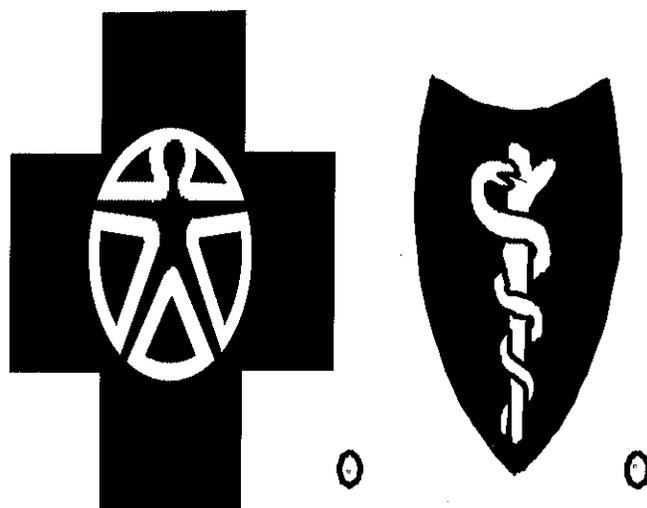


Schedule of Coverage
For
Medical, Dental and RX
Prescriptions

Blue Cross and Blue Shield



SCHEDULE OF COVERAGE – PLAN 700 NG

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Deductibles <ul style="list-style-type: none"> • Calendar Year Deductible <i>Three-month Deductible carryover applies</i> 	\$500 – per individual \$1,500 – per family	\$750 – per individual \$2,250 – per family
Co-Share Stop-Loss Amounts	\$2,000 – per individual \$6,000 – per family	\$4,000 – per individual \$12,000 – per family
Copayment Amounts Required <ul style="list-style-type: none"> • Physician office visit/consultation • Outpatient Hospital Emergency Room/Treatment Room visit 	\$25 Physician office visit \$100 outpatient Hospital Emergency Room/Treatment Room visit	Does Not Apply \$100 outpatient Hospital Emergency Room/Treatment Room visit
Maximum Lifetime Benefits per Participant	Unlimited	
Inpatient Hospital Expenses (Preauthorization is required) All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units.	90% of Allowable Amount No penalty for failure to preauthorize services	70% of Allowable Amount \$250 penalty for failure to preauthorize services
Medical-Surgical Expenses <ul style="list-style-type: none"> • Office visit/consultation including lab and x-rays • Allergy Injections (with office visit) • Inpatient visits and Certain Diagnostic Procedures • Home Infusion Therapy (Preauthorization is required) • Physician surgical services in any setting • Allergy Injections (without office visit) • Independent Lab & X-ray 	100% of Allowable Amount after \$25 Copayment Amount 90% of Allowable Amount after Calendar Year Deductible 100% of Allowable Amount Deductible waived 100% of Allowable Amount Deductible waived	70% of Allowable Amount after Calendar Year Deductible 70% of Allowable Amount after Calendar Year Deductible 70% of Allowable Amount after Calendar Year Deductible 70% of Allowable Amount after Calendar Year Deductible

SCHEDULE OF COVERAGE – PLAN 700 NG

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Extended Care Expenses (Preauthorization is required) <ul style="list-style-type: none"> • Skilled Nursing Facility Combined 25 visits per Calendar Year • Home Health Care Combined 60 visits per Calendar Year • Hospice Care Unlimited 	100% of Allowable Amount Deductible waived	70% of Allowable Amount after Calendar Year Deductible
Behavioral Health Services Serious Mental Illness (Preauthorization is required)		
Inpatient Services <ul style="list-style-type: none"> • Hospital services (facility) • Physician services 	90% of Allowable Amount 90% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount 70% of Allowable Amount after Calendar Year Deductible
Outpatient Services <ul style="list-style-type: none"> • Behavioral Health Practitioner Expenses (office setting) • Other Outpatient Services 	100% of Allowable Amount after \$25 Copayment Amount 90% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible 70% of Allowable Amount after Calendar Year Deductible
Mental Health Care/Treatment of Chemical Dependency (Preauthorization is required)		
Inpatient Services <ul style="list-style-type: none"> • Hospital Services (facility) • Physician Services 	90% of Allowable Amount 90% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount 70% of Allowable Amount after Calendar Year Deductible
Limited to 30 inpatient days/visits each Calendar Year		
Outpatient Services <ul style="list-style-type: none"> • Behavioral Health Practitioner Expenses (office setting) • Other Outpatient Services 	100% of Allowable Amount after \$25 Copayment Amount 90% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible 70% of Allowable Amount after Calendar Year Deductible
Limited to 30 visits each Calendar Year		
Chemical Dependency Lifetime Maximum	3 separate series of treatment for each covered individual	

SCHEDULE OF COVERAGE – PLAN 700 NG

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
<p>Emergency Care</p> <p>Accidental Injury & Emergency Care (Including Accidental Injury & Emergency Care for Behavioral Health Services)</p> <ul style="list-style-type: none"> • Facility Charges • Physician Charges 	<p>90% of Allowable Amount after \$100 outpatient Hospital emergency room Copayment Amount (waived if admitted)</p>	
	<p>90% of Allowable Amount after Calendar Year Deductible</p>	
<p>Non-Emergency Care (including Non-Emergency Care for Behavioral Health Services)</p> <ul style="list-style-type: none"> • Facility Charges • Physician Charges 	<p>90% of Allowable Amount after \$100 outpatient Hospital emergency room Copayment Amount (waived if admitted)</p>	<p>70% of Allowable Amount after \$100 outpatient Hospital emergency room Copayment Amount (waived if admitted) and Calendar Year Deductible</p>
	<p>90% of Allowable Amount after Calendar Year Deductible</p>	<p>70% of Allowable Amount after Calendar Year Deductible</p>
Ground and Air Ambulance Services	<p>90% of Allowable Amount after Calendar Year Deductible</p>	
<p>Preventive Care Services</p> <ul style="list-style-type: none"> • Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF"); • Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") with respect to the individual involved; • Evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") for infants, children, and adolescents; and 	<p>100% of Allowable Amount Deductible waived</p>	<p>70% of Allowable Amount after Calendar Year Deductible</p>
	<p>100% of Allowable Amount Deductible waived</p>	<p>100% of Allowable Amount Deductible waived</p>
	<p>100% of Allowable Amount Deductible waived</p>	<p>70% of Allowable Amount after Calendar Year Deductible</p>

SCHEDULE OF COVERAGE – 700 NG

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Preventive Care Services (Cont'd) <ul style="list-style-type: none"> • With respect to women, such additional preventive care and screenings, not described in the first bullet above, as provided for in comprehensive guidelines supported by the HRSA. • Routine physical examinations, well baby care, immunizations 6 years of age & older, and routine lab • Immunizations for Dependent children through the date of the child's 6th birthday • Colonoscopy Professional (physician charges) • Colonoscopy facility charges • Healthy diet counseling and obesity screening/counseling 	100% of Allowable Amount Deductible waived	70% of Allowable Amount after Calendar Year Deductible
Other Routine Services <ul style="list-style-type: none"> • X-Ray • Annual Hearing Examination • Annual Vision Examination 	90% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
Speech and Hearing Services, Excluding hearing aids	90% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
Chiropractic Services	90% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
	Limited to 35 visits each Calendar Year	
Physical Medicine Services	90% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible

SCHEDULE OF COVERAGE

Dependent Eligibility

Dependent Child Age Limit to age 26.

Dependent children are eligible for Maternity Care benefits.

Preexisting Conditions

Benefits for Eligible Expenses incurred for treatment of a Preexisting Condition will not be available during the 12-month period following the Participant's initial Effective Date or if a Waiting Period applies, the first day of the Waiting Period (typically the date you are hired). Credit will be given for time served under Creditable Coverage. The Preexisting Conditions waiting period is waived on initial enrollment.

Preexisting Conditions for Dependent children under age 19 and all other eligible individuals under age 19 will be covered without any waiting periods.

Waiting Period

30 days from date of hire



TEXAS ASSOCIATION of COUNTIES HEALTH AND EMPLOYEE BENEFITS POOL

Custom NG Prescription Drug Program For Webb County

Prescription Drug Program **Network**
(Copayments will not apply to Co-Share Stoploss Maximum)

Retail Pharmacy

Deductible

Non-Preferred Brand Name Drug

Brand Name Drug

Generic Drug

Participating CVS Caremark Retail Pharmacy

*\$0 Individual /
\$0 Family*

*\$40 Copayment Amount
(When no generic is available or Rx is prescribed
Dispense as Written-DAW)*

*\$25 Copayment Amount
(When no generic is available or Rx is prescribed
Dispense as Written-DAW)*

*Lesser of \$7 Copayment Amount
OR
Actual Cost*

Note: Members electing to purchase brand name drugs when "Dispense as Written" (DAW) is not indicated will be required to pay the difference between the cost of the Generic drug and Brand Name drug, plus the Brand Name Copayment.

Specialty and biotech medications are available only through mail order unless purchased and administered through the doctor's office.

Mail Service Pharmacy-up to a 90-day supply

Non-Preferred Brand Name Drug

\$80 Copayment Amount

Brand Name Drug

\$50 Copayment Amount

Generic Drug

\$14 Copayment Amount

Note: Prescription Drug Benefits are provided by CVS Caremark through a master contract with the Texas Association of Counties Health and Employee Benefits Pool. Prescription Drugs are not administered by Blue Cross and Blue Shield of Texas

Initials _____ Date _____

DENTAL SCHEDULE OF COVERAGE WITH ORTHODONTIC CARE

Benefits described in this booklet apply only if also listed here.

Plan Provisions	Dental Benefits
Deductibles <ul style="list-style-type: none"> • Calendar Year Deductible 	\$50 – per individual \$150 – per family
Maximum Calendar Year Benefits per Participant for Categories I, II, III, IV, V, VI, VII, IX Does not apply to Orthodontic	\$1,000
I. Diagnostic & Preventive Care Services Calendar Year Deductible does not apply	100% of Allowable Amount
II. Miscellaneous Services	80% of Allowable Amount after Calendar Year Deductible
III. Restorative Services	80% of Allowable Amount after Calendar Year Deductible
IV. General Services	80% of Allowable Amount after Calendar Year Deductible
V. Endodontic Services	80% of Allowable Amount after Calendar Year Deductible
VI. Periodontal Services	80% of Allowable Amount after Calendar Year Deductible
VII. Oral Surgery Services	80% of Allowable Amount after Calendar Year Deductible
VIII. Crowns, Inlays/Onlays Services	50% of Allowable Amount after Calendar Year Deductible
IX. Prosthodontic Services	50% of Allowable Amount after Calendar Year Deductible
OPTIONAL COVERAGE	
X. Orthodontic Services <ul style="list-style-type: none"> • \$1,000 maximum lifetime benefit 	50% of Allowable Amount
Predetermination Amount	\$300
Dependent Child Age Limit	Age 26

Waiting Period:

30 days from date of hire