



# TEXAS ASSOCIATION of COUNTIES HEALTH AND EMPLOYEE BENEFITS POOL

## BENEFIT HIGHLIGHTS PLAN 1200-NG

(Non-Grandfathered ACA)

## 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

#### Plan Year Deductibles

Per-admission Deductible Deductible  
Applies to all Eligible Expenses except Inpatient Hospital Expenses (unless otherwise indicated)

\$0  
\$1,000 Individual /  
\$3,000 Family

\$0  
\$3,000 Individual /  
\$9,000 Family

#### Plan Year Out-of-Pocket Maximum

Deductibles are not applied to the Out-of-Pocket Maximum (OOPM). Copayment Amounts will apply to the OOPM, and they will not be required after the maximum has been satisfied. Your benefit booklet will provide more details.

\$3,000 Individual /  
\$9,000 Family  
  
Network Deductible &  
Out-of-Pocket Maximum **will only**  
apply toward Network Deductible  
& Out-of-Pocket Maximum

\$6,000 Individual /  
\$18,000 Family  
  
Out-of-Network Deductible &  
Out-of-Pocket Maximum **do not**  
apply toward Network Deductible  
& Out-of-Pocket Maximum

#### Copayment Amounts Required

Physician office visit/consultation  
Refer to Medical/Surgical Expenses section for more information  
  
MDLIVE (Telemedicine)  
  
Urgent Care  
  
Outpatient Hospital Emergency Room/Treatment Room  
Refer to Emergency Room/Treatment Room section for more information

\$30 Copayment Amount  
  
\$0 Copayment Amount  
  
\$30 Copayment Amount  
  
\$150 Copayment Amount

N/A-Refer to Medical/Surgical  
Expense section for benefits  
  
Not Applicable  
  
70% of Allowable 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



A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,  
an Independent Licensee of the Blue Cross and Blue Shield Association



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<b>Medical/Surgical Expenses</b>	<b>In-Network Benefits</b>	<b>Out-of-Network Benefits</b>
<b>Medical / Surgical Expenses</b> 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

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

<b>Special Provisions Expenses</b>		
<b>Serious Mental Illness</b> All services must be preauthorized		
<b>Inpatient Services</b>		
-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
<b>Outpatient Services</b>		
-Services performed during Physician office visit/consultation (does not include psychological testing)	100% of Allowable Amount after \$30 Copayment	70% 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 shown.



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<b>Special Provisions Expenses, cont.</b>	<b>In-Network Benefits</b>	<b>Out-of-network Benefits</b>
<b>Mental Health Care/Chemical Dependency</b>		
<i>All services must be preauthorized. Inpatient treatment must be provided in a Chemical Dependency Treatment Center.</i>		
<b>Inpatient Services</b>		
-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
<b>Outpatient Services</b>		
-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 <i>(Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply)</i>	60% of Allowable Amount after \$150 Copayment Amount & Plan Year Deductible <i>(Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply)</i>
-Other Outpatient Services and psychological testing	80% of Allowable Amount after Plan Year Deductible	60% of Allowable Amount after Plan Year Deductible
<b>Emergency Room/Treatment Room</b>		
<b>Accidental Injury &amp; Emergency Care</b>		
-Facility charges (outpatient Hospital emergency treatment room charges)	80% of Allowable Amount after \$150 Copayment Amount <i>(Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply)</i>	
-Physician charges	80% of Allowable Amount after Plan Year Deductible	
<b>Non-Emergency Care</b>		
-Facility charges (outpatient Hospital emergency treatment room charges)	80% of Allowable Amount after \$150 Copayment Amount <i>(Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply)</i>	60% of Allowable Amount after \$150 Copayment Amount & Plan Year Deductible <i>(Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply)</i>
-Physician charges	80% of Allowable Amount after Plan Year Deductible	60% of Allowable Amount after Plan Year Deductible
<b>Ground and Air Ambulance Services</b>		
	80% of Allowable Amount after Plan Year Deductible	

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<b>Special Provisions Expenses, cont.</b>	<b>In-Network Benefits</b>	<b>Out-of-network Benefits</b>
<b>Preventive Care</b>		
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 6 <sup>th</sup> birthday	100% of Allowable Amount	100% of Allowable Amount
<b>Speech and Hearing Services</b>		
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
<b>Physical Medicine Services</b>		
Chiropractic Care-Office Services	80% of Allowable Amount after Plan Year Deductible	60% of Allowable Amount after Plan Year Deductible
Airrosti Rehab Centers	\$30 Copayment Amount	Not Applicable
<b>Plan Year Maximum</b>	35 visit maximum each Plan Year*	
<i>All other Physical Medicine Services rendered by any other eligible Provider will be allowed on the same basis as any other sickness.</i>		

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

## 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.

**MDLive** (Telemedicine) is part of your benefit plan design. Access to an independently contracted board-certified doctor is available 24 hours a day, seven days a week to speak to immediately or schedule an appointment based on your availability. Please refer to your benefit booklet for other details.

**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.