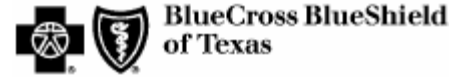


PPO-Insured-Standard-with Network Deductible

GROUP #029609



BENEFIT HIGHLIGHTS Prepared for Waco ISD – Plan 1

BlueChoice Network
 BlueChoice Solutions 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

	PPO (In-Network)	Non-PPO (Out-of-Network)
Calendar Year Deductible		
Applies to all Eligible Expenses, unless otherwise indicated, except Inpatient Hospital Expenses	\$2,000 Individual / \$6,000 Family	\$4,000 Individual / \$12,000 Family
4 th quarter Deductible carryover applies	Yes	Yes
Deductible credit from prior carrier (applied on initial group enrollment only)	Yes	Yes
Copayment Amounts Required		
Physician office visit/consultation	\$25 Copayment Amount	
Urgent Care center visit	\$40 Copayment Amount	
Outpatient Hospital Emergency Room (facility charges only)	\$100 Copayment Amount	\$100 Copayment Amount
Out-of-Pocket Maximum		
Deductibles are not applied to the Out-of-Pocket Maximum. Copayment Amounts are applied but will continue to be required after the benefit percentages increase to 100%. Your benefit booklet will provide more details.	\$500 Individual / \$1,500 Family <i>Network Deductible & Out-of-Pocket maximum will only apply toward Network Deductible & Out-of-Pocket Maximum</i>	\$1,000 Individual / \$3,000 Family <i>Out-of-Network Deductible & Out-of-Pocket maximum will also apply toward Network Deductible & Out-of-Pocket Maximum</i>
Credit for Out-of-Pocket Maximum from prior carrier (applied on initial group enrollment only)	Yes	Yes
Maximum Lifetime Benefits		
Per individual	\$5,000,000*	
Inpatient Hospital Expenses		
Inpatient Hospital Expenses (must be preauthorized)		
Inpatient Hospital Expenses	90% of Allowable Amount after Per-admission Deductible	60% of Allowable Amount after Per-admission Deductible
Per-admission Deductible	None	\$250
Penalty for failure to preauthorize	None	\$250
Medical/Surgical Expenses		
Medical / Surgical Expenses		
Physician office visit/consultation, including lab & x-ray	100% of Allowable Amount after \$25 Copayment Amount	70% of Allowable Amount after Calendar Year Deductible
Physician surgical services in any setting	90% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Urgent Care center visit, including all lab & x-ray services, except Certain Diagnostic Procedures	100% of Allowable Amount after \$40 Copayment Amount	70% of Allowable Amount after Calendar Year Deductible
Immunizations (birth through the day of the 6 th birthdate)	100% of Allowable Amount	100% of Allowable Amount
Lab & x-ray in other outpatient facilities (excluding Certain Diagnostic Procedures)	100% of Allowable Amount	70% of Allowable Amount after Calendar Year Deductible
Certain Diagnostic Procedures: Bone Scan, Cardiac Stress Test, CT Scan (with or without contrast), Ultrasound, MRI, Myelogram, PET Scan	90% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Home Infusion Therapy (must be preauthorized)	90% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
In Vitro Fertilization Services	Declined	
All other outpatient services and supplies	90% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible

* Benefits used In-Network and Out-of-Network will apply toward satisfying any day, visit, Calendar Year, or Lifetime Maximum amounts indicated

Extended Care Expenses	PPO (In-Network)	Non-PPO (Out-of-Network)
Extended Care Expenses (must be preauthorized)	100% of Allowable Amount	70% of Allowable Amount after Calendar Year Deductible
Skilled Nursing Facility	\$10,000 Calendar Year maximum*	
Home Health Care	\$10,000 Calendar Year maximum*	
Calendar Year Maximum		
OR		
60 Visit Maximum per Calendar Year	Declined	
Hospice Care	\$20,000 lifetime maximum*	
Special Provisions Expenses		
Treatment of Chemical Dependency (must be preauthorized)		
Inpatient treatment must be provided in a Chemical Dependency Treatment Center	Three separate series of treatments for each covered individual*/Covered as any other sickness	
All other outpatient treatment	Covered as any other sickness	Covered as any other sickness
Serious Mental Illness (must be preauthorized)		
Inpatient Services		
Hospital services (facility)	90% of Allowable Amount after Per- admission Deductible	60% of Allowable Amount after Per- admission Deductible
Physician services	90% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Calendar Year Maximum	45 inpatient days/45 inpatient Physician visits each Calendar Year*	
Outpatient Services		
Physician office visit/consultation, including lab & x-ray	100% of Allowable Amount after \$25 Copayment Amount	70% of Allowable Amount after Calendar Year Deductible
Other outpatient services, including psychological testing	90% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Calendar Year Maximum	60 outpatient visits each Calendar Year*	
Mental Health Care (must be preauthorized)		
Inpatient Services		
Hospital services (facility)	90% of Allowable Amount after Per-admission Deductible	60% of Allowable Amount after Per- admission Deductible
Physician services	90% of Allowable Amount after Calendar year Deductible	60% of Allowable Amount after Calendar Year Deductible
Calendar Year Maximum	30 inpatient days/30 inpatient Physician visits each Calendar Year*	
Outpatient Services		
Physician office visit/consultation, including lab & x-ray	100% of Allowable Amount after \$25 Copayment Amount	70% of Allowable Amount after Calendar Year Deductible
Other outpatient services, including psychological testing	90% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Calendar Year Maximum	30 visits each Calendar Year*	

* Benefits used In-Network and Out-of-Network will apply toward satisfying any day, visit, Calendar Year, or Lifetime Maximum amounts indicated

Special Provisions Expenses, cont.

Emergency Care/Outpatient Hospital Emergency Room

	PPO (In-Network)	Non-PPO (Out-of-Network)
Accidental Injury & Medical Emergency Care (within 48 hours) Facility charges	90% of Allowable Amount after \$100 Copayment Amount (Copayment Amount waived if admitted)	
Physician charges	90% of Allowable Amount after Calendar Year Deductible	
Non-Emergency Situations (after 48 hours) Facility charges	90% of Allowable Amount after \$100 Copayment Amount (Copayment Amount waived if admitted)	60% of Allowable Amount after \$100 Copayment Amount & Calendar Year Deductible (Copayment Amount waived if admitted)
Physician charges	90% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible

Preventive Care

Routine physicals, well-baby care, immunizations (after 6 th birthdate), vision and hearing exams	100% of Allowable Amount after \$25 Copayment Amount	70% of allowable Amount after Calendar Year Deductible
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Speech and Hearing Services

Services to restore loss of or correct an impaired speech or hearing function with hearing aids Hearing Aids	Covered same as any other sickness 90% of Allowable Amount after Calendar Year Deductible	Covered same as any other sickness 60% of Allowable Amount after Calendar Year Deductible
Hearing Aids Maximum Benefit	Hearing aids are subject to a \$1,000 maximum amount each 36-month period*	

Physical Medicine Services

Physical Medicine Services (includes but is not limited to physical, occupational, and manipulative therapy)	90% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Calendar Year Maximum	\$1,500 maximum benefit each Calendar Year*	

* Benefits used In-Network and Out-of-Network will apply toward satisfying any day, visit, Calendar Year, or Lifetime Maximum amounts indicated

Prescription Drug Program

Participating Pharmacy

**Non-Participating Pharmacy
(member files claim)**

Prescription Drugs*

Retail Prescription (All Copayment Amounts are per 30-day supply and will not apply to Out-of-Pocket Maximum) Generic	\$15 Copayment Amount	80% of Allowable Amount minus Copayment Amount
Preferred Brand Name	\$30 Copayment Amount	80% of Allowable Amount minus Copayment Amount
Non-Preferred Brand Name	\$50 Copayment Amount	80% of Allowable Amount minus Copayment Amount
Mail Service Prescription (All Copayment Amounts are per 90-day supply and will not apply to Out-of-Pocket Maximum) Generic	Yes	
Preferred Brand Name	\$30 Copayment Amount	
Non-Preferred Brand Name	\$60 Copayment Amount	
	\$100 Copayment Amount	

Generic Incentive-Members electing to purchase Preferred/Non-Preferred Brand Name Drugs when 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 Copayment Amount.

** 4th quarter carryover does not apply to Prescription Drug Deductible.

Diabetes Supplies are available under the Prescription Drug Program portion 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.

EMPLOYEE INFORMATION

The following benefits apply to dependent coverage:

- Dependent children are covered for maternity benefits.
- 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 or Out-of-Pocket Amounts, and Copayments. Plan benefits paid to Out-of-Network providers are based on the BCBSTX-determined Allowable Amount. These providers may balance bill covered individuals for charges in excess of the BCBSTX Allowable Amount. The covered individual will be responsible for charges in excess of the Allowable Amount in addition to any applicable Deductibles, Coinsurance or Out-of-Pocket Amounts, and Copayments. For cost savings information, refer to the section on ParPlan Providers and the definition of Allowable Amount in the benefit booklet.

Preexisting conditions are defined in the benefit booklet and are excluded for 12 months. Appropriate credit will be given for time served under Creditable Coverage as defined under the law and shown in your benefit booklet.

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.

Members residing in other states may use that state's network through the BlueCard program. To locate a participating provider in your state, please contact 1-800-810-BLUE or visit our web site at www.bcbstx.com to use our Provider Finder® tool.