</p>		