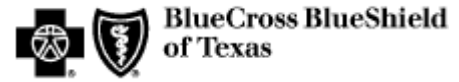


Blue Essentials HMO – ASO

BENEFIT HIGHLIGHTS *Prepared For* Goose Creek CISD TX401496
Effective Date: 1/1/2025

Benefit Agreement #: 0002 - Standard Plan **Blue Essentials Network**

This is a general summary of your benefits. Please refer to your Summary of Benefits and Coverage (SBC) 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.

Deductible per Calendar Year

Per Individual Member	\$4,000
Per Family	\$8,000
Three-month Deductible carryover applies***	No
Deductible credit from prior carrier (Applied on initial group enrollment only)	No
<i>Common (One deductible that applies to Inpatient Facility and Medical / Surgical Services)</i>	

Out-of-Pocket Maximums Per Calendar Year

Per Individual Member	\$7,000
Per Family	\$14,000
Credit for Out-of-Pocket Maximum from prior carrier (applied on initial group enrollment only)	No
Deductible applies to Out-of-Pocket	Yes
Copayment applies to Out-of-Pocket	Yes

Professional Services

Primary Care Physician ("PCP") Office or Home Visit	Deductible Applies <u>No</u> \$35 Copay
Participating Specialist Physician ("Specialist") Office or Home Visit	Deductible Applies <u>No</u> \$70 Copay

Blue Essentials HMO – ASO**BlueCross BlueShield
of Texas*****Inpatient Hospital Services*****Inpatient Hospital Services
(for each admission)**Deductible Applies Yes
then 20% coinsurance

Penalty for failure to preauthorize services

None

Outpatient Facility Services**Outpatient Surgery**Deductible Applies Yes
then 20% coinsurance**Radiation Therapy**Deductible Applies Yes
then 20% coinsurance**Dialysis**Deductible Applies Yes
then 20% coinsurance***Outpatient Diagnostic Laboratory and X-Ray Services*****Arteriograms, Computerized Tomography (CT Scan), Magnetic
Resonance Imaging (MRI), Electroencephalogram (EEG), Myelogram,
Positron Emission Tomography (PET Scan)
(per procedure)**Deductible Applies Yes
then 20% coinsurance**Other Outpatient Lab**Deductible Applies Yes
then 20% coinsurance**Other X-Ray Services**Deductible Applies Yes
then 20% coinsurance***Rehabilitation Services*****Rehabilitation Services and Therapies**

PCP

\$35 Copay

Specialist

\$70 Copay

Inpatient Hospital Services

Deductible Applies Yes
then 20% coinsurance

Blue Essentials HMO – ASO**BlueCross BlueShield
of Texas**

Outpatient Facility Services (as applicable)

Deductible Applies Yes
then 20% coinsurance**Maternity Care and Family Planning Services****Maternity Care**

Prenatal and Postnatal Visit

PCP

\$35 Copay

Specialist

\$70 Copay

Inpatient Hospital Services, for each admission

Deductible Applies Yes
then 20% coinsurance**Voluntary sterilization**

Vasectomy

PCP

\$35 Copay

Specialist

\$70 Copay

Outpatient Surgery Services (as applicable)

Deductible Applies Yes**Infertility Services**

Diagnostic counseling, consultations, planning and treatment services

PCP

\$35 Copay

Specialist

\$70 Copay

Artificial insemination, for each procedure and all services related to
procedure (cost of sperm not covered)-(Optional)

PCP

Not Covered

Blue Essentials HMO – ASOBlueCross BlueShield
of Texas

Specialist	Not Covered
Outpatient Surgery Services (as applicable)	Not Covered
Pregnancy Terminations Limited to Medically Necessary therapeutic terminations of pregnancy PCP	\$35 Copay
Specialist	\$70 Copay
Inpatient Hospital Services	Deductible Applies <u>Yes</u> then 20% coinsurance
Outpatient Surgery Services (as applicable)	Deductible Applies <u>Yes</u> then 20% coinsurance
Behavioral Health Services	
Outpatient Mental Health Care	Covered / Same as any other illness
Mental Health (Serious Mental Illness (SMI) included)	Covered / Same as any other illness
Chemical Dependency (Substance Use Disorder) Services	Covered / Same as any other illness
Emergency Care Services	
Emergency Care- Facility	Deductible Applies <u>Yes</u> then 20% coinsurance/OON per visit
Emergency Care- Physician	Deductible Applies <u>Yes</u> then 20% coinsurance
Urgent Care Center, per visit	Deductible Applies <u>Yes</u> then 20% coinsurance
Ambulance Services	
Ambulance Services	Deductible Applies <u>Yes</u> then 20% coinsurance
Extended Care Services	
Skilled Nursing Facility Services	Deductible Applies <u>Yes</u> then 20% coinsurance Day limit per calendar year <u>25</u>

Blue Essentials HMO – ASO



Hospice Care

Deductible Applies Yes
then 20% coinsurance

Home Health Care

Deductible Applies Yes
then 20% coinsurance
Visit Max 60

Health Maintenance and Preventive Services

Well child care through age 17

0 - No Deductible

Periodic health assessments for Members age 18 and older

0 - No Deductible

Immunizations

- Childhood immunizations required by law for Members through age 6
- Immunizations for Members over age 6

0 - No Deductible

0 - No Deductible

Eye and ear screenings for Members through age 17, once every twelve months

same as PCP copay or Specialist copay

Eye and ear screening for Members age 18 and older, once every two years

same as PCP copay or Specialist copay

Preventive Lab & X-Ray Services

- Outpatient Lab, includes independent lab
- X-Ray services, includes routine EKG

0 - No Deductible

0 - No Deductible

Exam for prostate cancer, once every twelve months

0 - No Deductible

Bone mass measurement for osteoporosis

0 - No Deductible

Well-woman exam, once every twelve months, includes, but not limited to, exam for cervical cancer (Pap smear)

0 - No Deductible

Screening mammogram for female Members age 35 and over and for female Members with other risk factors, once every twelve months

0 - No Deductible

- Outpatient facility or imaging centers

Family Planning Services:

- Diagnostic counseling, consultations and planning services
- Insertion or removal of intrauterine device (IUD), including cost of device
- Diaphragm or cervical cap fitting, including cost of device
- Insertion or removal of birth control device implanted under the skin, including cost of device

0 - No Deductible

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BlueCross BlueShield
of Texas

- Injectable contraceptive drugs, including cost of drug
- Tubal Ligation
- Contraceptive Services Supplies: Certain FDA approved contraceptive methods for women, female sterilization procedures and devices included on the Contraceptive Drug & Devices list
- Breastfeeding Support and Counseling Services

Hearing Loss

- Screening test from birth through 30 days
- Follow-up care from birth through 24 months

0 - No Deductible

0 - No Deductible

Rectal screening for the detection of colorectal cancer for Members age 45 and older:

- Annual fecal occult blood test, once every twelve months
- Flexible sigmoidoscopy with hemoccult of the stool, limited to 1 every 5 years
- Colonoscopy, limited to 1 every 10 years

0 - No Deductible

0 - No Deductible

0 - No Deductible

Early detection test for cardiovascular disease

Not Covered

Early detection test for Ovarian Cancer

Same as PCP Copay or Specialist Copay
Limited to 1 test every 12 months

Dental Surgical Procedures

Dental Surgical Procedures (limited Covered Services)

PCP

\$35 Copay

Specialist

\$70 Copay

Inpatient Hospital Services (as applicable)

Deductible Applies Yes
then 20% coinsurance

Outpatient Surgery Services (as applicable)

Deductible Applies Yes
then 20% coinsurance

Cosmetic, Reconstructive or Plastic Surgery

Cosmetic, Reconstructive or Plastic Surgery (limited Covered Services)

PCP

\$35 Copay

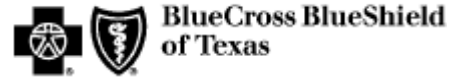
Specialist

\$70 Copay

Blue Essentials HMO – ASO**BlueCross BlueShield
of Texas**

Inpatient Hospital Services, as applicable	Deductible Applies <u>Yes</u> then 20% coinsurance
Outpatient Surgery Services (as applicable)	Deductible Applies <u>Yes</u> then 20% coinsurance
Allergy Care	
Testing and Evaluation	Deductible Applies <u>Yes</u> then 20% coinsurance
Injections	Deductible Applies <u>Yes</u> then 20% coinsurance
Serum	Deductible Applies <u>Yes</u> then 20% coinsurance
Diabetes Care	
Diabetes Self-Management Training PCP	\$35 Copay
Specialist	\$70 Copay
Diabetes Equipment	Deductible Applies <u>Yes</u> then 20% coinsurance
Diabetes Supplies	Deductible Applies <u>Yes</u> then 20% coinsurance
Prosthetic Appliances and Orthotic Devices	
Prosthetic Appliances and Orthotic Devices	Deductible Applies <u>Yes</u> then 20% coinsurance
\$300 maximum benefit for purchase of one (1) wig needed as a result of current chemotherapy or radiation treatment for cancer.	Deductible Applies <u>Yes</u> then 20% coinsurance
Cochlear Implants Limit one (1) per impaired ear, with replacements as Medically Necessary or audiologically necessary.	Any additional charges as described in Outpatient Surgery may also apply.

Blue Essentials HMO – ASO



Hearing Aids

Hearing Aids

Hearing Aid (paid AAOI) no limit
Maximum for hearing aids is \$2000 every 36 months

Deductible Applies Yes
then 20% coinsurance

Additional Options and Offers (Riders) – Standard

Durable Medical Equipment

Rental or purchase of DME (initial placement only, and standard replacements because of physical growth of members under age 18)

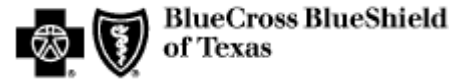
DM8 Deductible Applies: Yes
General payment level

Speech and Hearing Services

SH – Speech and Hearing Inpatient and Outpatient necessary care and treatment for loss or impairment of speech and hearing; hearing aids **not** covered under this mandated benefit offer.

Inpatient and Outpatient necessary care and treatment for loss or impairment of speech and hearing.

Paid same as any other illness

Blue Essentials HMO – ASO***Inpatient Mental Health Care***

Copay-Same as that required for other Inpatient Hospital Services. If the plan has no copayment for Inpatient Hospital Service, there is no copayment for inpatient mental health care services under this additional benefit option.

IM5 Deductible Applies Yes

Additional Options for State Mandated Offerings (Optional)

(Coverage provided for in vitro fertilization procedures to the same extent and at the same copayment levels as other pregnancy-related services (specific conditions must be met).

Benefits also available for non-experimental fertility drugs (subject to a 50% Copayment).

IV1 – In Vitro Fertilization Deductible Applies Yes

Additional Provisions

Treatment of acquired brain injury (ABI) - Medical coverage for cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological, and psycho-physiological testing or treatment, neurofeedback therapy, remedation, post-acute transition services, or community reintegration services necessary as a result of and related to an acquired brain injury.

Pay ABI benefit on the same basis as any other medical/surgical services – choose A or B

a) Pay in accordance with the Texas state mandate - Benefits determined on same basis as any other medical/surgical service with no maximums

Autism Spectrum Disorder

Pay in accordance with Mental Health Parity (MHP). No maximums apply for Applied Behavior Analysis. All other maximums will be applied per contract.

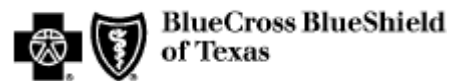
Developmental Delay (in accordance with state mandate)

Yes
If Yes, treatment includes the necessary rehabilitative and habilitative therapies in accordance with an "Individualized Family Service Plan", which is the initial and ongoing treatment plan developed and issued by the Interagency Council on Early Childhood Intervention under Chapter 73 of the Human Resources Code for a dependent child with Developmental Delays, including occupational therapy evaluations and services, physical therapy evaluations and services, speech therapy evaluations and services and dietary or nutritional evaluations.

Organ and Tissue Transplant – Donor Search & Acceptability Testing

Covered same as any other medical/surgical expense, no maximums

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Telemedicine	Covered
Foot Orthotics	Covered in treatment of diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency.

Pharmacy Benefits

Prescription Drug Benefits (Prime Therapeutics)

Drug List**

NOTE: For Performance and Performance Select and Balanced, no customization is allowed for individual drug categories. UM programs will apply and are not customizable.

Performance Select

Prescription Drug Deductible***

Separate Prescription Drug Deductible applies to Retail & Mail

*Service Pharmacy: Individual: \$ 4,000 / Family: \$ 8,000
Deductible will apply to the Out-of-Pocket Maximum.*

Prescription Drug Out-of-Pocket Maximum

Separate Prescription Drug Out-of-Pocket Maximum applies to Retail & Mail

Service Pharmacy: Individual: \$ 7,000 / Family: \$ 14,000

Compound Drugs

Not covered

Non-sedating antihistamine (NSA) drugs and combination medications containing a non-sedating antihistamine and decongestant

NOTE: For Performance and Performance Select and Balanced drug lists, coverage will be based on the drug list. Customization is not allowed.

Cover prescription strength NSA's only

Proton Pump Inhibitors

NOTE: For Performance and Performance Select and Balanced drug lists, coverage will be based on the drug list. Customization is not allowed.

Cover generics and brands

Cover prescribed over-the-counter (OTC) medications

NOTE: For Performance and Performance Select and Balanced drug lists, coverage will be based on the drug list. Customization is not allowed.

Cover only prescribed ACA OTCs

NOTE: ACA OTCs (nicotine products, aspirin, folic acid, iron, prenatal and fluoride) are standardly covered for Non-Grandfathered plans due to ACA with no cost share with a prescription from a provider.

Cover prescription medications with OTC equivalents (same strength, same active ingredients)

NOTE: For Performance and Performance Select and Balanced drug lists, coverage will be based on the drug list. Customization is not allowed.

No
If no, cover OTC equivalent PPI's (for example Omeprazole)

20 mg
Yes

Affordable Care Act (ACA) Preventive (including Vaccinations Obtained Through Pharmacies):

Yes
The group accepts all ACA Preventive categories

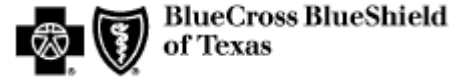
90 Day My Way mandatory program applies?

(available for non-grandfathered ASO groups only – CBSR required)

Benefit design that requires all maintenance medications to be filled as a 90-day supply either at a retail pharmacy (Extended Supply Network [ESN] or Walgreens) or by mail order. ESN copay/coinsurance must be equal to mail order copay/coinsurance. It will apply at the applicable pharmacy network ESN or Walgreens, along with mail order. Two grace fills are allowed.

No

Blue Essentials HMO – ASO



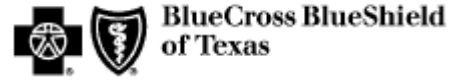
Retail Pharmacy If 90 Day My Way was selected, the 90 Day My Way option chosen determines the Pharmacy Retail Network ESN. NOTE: For Performance and Performance Select and Balanced drug lists, coverage will be based on the drug list. Customization is not allowed for route of administration. (Copayment amounts are based on a 30-day supply. With appropriate prescription order, up to a 90-day supply is available. Copayment amounts apply to the Out-of-Pocket Maximum.)	Preferred Participating Pharmacy, only use these selections if using the Preferred Pharmacy Network	Participating Pharmacy
	Pharmacy Retail Network Selection: <i>Traditional Select</i> <i>If 90-day supply selected, ESN network would apply</i> Preferred Pharmacy Retail Network Differential: <i>N/A (Select if not using the Preferred Pharmacy Retail Network)</i>	
Specialty Drugs	<u>Yes</u> , Specialty Lock-out through Preferred Specialty Pharmacy Network applies No coverage available for specialty drugs when purchased through any other provider. If Specialty Lock-out, are retail grace fills allowed? <u>Yes</u> , 1 fill	
GLP-1 30-day supply New to Therapy (NTT): Initial fill(s) for GLP-1 products limited to a 30-day supply for new to therapy with a 120-day lookback	Yes Diabetes Only	
GLP-1 30-day supply Max All Fill(s):	No	
Dietary Formulas for treatment of phenylketonuria or other heritable diseases:	Covered	
Services Related to Gender Reassignment	Covered	
4 Tier Optimal Generic Drug Preferred Brand Name Drug Non-Preferred Brand Name Drug Preferred Specialty Drug (preferred specialty pharmacy network) Non-Preferred Specialty Drug (preferred specialty pharmacy) <i>Specialty Drugs are not covered unless obtained through the specialty pharmacy network.</i>	Copay \$15 20% after deductible 20% after deductible NA	Copay \$ or % after deductible Copay \$ or % after deductible Copay \$ or % after deductible Copay \$ or % after deductible

Blue Essentials HMO – ASO



<p>Contraceptives</p> <p>NOTE: For Performance, Performance Select, and Balance drug lists, coverage will be based on the drug list. Customization is not allowed.</p>	<p><i>Unless religious employer exemption/eligible organization accommodation applies, certain FDA approved female prescription contraception methods (as identified in the Pharmacy Coverage list in the Preventive Services toolkit) are covered when using a participating pharmacy under retail and mail service with no cost sharing (no copay, no deductible, no co-share).</i></p> <p><i>Cover additional contraceptives (oral, patches, and rings) not listed in the Pharmacy coverage list?</i></p> <p><i>Yes – Cover as any other generic, or preferred or non-preferred brand name</i></p> <p><i>Cover additional contraceptive devices not listed in the Pharmacy Coverage list?</i></p> <p><i>Yes – Cover as any other generic, or preferred or non-preferred brand name</i></p> <p><i>NOTE: Non-self injectable contraceptive drugs may be covered under medical.</i></p>
<p>Retin A or Pharmacologically Similar Topical Drugs:</p> <p>NOTE: For Performance, Performance Select and Balanced drug lists, coverage will be based on the drug list. Customization is not allowed.</p>	<p><i>Covered</i></p> <p><i>Does age limit apply? No</i></p>
<p>Self-injectable Drugs:</p> <p>NOTE: For Performance, Performance Select and Balanced drug lists, coverage will be based on the drug list. Customization is not allowed.</p>	<p><i>Cover drugs approved by the FDA for self-administration</i></p>
<p>Preferred Emergency Medications</p> <p>Select covered drugs from these categories are included at \$0 cost share</p> <ul style="list-style-type: none"> • Severe allergic reactions • Hypoglycemia • Opioid overdoses • Nitrates 	<p><i>Covered at applicable drug tier</i></p>
<p>Mail Order Program</p> <p>(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 the Out-of-Pocket Maximum.)</p>	<p><i>Preferred Mail Order Pharmacy</i></p>
<p>4 Tier</p> <p>Generic Drug</p> <p>Preferred Brand Name Drug</p> <p>Non-Preferred Brand Name Drug</p>	<p><i>Copay \$30</i></p> <p><i>20% after deductible</i></p> <p><i>20% after deductible</i></p>

Blue Essentials HMO – ASO



Member Pays the Difference to Brand Name Drugs (was MAC)

Does Member Pays the Difference penalty apply to brand name drugs when there is a generic drug available?:

Yes

Will Member Pays the Difference Penalty apply if prescriber indicates brand medically necessary?

No (was MAC II)

Does Member Pays the Difference Penalty waiver apply? (prescriber fills out waiver)

No

NOTE: The intent of the MPTD Penalty Waiver program is to have criteria to waive the MPTD penalty when a prescriber provides documentation to support that a member cannot tolerate a generic drug.

**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*

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

†For more information on the specialty drug program, call (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.

Note: To confirm standard benefits, refer to the Pharmacy page on Product Central on FYIBlue.