Preferred Provider Benefit Plan (PPO) – RM24

Huston-Tillotson University

BENEFIT HIGHLIGHTS — *BlueChoice Network*

This is a general summary of your benefits. Please refer to your benefit booklet for additional details and a description of the plan requirements and benefit design. This plan does not cover all health care expenses. Upon receipt of your benefit booklet, carefully review the plan's limitations and exclusions.

Overall Payment Provisions	PPO (In-Network)	Non-PPO (Out-of-Network)
Calendar Year Deductible (Combined)		
Applies to all Eligible Expenses (unless otherwise indicated)	*$2500 Individual /$7500 Family*	
4th quarter Deductible carryover applies	*Yes*	
Deductible credit from prior carrier (applied on initial group enrollment only)	*Yes*	
Copayment Amounts Required		
Physician office visit/consultation	*$30 Copayment Amount*	
Urgent Care center visit	*$55 Copayment Amount*	
Outpatient Hospital Emergency Room visit	*$100 Copayment Amount*	*$100 Copayment Amount*
Coinsurance Stop-Loss Amount		
Deductibles are not applied to Coinsurance Stop-Loss Amount. Your benefit booklet will provide more details.	*$4,000 Individual / $12,000 Family* *Network Coinsurance Stop-Loss Amount **will only** apply toward Network Coinsurance Stop-Loss Amount*	*$8,000 Individual / $24,000 Family* *Out-of-Network Coinsurance Stop-Loss Amount **will also** apply toward Network Coinsurance Stop-Loss Amount*
Credit for Coinsurance Stop-Loss Amount from prior carrier (applied on initial group enrollment only)	*Yes*	*Yes*
Maximum Lifetime Benefits		
Per individual	*Unlimited*	
Inpatient Hospital Expenses		
Inpatient Hospital Expenses *(must be preauthorized)*		
Inpatient Hospital Expenses	*70% of Allowable Amount after Calendar Year Deductible*	*50% of Allowable Amount after Calendar Year Deductible*
Penalty for failure to preauthorize	*None*	*$250*
Medical/Surgical Expenses		
Medical / Surgical Expenses		
Physician office visit/consultation, including lab & x-ray	*100% of Allowable Amount after $30 Copayment Amount*	*70% of Allowable Amount after Calendar Year Deductible*
Physician surgical services in any setting	*70% of Allowable Amount after Calendar Year Deductible*	*50% of Allowable Amount after Calendar Year Deductible*
Lab & x-ray in other outpatient facilities (excluding Certain Diagnostic Procedures)	*100% of Allowable Amount*	*70% of Allowable Amount after Calendar Year Deductible*
Certain Diagnostic Procedures: Bone Scan, Cardiac Stress Test, CT Scan (with or without contrast), Ultrasound, MRI, Myelogram, PET Scan	*70% of Allowable Amount after Calendar Year Deductible*	*50% of Allowable Amount after Calendar Year Deductible*
Home Infusion Therapy (must be preauthorized)	*70% of Allowable Amount after Calendar Year Deductible*	*50% of Allowable Amount after Calendar Year Deductible*
In Vitro Fertilization Services	*Declined*	
All other outpatient services and supplies	*70% of Allowable Amount after Calendar Year Deductible*	*50% of Allowable Amount after Calendar Year Deductible*

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Extended Care Expenses	PPO (In-Network)	Non-PPO (Out-of-Network)
Extended Care Expenses *(must be preauthorized)*	*100% of Allowable Amount*	*70% of Allowable Amount after Calendar Year Deductible*
Skilled Nursing Facility Home Health Care Hospice Care	*Limited to 25 days maximum each Calendar Year** *Limited to 60 visits each Calendar Year** *Unlimited*	
Special Provisions Expenses		
Treatment of Chemical Dependency *(must be preauthorized)*		
Inpatient treatment must be provided in a Chemical Dependency Treatment Center	*Covered as any other sickness*	*Covered as any other sickness*
All other outpatient treatment	*Covered as any other sickness*	*Covered as any other sickness*
Serious Mental Illness *(must be preauthorized)*		
Inpatient Services Hospital services (facility)	*70% of Allowable Amount after Calendar Year Deductible*	*50% of Allowable Amount after Calendar Year Deductible*
Physician services	*70% of Allowable Amount after Calendar Year Deductible*	*50% of Allowable Amount after Calendar Year Deductible*
Outpatient Services Physician office visit/consultation, including lab & x-ray	*100% of Allowable Amount after $30 Copayment Amount*	*70% of Allowable Amount after Calendar Year Deductible*
Other outpatient services, including psychological testing	*70% of Allowable Amount after Calendar Year Deductible*	*50% of Allowable Amount after Calendar Year Deductible*
Mental Health Care *(must be preauthorized)*		
Inpatient Services Hospital services (facility)	*70% of Allowable Amount after Calendar Year Deductible*	*50% of Allowable Amount after Calendar Year Deductible*
Physician services	*70% of Allowable Amount after Calendar Year Deductible*	*50% of Allowable Amount after Calendar Year Deductible*
Outpatient Services Physician office visit/consultation, including lab & x-ray	*100% of Allowable Amount after $30 Copayment Amount*	*70% of Allowable Amount after Calendar Year Deductible*
Other outpatient services, including psychological testing	*70% of Allowable Amount after Calendar Year Deductible*	*50% of Allowable Amount after Calendar Year Deductible*
Emergency Care/Outpatient Hospital Emergency Room		
Accidental Injury & Medical Emergency Care Facility charges	*70% of Allowable Amount after $100 Copayment Amount (Copayment Amount waived if admitted)*	
Physician charges	*70% of Allowable Amount after Calendar Year Deductible*	
Non-Emergency Situations Facility charges	*70% of Allowable Amount after $100 Copayment Amount (Copayment Amount waived if admitted)*	*50% of Allowable Amount after $100 Copayment Amount & Calendar Year Deductible (Copayment Amount waived if admitted)*
Physician charges	*70% of Allowable Amount after Calendar Year Deductible*	*50% of Allowable Amount after Calendar Year Deductible*

* Benefits used In-Network and Out-of-Network will apply toward satisfying any day, visit, or Calendar Year Maximum amounts indicated

Special Provisions Expenses, cont.	PPO (In-Network)	Non-PPO (Out-of-Network)
Urgent Care Services		
Urgent Care center visit, including all lab & x-ray services, except Certain Diagnostic Procedures	*100% of Allowable Amount after $55 Copayment Amount*	*70% of Allowable Amount after Calendar Year Deductible*
Certain Diagnostic Procedures and all services and supplies	*70% of Allowable Amount after Calendar Year Deductible*	*50% of Allowable Amount after Calendar Year Deductible*
Preventive Care		
Routine annual physicals, well-baby care, immunizations(after 6th birthdate), and other preventive health services as determined by the USPSTF	*100% of Allowable Amount*	*70% of Allowable Amount after Calendar Year Deductible*
Immunizations (birth through the day of the 6th birthdate)	*100% of Allowable Amount*	*100% of Allowable Amount*
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 Aids	*70% of Allowable Amount after Calendar Year Deductible*	*50% of Allowable Amount after Calendar Year Deductible*
Hearing Aids Maximum Benefit	*Hearing aids are subject to a $1,000 maximum amount each 36-month period**	
Physical Medicine Services		
Physical Medicine Services (includes but is not limited to physical, occupational, and manipulative therapy)	*70% of Allowable Amount after Calendar Year Deductible*	*50% of Allowable Amount after Calendar Year Deductible*
Calendar Year Maximum	*Limited to 35 visits each Calendar Year**	

* All benefit payments made for both In-Network and Out-of-Network services will apply toward any maximum amounts indicated.

Prescription Drug Program	Participating Pharmacy	Non-Participating Pharmacy (member files claim)
Prescription Drugs		
Retail Prescription** (All Copayment Amounts are per 30-day supply and will not apply to Coinsurance Stop-Loss Amount)		
Generic	*$20 Copayment Amount*	*80% of Allowable Amount minus Copayment Amount*
Preferred Brand Name	*$40 Copayment Amount*	*80% of Allowable Amount minus Copayment Amount*
Non-Preferred Brand Name	*$60 Copayment Amount*	*80% of Allowable Amount minus Copayment Amount*
Mail Service Prescription** (All Copayment Amounts are per 30-day supply and will not apply to Coinsurance Stop-Loss Amount)		
Generic	*$20 Copayment Amount*	
Preferred Brand Name	*$40 Copayment Amount*	
Non -Preferred Brand Name	*$60 Copayment Amount*	

***Generic Incentive**-Members electing to purchase Preferred/Non-Preferred Brand Name Drugs when a Generic equivalent is available, will be required to pay the difference between the cost of the Generic and Preferred/Non-Preferred Brand Name Drug, plus the Preferred Brand Name Copayment Amount.*

***Diabetes Supplies** are available under the Prescription Drug Program portion of your plan. Diabetes 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.*

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EMPLOYEE INFORMATION

The following benefits apply to dependent coverage:

- Dependent children are covered for maternity benefits.
- Automatic coverage for newborns for the first 31 days following birth. Infants not enrolled for coverage within the first 31 days after birth will not be eligible for coverage until the following open enrollment period or special enrollment event.

Payments: Network providers agree to accept amounts negotiated with BCBSTX and are paid according to this BCBSTX-determined Allowable Amount. Covered individuals are responsible for any required Deductibles, Coinsurance Amounts, and Copayments. Plan benefits paid to Out-of-Network providers are also based on the BCBSTX-determined Allowable Amount. Covered individuals will be responsible for charges in excess of the Allowable Amount in addition to any applicable Deductibles, Coinsurance Amounts, and Copayments. For cost savings information, refer to the section on ParPlan Providers and the definition of Allowable Amount in the benefit booklet.

Preexisting conditions Provision: Benefits for Eligible Expenses incurred for treatment of a Preexisting Condition will not be available during the twelve-month period following the individual's initial Effective Date, or if a Waiting Period applies, the first day of the Waiting Period. In accordance with state and federal law, certain conditions will not be considered Preexisting Conditions and the Preexisting Condition exclusion will not apply to certain individuals. Details are provided in the benefit booklet.

Replacement of Medical Coverage: In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Texas State law, the following provisions apply to each eligible participant who has health coverage under the employer's plan immediately prior to the effective date of the health contract between the employer and BCBSTX (the contract date):

- Benefits for Eligible Expenses incurred for any service or supplies prior to the Contract Date, are not covered under the contract.
- Eligible Expenses for services or supplies incurred on or after the effective date will be considered for benefits subject to all applicable contract provisions.

Members residing in other states may use that state's network through the BlueCard program. To locate a participating provider in your state, please contact 1-800-810-BLUE or visit our web site at www.bcbstx.com to use our Provider Finder® tool.

This proposal assumes the group contract will be issued in Texas. In addition to the benefits stated herein, benefits for covered persons who reside outside of Texas will conform to all Extraterritorial requirements of those states.

This proposal is made on the condition you are not a Small Employer as defined in the Texas Insurance Code. A proposal to a Small Employer would have to contain specific contractual elements and mandated insurance plans not contained in this proposal. Should it be determined you were a Small Employer, this proposal and any health insurance contract issued to you, shall be null and void.

______________________	______________________	__________
Group Executive Name and Title (Please type or print)	Signature	Date
______________________	______________________	__________
Agent of Record Name (Please type or print)	Signature	Date
______________________	______________________	__________
BCBSTX Representative Name (Please type or print)	Signature	Date