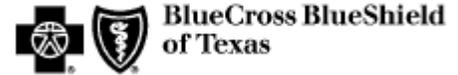


**Blue Essentials<sup>SM</sup> Network**  
**Blue Essentials<sup>SM</sup> Plan**  
**(HMO)**



**Insured Benefit Highlights**

Prepared For: College Station ISD  
Effective Date: 09-01-2023

The following chart summarizes the coverage available under the offered HMO plan. All Covered Services (except in emergencies) must be provided by or through the Member's Participating Primary Care Physician/Practitioner (PCP), who may refer them for further treatment by Providers in the applicable network of Participating Specialists and Hospitals. Female Members may visit a Participating OB/GYN Physician in their PCP's Provider network for diagnosis and treatment without a Referral from their PCP. Urgent Care and Retail Health Clinics do not require Primary Care Physician/Practitioner Referral. This summary should be reviewed along with the Limitations and Exclusions.

IMPORTANT NOTE: Copayments and, if applicable, Coinsurance shown below indicate the amount you are required to pay, expressed as either a fixed dollar amount or a percentage of the Allowable Amount. Copayment and any applicable Coinsurance or Deductibles will be applied for each occurrence unless otherwise indicated. Copayments/Coinsurance, Deductibles and out-of-pocket maximums may be adjusted for various reasons as permitted by applicable law. Some services may require Preauthorization by HMO.

***Out-of-Pocket Maximums Per Plan 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)	Yes
Deductible applies to Out-of-Pocket	Yes
Copayment applies to Out-of-Pocket	Yes

## ***Deductible Per Plan Year***

Per Individual Member	\$ 1,500
Per Family	\$ 3,000
Deductible credit from prior carrier (Applied on initial group enrollment only)	Yes
Common (One Deductible that applies to Inpatient Facility and Medical/Surgical Services)	

## ***Professional Services***

<b>Primary Care Physician/Practitioner (“PCP”) Office or Home Visit</b>	\$ 30 Copay
<b>Participating Specialist Physician (“Specialist”) Office or Home Visit</b>	\$ 45 Copay

## ***Inpatient Hospital Services***

<b>Inpatient Hospital Services, facility per admission</b>	20% Coinsurance after Deductible
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## ***Outpatient Facility Services***

<b>Outpatient Surgery</b>	20% Coinsurance after Deductible
<b>Radiation Therapy and Chemotherapy</b>	20% Coinsurance after Deductible
<b>Dialysis</b>	20% Coinsurance after Deductible

## ***Outpatient Laboratory and X-Ray Services***

Arteriograms, Computerized Tomography (CT Scan), Magnetic Resonance Imaging (MRI) Electroencephalogram (EEG), Myelogram, Positron Emission Tomography (PET Scan), per procedure	20% Coinsurance after Deductible
Other X-Ray Services	20% Coinsurance after Deductible
Outpatient Lab	20% Coinsurance after Deductible

## ***Diagnostic Mammograms***

Diagnostic Mammograms are covered to the same extent as screening mammograms without member age limits as described in the <b>COVERED SERVICES AND BENEFITS; Health Maintenance and Preventive Services.</b>	No Copay
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## *Rehabilitation Services*

<b>Rehabilitation Services and Therapies</b> , per visit	\$ 30 Copay for PCP or \$ 45 Copay for Specialist, 20% Coinsurance after Deductible for Inpatient Hospital Services or 20% Coinsurance after Deductible for Outpatient Facility Services, as applicable.
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## *Maternity Care and Family Planning Services*

<b>Maternity Care</b>	
Prenatal and Postnatal Visit - Copay is applied to the first office visit only. Subsequent office visits are covered in full.	\$ 30 Copay for PCP or \$ 45 Copay for Specialist
Inpatient Hospital Services, for each admission	20% Coinsurance after Deductible
<b>Family Planning Services:</b>	
<ul style="list-style-type: none"> <li>• Diagnostic counseling, consultations and planning services</li> <li>• Insertion or removal of intrauterine device (IUD), including cost of device</li> <li>• Diaphragm or cervical cap fitting, including cost of device</li> <li>• Insertion or removal of birth control device implanted under the skin, including cost of device</li> <li>• Injectable contraceptive drugs, including cost of drug</li>   <li>• Vasectomy</li> </ul>	<p>\$ 30 Copay for PCP or \$ 45 Copay for Specialist; unless otherwise covered under Contraceptive Services described in <b>Health Maintenance and Preventive Services</b>.</p> <p>\$ 30 Copay for PCP or \$ 45 Copay for Specialist, or 20% Coinsurance after Deductible for Outpatient Surgery, as applicable.</p>
<b>Infertility Services</b>	
Diagnostic counseling, consultations, planning and treatment services	\$ 30 Copay for PCP or \$ 45 Copay for Specialist
Artificial insemination, for each procedure and all services related to procedure (cost of sperm not covered)	\$ 30 Copay for PCP or \$ 45 Copay for Specialist, 20% Coinsurance after Deductible for Outpatient Surgery
<b>In Vitro Fertilization</b> , benefits paid same as any other pregnancy-related illness	Not Covered
<b>IV – In Vitro Fertilization</b>	Not Covered

<b>Pregnancy Terminations</b> , limited to Medically Necessary therapeutic terminations of pregnancy	\$ 30 Copay for PCP or \$ 45 Copay for Specialist, 20% Coinsurance after Deductible for Inpatient Hospital Services, or 20% Coinsurance after Deductible for Outpatient Surgery, as applicable.
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***Behavioral Health Services***

<b>Outpatient Mental Health Care</b>	Same as PCP amount described in <b>Professional Services</b> .
<b>Inpatient MI Mental Health Care</b>	Any charges described in <b>Inpatient Hospital Services</b> will apply.
<b>Inpatient Mental Health Care (IM5)</b>	Deductible Applies 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.
<b>Serious Mental Illness</b>	Benefits paid same as any other physical illness.
<b>Chemical Dependency Services</b>	Benefits paid same as any other Behavioral Health Service.

***Emergency Services***

<b>Emergency Care</b>	\$ 500 Copay, plus 20% Coinsurance after Deductible, Copayment waived if admitted. (If admitted, any charges described in <b>Inpatient Hospital Services</b> will apply.)
<b>Physician</b>	20% Coinsurance after Deductible

***Urgent Care Services***

<b>Urgent Care</b>	\$ 75 Copay Any additional charges as described in <b>Outpatient Laboratory and X-Ray Services</b> may also apply.
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***Retail Health Clinics***

<b>Retail Health Clinics</b>	PCP amount listed in <b>Professional Services</b>
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***Ambulance Services***

<b>Ambulance Services</b>	20% Coinsurance after Deductible
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***Extended Care Services***

<b>Skilled Nursing Facility Services</b> , for each day, up to 60 days per Calendar Year	20% Coinsurance after Deductible
<b>Hospice Care</b> , for each day	20% Coinsurance after Deductible; unless otherwise covered under <b>Inpatient Hospital Services</b> .
<b>Home Health Care</b> , per visit	20% Coinsurance after Deductible

***Health Maintenance and Preventive Services***

Well child care through age 17	No Copay
Periodic health assessments for Members age 18 and older	No Copay
Immunizations <ul style="list-style-type: none"> <li>Childhood immunizations required by law for Members through age 6</li> <li>Immunizations for Members over age 6</li> </ul>	No Copay No Copay
Exam for prostate cancer, once every twelve months	\$ 30 Copay for PCP or \$ 45 Copay for Specialist
Bone mass measurement for osteoporosis	No Copay
Well-woman exam, once every twelve months, includes, but not limited to, exam for cervical cancer (Pap smear)	No Copay
Screening mammogram for female Members age 25 and over and for female Members with other risk factors, once every twelve months <ul style="list-style-type: none"> <li>Outpatient facility or imaging centers</li> </ul>	No Copay No Copay
Contraceptive Services and Supplies <ul style="list-style-type: none"> <li>Contraceptive education, counseling and certain female FDA approved contraceptive methods, female sterilization procedures and devices</li> <li>Tubal Ligation</li> </ul>	No Copay No Copay
Breastfeeding Support, Counseling and Supplies <ul style="list-style-type: none"> <li>Electric breast pumps limited to one (1) per Calendar Year</li> </ul>	No Copay
Hearing Loss <ul style="list-style-type: none"> <li>Screening test from birth through 30 days</li> <li>Follow-up care from birth through 24 months</li> </ul>	No Copay No Copay
Rectal screening for the detection of colorectal cancer for Members age 75 and older: <ul style="list-style-type: none"> <li>Annual fecal occult blood test, once every twelve months</li> <li>Flexible sigmoidoscopy with hemoccult of the stool, limited to 1 every 5 years</li> <li>Colonoscopy, limited to 1 every 30 years</li> </ul>	No Copay No Copay No Copay
Eye and ear screenings for Members through age 17, once every twelve months	\$30 Copay for PCP or \$45 Copay for Specialist
Eye and ear screening for Members age 18 and older, once every two years	\$30 Copay for PCP or \$45 Copay for Specialist
Early detection test for cardiovascular disease, limited to 1 every 5 years. <ul style="list-style-type: none"> <li>Computer tomography (CT) scanning</li> <li>Ultrasonography</li> </ul>	20% Coinsurance after Deductible 20% Coinsurance after Deductible
Early detection test ovarian cancer (CA125 blood test), once every twelve months	\$30 Copay for PCP or \$45 Copay for Specialist

### ***Dental Surgical Procedures***

<b>Dental Surgical Procedures</b> (limited Covered Services)	\$30 Copay for PCP or \$45 Copay for Specialist, 20% Coinsurance after Deductible for Inpatient Hospital Services, or 20% Coinsurance after Deductible for Outpatient Surgery, as applicable.
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### ***Cosmetic, Reconstructive or Plastic Surgery***

<b>Cosmetic, Reconstructive or Plastic Surgery</b> (limited Covered Services)	\$30 Copay for PCP or \$45 Copay for Specialist, 20% Coinsurance after Deductible for Inpatient Hospital Services, or 20% Coinsurance after Deductible for Outpatient Surgery, as applicable.
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### ***Allergy Care***

<b>Testing and Evaluation</b>	20% Coinsurance after Deductible
<b>Injections</b>	20% Coinsurance after Deductible
<b>Serum</b>	20% Coinsurance after Deductible

### ***Diabetes Care***

<b>Diabetes Self-Management Training</b> , for each visit	\$30 Copay for PCP or \$45 Copay for Specialist
<b>Diabetes Equipment</b>	20% Coinsurance after Deductible
<b>Diabetes Supplies</b> Some Diabetes Supplies are only available utilizing pharmacy benefits, through a Participating Pharmacy. You must pay the applicable <b>PHARMACY BENEFITS</b> amount shown in the <b>SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS</b> and any applicable pricing differences.	20% Coinsurance after Deductible

### ***Prosthetic Appliances and Orthotic Devices***

<b>Prosthetic Appliances and Orthotic Devices</b>	20% Coinsurance after Deductible
\$300 maximum benefit for purchase of one (1) wig needed as a result of current chemotherapy or radiation treatment for cancer.	
<b>Cochlear Implants</b> Limit one (1) per impaired ear, with replacements as Medically Necessary or audiological necessary.	20% Coinsurance after Deductible. Any additional charges as described in <b>Outpatient Surgery</b> may also apply.

### ***Hearing Aids***

<b>Hearing Aids</b> Maximum benefit - one per ear, every 36 months	20% Coinsurance after Deductible
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## *Durable Medical Equipment*

### **Durable Medical Equipment (DM8)**

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

General Payment Level; Deductible Applies

## *Speech and Hearing Services*

**SH1 – 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.

Deductible Applies *Yes*

## *Pharmacy Benefits*

Prescription Drug Benefits (Prime Therapeutics)

**Drug List\*\***

Performance

**Prescription Drug Out-of-Pocket Maximum**

All benefits, including prescription drug benefits (retail and mail service) apply to the Out-of-Pocket Maximum shown on page 1.

**Prescription Drug Deductible\*\*\***

None

**Participating Pharmacy  
Retail Pharmacy**

One Copayment amount per 30-day supply, up to a 30-day supply.

Preferred Generic Drug

\$10 Copay

Preferred Brand Name Drug

\$40 Copay

Non-Preferred Brand Name Drug

\$70 Copay

**Mail-Order Program**

One Copayment amount per 90-day supply, up to a 90-day supply only

Preferred Generic Drug

\$30 Copay

Preferred Brand Name Drug

\$120 Copay

Non-Preferred Brand Name Drug

\$210 Copay

<b>Specialty Pharmacy Program</b> One Copayment amount per 30-day supply, up to a 30-day supply only	Preferred Specialty Drug  Non-Preferred Specialty Drug	\$100 Copay

\*\*The drug lists are available at: [bcbstx.com/member/rx\\_drugs.html](http://bcbstx.com/member/rx_drugs.html)

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

For additional information regarding the applicable Drug List/Preferred Drug List, please call customer service or visit the website at [http://www.bcbstx.com/members/rx\\_drugs.html](http://www.bcbstx.com/members/rx_drugs.html)