Texas Association of Counties Health and Employee Benefits Pool

BENEFIT HIGHLIGHTS
HENDERSON COUNTY CUSTOM PLAN
(Non-Grandfathered ACA 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 or Out-of-Network Benefits. Please carefully review the plan's limitations and exclusions in your benefit booklet. All Covered Services (except in emergencies) must be provided by or through your Participating Primary Care Physician/Practitioner (PCP), who may refer you 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 does not require a PCP referral.

Deductible per Plan Year	
Per Individual Member	*$1,500*
Per Family	*$4,500*

Out-of-Pocket Maximums Per Plan Year	
Per Individual Member	*$5,500*
Per Family	*$8,700*
Deductible applies to Out-of-Pocket	*No*
Copayment applies to Out-of-Pocket	*Yes*

Professional Services	
Primary Care Physician ("PCP") Office or Home Visit	Deductible Applies No *$30 Copay*
Participating Specialist Physician ("Specialist") Office or Home Visit	Deductible Applies No *$40 Copay*
MDLIVE (Telemedicine)	*$10 Copay*

Inpatient Hospital Services	
Inpatient Hospital Services (for each admission)	Deductible Applies No *80% of Allowable Amount*
Penalty for failure to preauthorize services	*None*

BlueCross BlueShield of Texas

Outpatient Facility Services	
Outpatient Surgery	Deductible Applies Yes *80% of Allowable Amount after Plan Year Deductible*
Radiation Therapy	Deductible Applies Yes *80% of Allowable Amount after Plan Year Deductible*
Dialysis	Deductible Applies Yes *80% of Allowable Amount after Plan Year Deductible*
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 *80% of Allowable Amount*
Other Outpatient Lab	Deductible Applies No *100% of Allowable Amount after Plan Year Deductible*
Other X-Ray Services	Deductible Applies No *100% of Allowable Amount after Plan Year Deductible*
Rehabilitation Services	
Rehabilitation Services and Therapies	
PCP	*$30 Copay*
Specialist	*$40 Copay*
Inpatient Physician Services	Deductible Applies Yes *80% of Allowable Amount after Plan Year Deductible*
Inpatient Hospital Services	Deductible Applies No *80% of Allowable Amount*
Outpatient Facility Services (as applicable)	Deductible Applies Yes *80% of Allowable Amount after Plan Year Deductible*
Maternity Care and Family Planning Services	
Maternity Care	
Prenatal and Postnatal Visit	
PCP	*$30 Copay*
Specialist	*$40 Copay*
Inpatient Physician Services	Deductible Applies Yes *80% of Allowable Amount after Plan Year Deductible*

Inpatient Hospital Services, for each admission	Deductible Applies No *80% of Allowable Amount*
Voluntary sterilization Vasectomy	
PCP	*$30 Copay*
Specialist	*$40 Copay*
Outpatient Surgery Services (as applicable)	Deductible Applies Yes *80% of Allowable Amount after Plan Year Deductible*
Infertility Services	
Diagnostic counseling, consultations, planning and treatment services	Not Covered
Artificial insemination, for each procedure and all services related to procedure	Not Covered
Pregnancy Terminations	
Limited to Medically Necessary therapeutic terminations of pregnancy	
PCP	*$30 Copay*
Specialist	*$40 Copay*
Inpatient Physician Charges	Deductible Applies Yes *80% of Allowable Amount after Plan Year Deductible*
Inpatient Hospital Services	Deductible Applies No *80% of Allowable Amount*
Outpatient Surgery Services (as applicable)	Deductible Applies Yes *80% of Allowable Amount after Plan Year Deductible*
Behavioral Health Services	
Mental Health Care (Serious Mental Illness (SMI) included)	*All services must be preauthorized*
Inpatient Services -Hospital services (facility)	Deductible Applies No *80% of Allowable Amount*
-Physician services	Deductible Applies Yes *80% of Allowable Amount after Plan Year Deductible*
Plan Year Maximum	*30 inpatient days/30 inpatient Physician visits each Plan Year*
Outpatient Services -Services performed during Physician office visit/consultation *(does not include psychological testing)*	Deductible Applies No *$30 Copay*
-Other Outpatient Services and psychological testing	Deductible Applies Yes *80% of Allowable Amount after Plan Year Deductible*
Plan Year Maximum	*30 outpatient visits each Plan Year*

Chemical Dependency (Substance Use Disorder) Services *All services must be preauthorized*	
Inpatient Services -Hospital services (facility)	Deductible Applies No *80% of Allowable Amount*
-Physician services	Deductible Applies Yes *80% of Allowable Amount after Plan Year Deductible*
Outpatient Services -Services performed during Physician office visit/consultation *(Does not include psychological testing)*	Deductible Applies No *$30 / $40 Copay*
Chemical Dependency Maximum *(Inpatient treatment must be provided in a Chemical Dependency Treatment Center)*	*Limited to three separate series of treatments for each covered individual per lifetime*
Emergency Care Services	
Emergency Care- Facility *(Copayment amount waived if admitted, Inpatient Hospital Expenses will apply)*	*Deductible Applies No* *$400 Copay*
Emergency Care- Physician	Deductible Applies Yes *80% of Allowable Amount after Plan Year Deductible*
Urgent Care Center, per visit	Deductible Applies No *$60 Copay*
Ambulance Services	
Ambulance Services	Deductible Applies Yes *80% of Allowable Amount after Plan Year Deductible*
Extended Care Services *All services must be preauthorized*	
Skilled Nursing Facility Services	Deductible Applies No *100% of Allowable Amount* Day limit per Plan year *25 days*
Home Health Care	Deductible Applies No *100% of Allowable Amount* Day limit per Plan year *60 visits*
Hospice Care	Deductible Applies No *100% of Allowable Amount* Unlimited
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	$0 - No Deductible
Eye and ear screening for Members age 18 and older	$0 - No Deductible
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 • 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 • Annual fecal occult blood test • Flexible sigmoidoscopy with hemoccult of the stool • Colonoscopy	 $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

Dental Surgical Procedures	
Dental Surgical Procedures (limited Covered Services)	
PCP	*$30 Copay*
Specialist	*$40 Copay*
Inpatient Physician Charges	Deductible Applies Yes *80% of Allowable Amount after Plan Year Deductible*
Inpatient Hospital Services (as applicable)	Deductible Applies No *80% of Allowable Amount*
Outpatient Surgery Services (as applicable)	Deductible Applies Yes *80% of Allowable Amount after Plan Year Deductible*
Cosmetic, Reconstructive or Plastic Surgery	
Cosmetic, Reconstructive or Plastic Surgery (limited Covered Services)	
PCP	*$30 Copay*
Specialist	*$40 Copay*
Inpatient Physician Charges	Deductible Applies Yes *80% of Allowable Amount after Plan Year Deductible*
Inpatient Hospital Services (as applicable)	Deductible Applies No *80% of Allowable Amount*
Outpatient Surgery Services (as applicable)	Deductible Applies Yes *80% of Allowable Amount after Plan Year Deductible*
Allergy Care	
Testing and Evaluation	Deductible Applies Yes *80% of Allowable Amount after Plan Year Deductible*
Injections	Deductible Applies No *100% of Allowable Amount*
Serum	Deductible Applies No *100% of Allowable Amount*
Diabetes Care	
Diabetes Self-Management Training	
PCP	*$30 Copay*
Specialist	*$40 Copay*
Diabetes Equipment	Deductible Applies Yes *80% of Allowable Amount after Plan Year Deductible*

Diabetes Supplies	Deductible Applies Yes *80% of Allowable Amount after Plan Year Deductible*
Prosthetic Appliances and Orthotic Devices	
Prosthetic Appliances and Orthotic Devices	Deductible Applies Yes *80% of Allowable Amount after Plan Year Deductible*
Cochlear Implants Based on medical necessity	Deductible Applies Yes *80% of Allowable Amount after Plan Year Deductible*
Hearing Aids	
Hearing Aids	Not Covered
Physical Medicine Services*	
Chiropractic Care-Office Services	*80% of Allowable Amount after Plan Year Deductible* *35 visit maximum each Plan Year*
Airrosti Rehab Centers	*$30 Copayment Amount*

**All other Physical Medicine Services rendered by any other eligible Provider will be allowed on the same basis as any other sickness.*

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)	☐ **DM3** Deductible Applies *No* *No Copay* ☐ **DM4** Deductible Applies *No* *80% coinsurance* ☐ **DM5** Deductible Applies *Yes* *No Copay* ☐ **DM6** Deductible Applies *Yes* *80% coinsurance* ***OR*** ☐ **DM7** Deductible Applies: No General payment level ☒ **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.	Deductible Applies - 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* ***OR*** ☒ **IM4** Deductible Applies *No*
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).*	☒ **Not Covered** ☐ **IV – In Vitro Fertilization** Deductible Applies *No* **OR** ☐ **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.	**Pay ABI benefit on the same basis as any other medical/surgical services – choose A or B** ☐ a) Pay in accordance with the Texas state mandate - Benefits determined on same basis as any other medical/surgical service with no maximums **or** ☐ b) Benefits determined on same basis as any other medical/surgical service, visit maximums will apply to certain services, when applicable. ☒ Decline Mandate - If declined, benefits will be excluded for certain therapies or services, including community reintegration services, **however,** medically necessary services in connection with treatment of acquired brain injury will be covered. ☐ Other, explain:
Autism Spectrum Disorder	☒ Pay in accordance with the Texas state mandate - Benefits determined on same basis as any other medical/surgical service with no maximums, including benefits for ASD screening and Applied Behavioral Analysis. (NOTE: The $36,000 maximum allowed by the State Mandate would not apply.) ☐ Not Applicable. Mental Health services, including Applied Behavior Analysis, carved out to third-party vendor (see above for vendor information). All Other Medical Services/maximums will be applied per the contract benefits ☐ Benefits determined on same basis as any other medical/surgical service, visit maximums will apply to certain services, when applicable
Developmental Delay (in accordance with state mandate)	☐ No ☒ 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 ☐ Other, explain:
Telemedicine	☒ Covered (Standard) ☐ Not Covered ☐ Other, explain:
Foot Orthotics	☒ Covered in treatment of diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency. (standard)

	☐ Covered, as any other medical service: medically necessary foot orthotics that are consistent with the Medicare Benefit Policy Manual (in accordance with Insurance Code Section 1371.003). ☐ Not covered

EMPLOYEE INFORMATION

This is a general Summary of your benefit design. This plan does not cover Out-of-Network benefits. Please refer to your benefit booklet for other details and for limitations and exclusions.

MDLIVE is part of your benefit plan design. Access to an independently contracted board-certified doctor is available 24 hours a day, seven days a week to speak to immediately or schedule an appointment based on your availability. Please refer to your benefit booklet for other details.

The following benefits apply to dependent coverage:

- Dependent children are covered to age 26.
- 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. Out-of-Network services/providers are not covered, except in the event of Emergency Care. For all other services received by an Out-of-Network Provider, the covered individual will be responsible for all charges in addition to any applicable Deductibles, Coinsurance Amounts, and Copayments

Replacement of Medical Coverage: In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 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.