Blue Edge HSA/HCA

Non-Grandfathered

BlueCross BlueShield of Texas

BENEFIT SUMMARY
Prepared for Goose Creek CISD TX401496
Funding: ASO
HSA: Embedded
Effective Date: 1/1/2025
Benefit Agreement #: 0001 – HSA HDHP

BlueChoice PPO Network

This is a general summary of our proposed 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	PPO (In-Network)	Non-PPO (Out-of-Network)
Lifetime Maximum	*Unlimited*	
Individual/Family Coverage Deductible		
Applies to all Eligible Expenses, unless otherwise indicated.	*$3,500 Individual $7,000 Family*	*$7,000 Individual $14,000 Family*
Coinsurance	*20%*	*50%*
Individual/Family Medical Coverage Out-of-Pocket Expense (OPX) Limit		
Deductible and 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%.	*$6,500 Individual $13,000 Family*	*$13,000 Individual** $26,000 Family**
Plan Year or Calendar Year Deductible/OPX	*Calendar Year*	
Deductible/OPX credit from prior carrier	*No*	
4th Quarter Carryover	*No*	

Physician Services	PPO (In-Network)	Non-PPO (Out-of-Network)
Physician Office Visits		
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	*20% of Allowable Amount after Deductible PCP*	*50% of Allowable Amount after Deductible*
Specialty Care Copayment Amount for office visit/consultation when services rendered by a Specialty Care Provider Including lab and x-ray (does not include Certain Diagnostic Procedures and surgical services). Copayment applies for each visit to the physician's office. Surgeries, therapies, and certain diagnostic procedures performed in a physician's office may be subject to the Deductible and/or coinsurance.	*20% of Allowable Amount after Deductible Specialist*	*50% 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*	*50% of Allowable Amount after Deductible*
Immunizations for Dependent children through the date of the child's 6th birthday	*100% of Allowable Amount*	*100% of Allowable Amount*
Medical / Surgical Services		
Physician inpatient hospital visits or surgical services performed in any setting	*20% of Allowable Amount after Deductible*	*50% of Allowable Amount after Deductible*
Virtual Visits – MD Live		
Medical and Behavioral Health	*100% of Allowable Amount after Deductible*	*NA*
In-Vitro Fertilization Services	*Decline*	

* 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.

Blue Edge HSA/HCA

Non-Grandfathered

BlueCross BlueShield of Texas

Hospital Services- Inpatient and Outpatient	PPO (In-Network)	Non-PPO (Out-of-Network)
Penalty for failure to preauthorize services	*None*	*$250*
For Inpatient Facility Services, Blue Cross Blue Shield of TX or the Host Blue's Participating Provider is required to obtain preauthorization. If preauthorization is not obtained, the Participating Provider will be sanctioned based on Blue Cross Blue Shield of TX or the Host Blue's contractual agreement with the Provider, therefore the member will be held harmless for the Provider sanction		
Hospital Admission Deductible		
Per admission, per individual	*20% of Allowable Amount after Deductible*	*50% of Allowable Amount after Deductible*
Inpatient Hospital Services		
All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units Room allowances based on the hospital's most common semi-private room rates.	*20% of Allowable Amount after Deductible*	*50% of Allowable Amount after Deductible*
Outpatient Hospital Services		
Coverage for services performed in an outpatient facility or ambulatory surgical center. All other outpatient services and supplies Home Infusion Therapy *(Services must be preauthorized)*	*20% of Allowable Amount after Deductible*	*50% of Allowable Amount after Deductible*
Lab/X-Ray in other Outpatient Facilities, excluding Certain Diagnostic Procedures	*20% of Allowable Amount after Deductible*	*50% 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	*20% of Allowable Amount after Deductible*	*50% of Allowable Amount after Deductible*

Extended Care Services	PPO (In-Network)	Non-PPO (Out-of-Network)
Deductible Applies? *Yes*	*20% of Allowable Amount after Deductible*	*50% of Allowable Amount after Deductible*
Skilled Nursing (Minimum 25 visits)	*25 visits per benefit period*	
Home Health Care (Minimum 60 visits)	*60 visits per benefit period*	
Hospice Services **Bereavement counseling and respite care are standardly included in the Hospice benefit.* ***Note: Private Duty Nursing is not covered.*	*Unlimited*	

Special Provisions Expenses	PPO (In-Network)	Non-PPO (Out-of-Network)
Mental Health & Chemical Dependency Treatment Services ***Penalty for failure to preauthorize services***	*Same as any other illness* *Same as Inpatient Penalty (None INN / $250 OON)*	
Emergency Room/Treatment Room		
Accidental Injury & Emergency Care		
Facility Charges	*20% of Allowable Amount after Deductible*	
Physician Charges	*20% of Allowed Amount after Deductible*	
Non-Emergency Care		
Facility Charges	*20% of Allowable Amount after Deductible*	*50% of Allowed Amount after Deductible*
Physician Charges	*20% of Allowable Amount after Deductible*	*50% of Allowable Amount after Deductible*
Urgent Care Services Urgent Care center visit, including lab & x-ray services *(Copayment does not include Certain Diagnostic Procedures and surgical services)*	*20% of Allowable Amount after Deductible*	*50% of Allowed Amount after Deductible*
Ground and Air Ambulance Services	*20% of Allowable Amount after Deductible*	
Physical Medicine Services – Occupational, Physical, Speech and Chiropractic		
Physical Medicine Services (includes, but is not limited to physical, occupational, and manipulative therapy) Coverage for services provided by a physician or therapist. Includes Physical, Occupational, Speech and Chiropractic Services. ***100*** *Combined* visits per benefit period	*20% of Allowable Amount after Deductible*	*50% of Allowable Amount after Deductible*
Durable Medical Equipment	*20% of Allowable Amount after Deductible*	*50% of Allowable Amount after Deductible*
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 Maximum	*Hearing aids max $2000 every 3 calendar years.*
Organ and Tissue Transplant Services		*Covered same as any other illness*

Acupuncture Services

Acupuncture Services in the Physician's Office	*Not Covered*	*Not Covered*
Acupuncture Services in an Outpatient Facility	*Not Covered*	*Not Covered*

Bariatric Surgery/Treatment of Morbid Obesity (Obesity drugs will also be covered)

Bariatric Surgery/Treatment of Morbid Obesity *Bariatric Surgery* *BDC+ Only (BDIS: BRCP)*	*Blue Distinction+* *20% of Allowable Amount after Deductible after calendar year*	*OON* *Not Covered*

Blue Edge HSA/HCA

Non-Grandfathered

BlueCross BlueShield of Texas

Pharmacy Benefits

Pharmacy Network	*Traditional Select (Includes CVS)*
Drug List	*Performance Select*
Prescription Drug Deductible***	*Aggregate* *Separate Prescription Drug Deductible applies to Retail & Mail Service Pharmacy: Individual: $ 3,500 / Family: $ 7,000.* *Deductible will apply to the Out-of-Pocket Maximum.*
Prescription Drug Out-of-Pocket Maximum	*Embedded* *Separate Prescription Drug Out-of-Pocket Maximum applies to Retail & Mail Service Pharmacy: Individual: $ 6,500 / Family: $ 13,000*
Specialty Drugs	*Yes, Specialty Lock-Out through specialty pharmacy network provider 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*
Preferred Pharmacy Network Differential	*Not Applicable*

Retail Copayment Amounts	***Participating Pharmacy****	***Non-Participating Pharmacy*** ***(member files claim)***
Generic Drugs	*20% of Allowable Amount after Deductible*	*50% of Allowed Amount minus Copayment and after Deductible*
Preferred Brand Name Drugs	*20% of Allowable Amount after Deductible*	*50% of Allowed Amount minus Copayment and after Deductible*
Non-Preferred Brand Name Drugs	*20% of Allowable Amount after Deductible*	*50% of Allowed Amount minus Copayment and after Deductible*
Specialty Drugs	*Not Applicable*	*Not Applicable*

Mail Order Copayment Amounts		
Days Supply: *90 day supply*		
Generic Drugs	*20% of Allowable Amount after Deductible*	NA
Preferred Brand Name Drugs	*20% of Allowable Amount after Deductible*	NA
Non-Preferred Brand Name Drugs	*20% of Allowable Amount after Deductible*	NA
MAC level	***MAC 2 - Rx Enhanced-****Members electing to purchase Brand Name Drugs when "Brand Medically Necessary" is not indicated and a Generic equivalent is available, will be required to pay the difference between the cost of the Generic and Brand Name Drug, plus the applicable Copayment Amount. If "Brand Medically Necessary" is indicated on the prescription, the member will pay the Brand Name Copayment Amount.*	

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

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.

This benefit summary is a Non-Grandfathered health plan. This is not a contract. This benefit summary does not contain a complete list of benefits available to you, nor does it contain a listing of exclusions, limitations and conditions that apply to the benefits shown. Full information can be found in the Certificate of Benefits.