Blue Essentials SM Network
Blue Essentials SM Plan
(HMO)

BlueCross BlueShield of Texas

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	$ *8,000*
Per Family	$ *16,000*
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	$ *2,500*
Per Family	$ *5,000*
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	
Primary Care Physician/Practitioner ("PCP") Office or Home Visit	$ *30* Copay
Participating Specialist Physician ("Specialist") Office or Home Visit	$ *45* Copay
Inpatient Hospital Services	
Inpatient Hospital Services, facility per admission	*20*% Coinsurance after Deductible
Outpatient Facility Services	
Outpatient Surgery	*20*% Coinsurance after Deductible
Radiation Therapy and Chemotherapy	*20*% Coinsurance after Deductible
Dialysis	*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 **COVERED SERVICES AND BENEFITS; Health Maintenance and Preventive Services.**	No Copay

Rehabilitation Services and Therapies, 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.

Maternity Care and Family Planning Services

Maternity Care	
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
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	$ *30* Copay for PCP or $ *45* Copay for Specialist; unless otherwise covered under Contraceptive Services described in **Health Maintenance and Preventive Services.**
• Vasectomy	$ *30* Copay for PCP or $ *45* Copay for Specialist, or *20%* Coinsurance after Deductible for Outpatient Surgery, as applicable.
Infertility Services	
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
In Vitro Fertilization, benefits paid same as any other pregnancy-related illness	Not Covered
IV – In Vitro Fertilization	Not Covered

Pregnancy Terminations, 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.
Behavioral Health Services	
Outpatient Mental Health Care	Same as PCP amount described in **Professional Services**.
Inpatient MI Mental Health Care	Any charges described in **Inpatient Hospital Services** will apply.
Inpatient Mental Health Care (IM5)	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.
Serious Mental Illness	Benefits paid same as any other physical illness.
Chemical Dependency Services	Benefits paid same as any other Behavioral Health Service.
Emergency Services	
Emergency Care	$ *500* Copay, plus *20%* Coinsurance after Deductible, Copayment waived if admitted. (If admitted, any charges described in **Inpatient Hospital Services** will apply.)
Physician	*20%* Coinsurance after Deductible
Urgent Care Services	
Urgent Care	$ 75 Copay Any additional charges as described in **Outpatient Laboratory and X-Ray Services** may also apply.
Retail Health Clinics	
Retail Health Clinics	PCP amount listed in **Professional Services**
Ambulance Services	
Ambulance Services	*20%* Coinsurance after Deductible
Extended Care Services	
Skilled Nursing Facility Services, for each day, up to 60 days per Calendar Year	*20%* Coinsurance after Deductible
Hospice Care, for each day	*20%* Coinsurance after Deductible; unless otherwise covered under **Inpatient Hospital Services**.
Home Health Care, 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 • Childhood immunizations required by law for Members through age 6 • Immunizations for Members over age 6	 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 • Outpatient facility or imaging centers	No Copay No Copay
Contraceptive Services and Supplies • Contraceptive education, counseling and certain female FDA approved contraceptive methods, female sterilization procedures and devices • Tubal Ligation Breastfeeding Support, Counseling and Supplies • Electric breast pumps limited to one (1) per Calendar Year	 No Copay No Copay No Copay
Hearing Loss • Screening test from birth through 30 days • Follow-up care from birth through 24 months	 No Copay No Copay
Rectal screening for the detection of colorectal cancer for Members age 75 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 30 years	 No Copay No Copay No Copay
Eye and ear screenings for Members through age 17, once every twelve months Eye and ear screening for Members age 18 and older, once every two years	$30 Copay for PCP or $45 Copay for Specialist $30 Copay for PCP or $45 Copay for Specialist
Early detection test for cardiovascular disease, limited to 1 every 5 years. • Computer tomography (CT) scanning • Ultrasonography	 *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	

Dental Surgical Procedures (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.
Cosmetic, Reconstructive or Plastic Surgery	
Cosmetic, Reconstructive or Plastic Surgery (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.
Allergy Care	
Testing and Evaluation	*20%* Coinsurance after Deductible
Injections	*20%* Coinsurance after Deductible
Serum	*20%* Coinsurance after Deductible
Diabetes Care	
Diabetes Self-Management Training, for each visit	$30 Copay for PCP or $45 Copay for Specialist
Diabetes Equipment	*20%* Coinsurance after Deductible
Diabetes Supplies Some Diabetes Supplies are only available utilizing pharmacy benefits, through a Participating Pharmacy. You must pay the applicable **PHARMACY BENEFITS** amount shown in the **SCHEDULE OF COPAYMENTS AND BENEFIT LIMITS** and any applicable pricing differences.	*20%* Coinsurance after Deductible
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.	*20%* Coinsurance after Deductible
Cochlear Implants Limit one (1) per impaired ear, with replacements as Medically Necessary or audiologically necessary.	*20%* Coinsurance after Deductible. Any additional charges as described in **Outpatient Surgery** may also apply.
Hearing Aids	
Hearing Aids Maximum benefit - one per ear, every 36 months	*20%* Coinsurance after Deductible

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 Preferred Brand Name Drug Non-Preferred Brand Name Drug	$*10* Copay $40 Copay $*70* Copay
Mail-Order Program One Copayment amount per 90-day supply, up to a 90-day supply only	Preferred Generic Drug Preferred Brand Name Drug Non-Preferred Brand Name Drug	$30 Copay $*120* Copay $*210* Copay

Specialty Pharmacy Program 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

*** 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