



TEXAS ASSOCIATION of COUNTIES HEALTH AND EMPLOYEE BENEFITS POOL

BENEFIT HIGHLIGHTS GALVESTON COUNTY CUSTOM BASE PLAN

(Non-Grandfathered ACA Plan)

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	In-Network Benefits	Out-of-Network Benefits
Plan Year Deductibles		
Deductible <i>Applies to all Eligible Expenses except Inpatient Hospital Expenses (unless otherwise indicated)</i>	\$2,250 Individual / \$4,500 Family	\$4,250 Individual / \$8,500 Family
3-Month Deductible Carryover Applies	Yes	Yes
Plan Year Total Out-of-Pocket Maximum		
Individual & Family Deductibles and Copayments are applied to the Out-of-Pocket Maximum. Copayment Amounts will not be required after Out-of-Pocket Maximum has been satisfied. Your benefit booklet will provide more details.	\$7,000 Individual / \$17,100 Family <i>Network Deductible & Out-of-Pocket Maximum will only apply toward Network Deductible & Out-of-Pocket Maximum</i>	Unlimited <i>Out-of-Network Deductible & Out-of-Pocket Maximum do not apply toward Network Deductible & Out-of-Pocket Maximum</i>
Copayment Amounts Required		
Physician office visit/consultation <i>Refer to Medical/Surgical Expenses section for more information</i>	80% of Allowable Amount after Plan Year Deductible	50% of Allowable Amount after Plan Year Deductible
Specialty Care Copayment Amount for office visit/consultation when services rendered by a Specialty Care Provider	80% of Allowable Amount after Plan Year Deductible	50% of Allowable Amount after Plan Year Deductible
Urgent Care	80% of Allowable Amount after Plan Year Deductible	50% of Allowable Amount after Plan Year Deductible
MDLIVE (Telemedicine)	\$10 Copayment Amount	Not Applicable
MDLIVE (Behavioral Health)	\$35 Copayment Amount	Not Applicable
Livongo (<i>Participants must enroll in this program to receive a glucometer, unlimited diabetic test strips and lancets</i>)	100% of Allowable Amount (Deductible Waived)	Not Applicable
Outpatient Hospital Emergency Room/Treatment Room <i>Refer to Emergency Room/Treatment Room section for more information</i>	80% of Allowable Amount after Plan Year Deductible	50% of Allowable Amount after Plan Year Deductible
Per Hospital Admission	\$100 Copayment Amount	\$500 Copayment Amount
Maximum Lifetime Benefits		
Per Participant	Unlimited	
Inpatient Hospital Expenses		
Inpatient Hospital Expenses		
<i>All services must be preauthorized</i> All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units (including Maternity Care)	\$100 Hospital Admission Copayment Amount and 80% of Allowable Amount after Plan Year Deductible	\$500 Hospital Admission Copayment Amount and 50% of Allowable Amount after Plan Year Deductible
Penalty for failure to preauthorize services	None	\$500



Initials _____ Date _____



TEXAS ASSOCIATION of COUNTIES HEALTH AND EMPLOYEE BENEFITS POOL

Medical/Surgical Expenses	In-Network Benefits	Out-of-Network Benefits
Medical / Surgical Expenses		
Services performed during the Physician's office visit/consultation, including lab & x-ray (does not include Certain Diagnostic Procedures and surgical services)	80% of Allowable Amount (Deductible Waived)	50% of Allowable Amount after Plan Year Deductible
Lab & x-ray in other outpatient facilities (excluding Certain Diagnostic Procedures)	80% of Allowable Amount after Plan Year Deductible	50% of Allowable Amount after Plan Year Deductible
Allergy Injections	80% of Allowable Amount after Plan Year Deductible	50% of Allowable Amount after Plan Year Deductible
Physician surgical services performed in any setting (including Maternity Care)	80% of Allowable Amount after Plan Year Deductible	50% of Allowable Amount after Plan Year Deductible
Certain Diagnostic Procedures; such as Bone Scan, Cardiac Stress Test, CT -Scan (with or without contrast), Ultrasound, MRI, Myelogram, PET Scan.	80% of Allowable Amount after Plan Year Deductible	50% of Allowable Amount after Plan Year Deductible
Home Infusion Therapy (Services must be preauthorized)	80% of Allowable Amount after Plan Year Deductible	50% of Allowable Amount after Plan Year Deductible
Organ Transplants	80% of Allowable Amount after Plan Year Deductible	50% of Allowable Amount after Plan Year Deductible
TMJ Treatments	80% of Allowable Amount after Plan Year Deductible	50% of Allowable Amount after Plan Year Deductible
All other outpatient services and supplies	80% of Allowable Amount after Plan Year Deductible	50% of Allowable Amount after Plan Year Deductible
In Vitro Fertilization Services		Not Covered
Extended Care Expenses		
Extended Care Expenses All services must be preauthorized		
Skilled Nursing Facility Home Health Care	80% of Allowable Amount after Plan Year Deductible	50% of Allowable Amount after Plan Year Deductible
Hospice Care		Unlimited
Special Provisions Expenses		
Serious Mental Illness All services must be preauthorized		
Inpatient Services		
-Hospital services (facility)	80% of Allowable Amount after Plan Year Deductible	50% of Allowable Amount after Plan Year Deductible
-Physician services	80% of Allowable Amount after Plan Year Deductible	50% of Allowable Amount after Plan Year Deductible
Outpatient Services		
-Services performed during Physician office visit/consultation (does not include psychological testing)	80% of Allowable Amount after Plan Year Deductible	50% of Allowable Amount after Plan Year Deductible
-All outpatient services and psychological testing	80% of Allowable Amount after Plan Year Deductible	50% of Allowable Amount after Plan Year Deductible

* Benefits used In-Network and Out-of-Network will apply toward satisfying any day, visit, Plan Year, Annual Maximum, series of treatments benefits indicated

Initials _____ Date _____



TEXAS ASSOCIATION of COUNTIES HEALTH AND EMPLOYEE BENEFITS POOL

Special Provisions Expenses, cont.

In-Network Benefits

Out-of-network Benefits

Mental Health Care/Chemical Dependency

All services must be preauthorized

Inpatient Services

-Hospital services (facility)

80% of Allowable Amount after
Plan Year Deductible

50% of Allowable Amount after
Plan Year Deductible

-Physician services

80% of Allowable Amount after
Plan Year Deductible

50% of Allowable Amount after
Plan Year Deductible

Outpatient Services

-Services performed during Physician office visit/consultation
(does not include psychological testing)

80% of Allowable Amount after
Plan Year Deductible

50% of Allowable Amount after
Plan Year Deductible

-Emergency Room/Treatment Room

80% of Allowable Amount after
Plan Year Deductible

50% of Allowable Amount after
Plan Year Deductible

(\$100 Per Hospital
Admission Copayment if admitted,
Inpatient Hospital Expenses will apply)

(\$500 Per Hospital
Admission Copayment if admitted,
Inpatient Hospital Expenses
will apply)

-Other Outpatient Services and psychological testing

80% of Allowable Amount after
Plan Year Deductible

50% of Allowable Amount after
Plan Year Deductible

Chemical Dependency Maximum

(Inpatient treatment must be provided in a Chemical Dependency
Treatment Center)

Unlimited

Emergency Room/Treatment Room

Accidental Injury & Emergency Care

-Facility charges (outpatient Hospital emergency treatment room
charges)

80% of Allowable Amount after Plan Year Deductible

(\$100 Per Hospital Admission Copayment if admitted,
Inpatient Hospital Expenses will apply)

-Physician charges

80% of Allowable Amount after Plan Year Deductible

Non-Emergency Care

-Facility charges (outpatient Hospital emergency treatment room
charges)

80% of Allowable Amount after
Plan Year Deductible

50% of Allowable Amount after
Plan Year Deductible

(\$100 Per Hospital
Admission Copayment if admitted,
Inpatient Hospital Expenses will apply)

(\$500 Per Hospital
Admission Copayment if admitted,
Inpatient Hospital Expenses
will apply)

-Physician charges

80% of Allowable Amount after
Plan Year Deductible

50% of Allowable Amount after
Plan Year Deductible

-Non-Emergency Ground (Air ambulance services are not available
for non-emergencies)

80% of Allowable Amount after
Plan Year Deductible

50% of Allowable Amount after Plan
Year Deductible

Ground and Air Ambulance Services

80% of Allowable Amount after
Plan Year Deductible

* Benefits used In-Network and Out-of-Network will apply toward satisfying any day, visit, Plan Year, Annual Maximum, series of treatments benefits indicated

Initials _____ Date _____



TEXAS ASSOCIATION of COUNTIES HEALTH AND EMPLOYEE BENEFITS POOL

<i>Special Provisions Expenses, cont.</i>	<i>In-Network Benefits</i>	<i>Out-of-network Benefits</i>
Preventive Care		
Routine annual physical examinations, well-baby care exams, immunizations 6 years of age & over, vision exams, hearing exams, and any other preventive health services as determined by USPSTF	100% of Allowable Amount (Deductible Waived)	50% of Allowable Amount after Plan Year Deductible
Immunizations for Dependent children through the date of the child's 6 th birthday	100% of Allowable Amount (Deductible Waived)	50% of Allowable Amount after Plan Year Deductible
Routine Colonoscopy	100% of Allowable Amount (Deductible Waived)	50% of Allowable Amount after Plan Year Deductible
Speech and Hearing Services		
Services to restore loss of or correct an impaired speech or hearing function without hearing aids	80% of Allowable Amount after Plan Year Deductible	50% of Allowable Amount after Plan Year Deductible
Physical Medicine Services		
Chiropractic Care-Office Services	80% of Allowable Amount after Plan Year Deductible	50% of Allowable Amount after Plan Year Deductible
Airrosti Rehab Centers	80% of Allowable Amount after Plan Year Deductible	Not Applicable
	<i>All other Physical Medicine Services rendered by any other eligible Provider will be allowed on the same basis as any other sickness.</i>	

* Benefits used In-Network and Out-of-Network will apply toward satisfying any day, visit, Plan Year, Annual Maximum, series of treatments benefits indicated

EMPLOYEE INFORMATION

This is a general Summary of your benefit design. Please refer to your benefit booklet for other details and for limitations and exclusions.

MDLIVE (Telemedicine & Behavioral Health) are 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. Plan benefits paid to Out-of-Network providers are based on the BCBSTX-determined Allowable Amount, except in the event of Emergency Care received in an outpatient hospital emergency treatment room within 48 hours of the incident. For all other services received by an Out-of-Network Provider, the covered individual 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.

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.

Initials _____ Date _____