Blue Essentials HMO – ASO

BlueCross BlueShield of Texas

BENEFIT HIGHLIGHTS *Prepared For* Goose Creek CISD TX401496
Effective Date: 1/1/2025
Benefit Agreement #: 0003 - Enhanced 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	*$2,000*
Per Family	*$4,000*
Three-month Deductible carryover applies***	*No*
Deductible credit from prior carrier (Applied on initial group enrollment only)	*No*
Common (One deductible that applies to Inpatient Facility and Medical / Surgical Services)	

Out-of-Pocket Maximums Per Calendar Year	
Per Individual Member	$*5,500*
Per Family	$*11,000*
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 No *$25 Copay*
Participating Specialist Physician ("Specialist") Office or Home Visit	Deductible Applies No *$50 Copay*

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	*$25 Copay*
Specialist	*$50 Copay*
Inpatient Hospital Services	Deductible Applies Yes *then 20% coinsurance*

Outpatient Facility Services (as applicable)	Deductible Applies Yes *then 20% coinsurance*
Maternity Care and Family Planning Services	
Maternity Care	
Prenatal and Postnatal Visit PCP	*$25 Copay*
Specialist	*$50 Copay*
Inpatient Hospital Services, for each admission	Deductible Applies Yes *then 20% coinsurance*
Voluntary sterilization Vasectomy PCP	*$25 Copay*
Specialist	*$50 Copay*
Outpatient Surgery Services (as applicable)	Deductible Applies Yes *then 20% coinsurance*
Infertility Services Diagnostic counseling, consultations, planning and treatment services PCP	*$25 Copay*
Specialist	*$50 Copay*
Artificial insemination, for each procedure and all services related to procedure (cost of sperm not covered)-(Optional) PCP	*Not Covered*

Specialist	*Not Covered*
Outpatient Surgery Services (as applicable)	*Not Covered*
Pregnancy Terminations Limited to Medically Necessary therapeutic terminations of pregnancy PCP	*$25 Copay*
Specialist	*$50 Copay*
Inpatient Hospital Services	Deductible Applies Yes *then 20% coinsurance*
Outpatient Surgery Services (as applicable)	Deductible Applies Yes *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 Yes *then 20% coinsurance /OON per visit*
Emergency Care- Physician	Deductible Applies Yes *then 20% coinsurance*
Urgent Care Center, per visit	Deductible Applies No *$50 Copay*
Ambulance Services	
Ambulance Services	Deductible Applies Yes *then 20% coinsurance*

Extended Care Services	
Skilled Nursing Facility Services	Deductible Applies Yes *then 20% coinsurance* Day limit per calendar year 25
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 • Outpatient facility or imaging centers	0 - No Deductible

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 • 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	0 - No Deductible
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	*$25 Copay*
Specialist	*$50 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	*$25 Copay*
Specialist	*$50 Copay*
Inpatient Hospital Services, as applicable	Deductible Applies Yes *then 20% coinsurance*
Outpatient Surgery Services (as applicable)	Deductible Applies Yes *then 20% coinsurance*
Allergy Care	
Testing and Evaluation	Deductible Applies Yes *then 20% coinsurance*
Injections	Deductible Applies Yes *then 20% coinsurance*
Serum	Deductible Applies Yes *then 20% coinsurance*
Diabetes Care	
Diabetes Self-Management Training PCP	*$25 Copay*
Specialist	*$50 Copay*
Diabetes Equipment	Deductible Applies Yes *then 20% coinsurance*
Diabetes Supplies	Deductible Applies Yes *then 20% coinsurance*

Prosthetic Appliances and Orthotic Devices	
Prosthetic Appliances and Orthotic Devices $300 maximum benefit for purchase of one (1) wig needed as a result of current chemotherapy or radiation treatment for cancer. **Cochlear Implants** Limit one (1) per impaired ear, with replacements as Medically Necessary or audiologically necessary.	Deductible Applies Yes *then 20% coinsurance* Deductible Applies Yes *then 20% coinsurance* *Any additional charges as described in **Outpatient Surgery** may also apply.*
Hearing Aids	
Hearing Aids Hearing Aid (paid AAOI) no limit Maximum for hearing aids is $2000 every 3 calendar years	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.	Paid same as any other illness

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, neuropsycho-logical, 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.	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

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: $ 2,000 / Family: $ 4,000. 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: $ 5,500 / Family: $ 11,000*
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*

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: *Traditional Select* *If 90-day supply selected, ESN would apply* **Preferred Pharmacy Retail Network Differential:** *N/A (Select if not using the Preferred Pharmacy Retail Network)*	
Specialty Drugs	*Yes, 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?* *Yes, 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	*Copay $15*	*Copay $ or % after deductible*
Preferred Brand Name Drug	*Copay $35*	*Copay $ or % after deductible*
Non-Preferred Brand Name Drug Preferred Specialty Drug (preferred specialty pharmacy network)	*Copay $55*	*Copay $ or % after deductible*
Non-Preferred Specialty Drug (preferred specialty pharmacy) *Specialty Drugs are not covered unless obtained through the specialty pharmacy network.*	*Copay $200*	*Copay $ or % after deductible*

Contraceptives ***NOTE*:** For Performance, Performance Select, and Balance drug lists, coverage will be based on the drug list. Customization is not allowed.	*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).* *Cover additional contraceptives (oral, patches, and rings) not listed in the Pharmacy coverage list?* *Yes – Cover as any other generic, or preferred or non-preferred brand name* *Cover additional contraceptive devices not listed in the Pharmacy Coverage list?* *Yes – Cover as any other generic, or preferred or non-preferred brand name* *NOTE: Non-self injectable contraceptive drugs may be covered under medical.*
Retin A or Pharmacologically Similar Topical Drugs: ***NOTE:*** For Performance, Performance Select and Balanced drug lists, coverage will be based on the drug list. Customization is not allowed.	*Covered* *Does age limit apply? No*
Self-injectable Drugs: ***NOTE:*** For Performance, Performance Select and Balanced drug lists, coverage will be based on the drug list. Customization is not allowed.	*Cover drugs approved by the FDA for self-administration*
Preferred Emergency Medications Select covered drugs from these categories are included at $0 cost share • Severe allergic reactions • Hypoglycemia • Opioid overdoses • Nitrates	*Covered at applicable drug tier*
Mail Order Program (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 Mail Order Pharmacy*
4 Tier Generic Drug Preferred Brand Name Drug Non-Preferred Brand Name Drug Specialty Drug	*Copay $30* *Copay $70* *Copay $110* *Not Applicable*

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.***