

Schedule of Coverage



BlueCross BlueShield
of Texas

The following information summarizes the benefits available under the Managed Health Care Benefits section of your coverage. To get the most out of your coverage, it is important that you carefully read your Benefit Booklet so you are aware of plan requirements, provisions and limitations and exclusions.

Core Plan

BlueChoice PPOSM Network

Overall Payment Provisions

In-Network Benefits

Out-of-Network Benefits

Copayment Amounts, Deductibles and Out-of-Pocket Maximums are subject to change or increase as permitted by applicable law

Deductibles

- Calendar Year Deductible
Three-month Deductible carryover applies
Applies to all Eligible Expenses

\$1,000 Individual /
\$2,000 Family

\$2,000 Individual /
\$4,000 Family

Out-of-Pocket Maximum

\$3,500 Individual /
\$7,000 Family

\$7,000 Individual /
\$14,000 Family

Copayment Amounts Required

Primary Care office visit/consultation, when services rendered by a Family Practitioner, OB/GYN, Pediatrician, Behavioral Health Practitioner or Internist and Physician Assistant or Advanced Practice Nurse who works under the supervision of one of these listed physicians

\$25 Primary Care Copayment Amount

Specialty Copayment Amount for office visit/consultation when services rendered by a Specialty Care Provider

\$35 Specialty Copayment Amount

Urgent Care center visit

\$50 Copayment Amount

Outpatient Hospital emergency room/treatment room visit

\$150 outpatient Hospital emergency room/treatment room visit Copayment Amount

\$150 outpatient Hospital emergency room/treatment room visit Copayment Amount

Inpatient Hospital Expenses

Inpatient Hospital Expenses

All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units.

80% of Allowable Amount after
Calendar Year Deductible

50% of Allowable Amount after
Calendar Year Deductible

Penalty for failure to preauthorize services

None

\$250

Medical/Surgical Expenses

Primary Care Copayment Amount for office visit/consultation, including lab and x-ray when services rendered by a Family Practitioner, OB/GYN, Pediatrician, or Internist and Physician Assistant or Advanced Practice Nurse who works under the supervision of one of these listed physicians

100% of Allowable Amount after \$25
Primary Care Copayment Amount

50% of Allowable Amount after
Calendar Year Deductible

Specialty Copayment Amount for office visit/consultation including lab and x-ray and Certain Diagnostic Procedures when services rendered by a Specialty Care Provider.

100% of Allowable Amount after \$35
Specialty Copayment Amount

50% of Allowable Amount after
Calendar Year Deductible

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Lab & x-ray in other outpatient facilities, excluding Certain Diagnostic Procedures	100% of Allowable Amount	50% of Allowable Amount after Calendar Year Deductible
Inpatient visits and Certain Diagnostic Procedures	80% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Home Infusion Therapy	80% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Physician surgical services performed in any setting	80% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible

Extended Care Expenses	In-Network Benefits	Out-of-Network Benefits
	100% of Allowable Amount	50% of Allowable Amount after Calendar Year Deductible
Skilled Nursing Facility	25 days per Calendar Year*	
Home Health Care	60 visits per Calendar Year*	
Hospice Care	Unlimited*	

Special Provisions Expenses		
Behavioral Health Services		
<p>Treatment of Chemical Dependency Certain Services will require Preauthorization. Failure to preauthorize will result in a \$250 penalty</p>		
<p>Inpatient Services Inpatient treatment must be provided in a Chemical Dependency Treatment Center</p>	80% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Behavioral Health Practitioner services	80% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
<p>Outpatient Services Behavioral Health Practitioner expenses (office setting)</p>	100% of Allowable Amount after \$25 Copayment Amount	50% of Allowable Amount after Calendar Year Deductible
Other outpatient services	80% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible

Serious Mental Illness		
<p>Certain Services will require Preauthorization. Failure to preauthorize will result in a \$250 penalty</p>		
<p>Inpatient Services Hospital services (facility)</p>	80% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Behavioral Health Practitioner services	80% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
<p>Outpatient Services Behavioral Health Practitioner expenses (office setting)</p>	100% of Allowable Amount after \$25 Copayment Amount	50% of Allowable Amount after Calendar Year Deductible

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Other outpatient services	80% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Mental Health Care Certain Services will require Preauthorization. Failure to preauthorize will result in a \$250 penalty		
Inpatient Services Hospital services (facility)	80% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Behavioral Health Practitioner services	80% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Outpatient Services Behavioral Health Practitioner expenses (office setting)	100% of Allowable Amount after \$25 Copayment Amount	50% of Allowable Amount after Calendar Year Deductible
Other outpatient services	80% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Emergency Room/Treatment Room Accidental Injury & Emergency Care (including Accidental Injury & Emergency Care for Behavioral Health Services)		
Facility charges (excluding Certain Diagnostic Procedures)	100% of Allowable Amount after \$150 outpatient Hospital emergency room/treatment room Copayment Amount (waived if admitted, and Inpatient Hospital Expenses will apply)	
Physician charges	100% of Allowable Amount after Calendar Year Deductible	
Non-Emergency Care (including Non-Emergency Care for Behavioral Health Services)		
Facility charges (excluding Certain Diagnostic Procedures)	80% of Allowable Amount after \$150 outpatient Hospital emergency room/treatment room Copayment Amount (waived if admitted, and Inpatient Hospital Expenses will apply)	50% of Allowable Amount after \$150 outpatient Hospital emergency room/treatment room Copayment Amount (waived if admitted, and Inpatient Hospital Expenses will apply) and after Calendar Year Deductible
Physician charges	80% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Urgent Care Services		
Urgent Care center visit, including lab & x-ray services (excluding Certain Diagnostic Procedures)	100% of Allowable Amount after \$50 Copayment Amount	50% of Allowable Amount after Calendar Year Deductible
Services received during an Urgent Care visit - Certain Diagnostic Procedures	80% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Ambulance Services		
80% of Allowable Amount after Calendar Year Deductible		

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<p>Preventive Care</p> <p>Routine annual physicals, well-baby exam, immunizations, and other preventive health services as determined by the USPSTF (Deductibles will not be applicable to immunizations of a Dependent child under the age of 6.)</p>	<p><i>100% of Allowable Amount</i></p>	<p><i>50% of Allowable Amount after Calendar Year Deductible</i></p>
<p>Speech and Hearing Services</p> <p>Services to restore loss of or correct an impaired speech or hearing function with hearing aids</p> <p>Hearing Aids</p> <p>Hearing Aids maximum</p>	<p><i>Covered as any other sickness</i></p> <p><i>80% of Allowable Amount after Calendar Year Deductible</i></p> <p><i>Limited to one hearing aid per ear each 36-Month period*</i></p>	<p><i>Covered as any other sickness</i></p> <p><i>50% of Allowable Amount after Calendar Year Deductible</i></p>
<p>Cardiovascular Tests</p> <p>One of the following early detection tests for cardiovascular disease will be covered for a Participant who meets the age requirements and is a diabetic or has been determined to have a risk of developing coronary heart disease:</p> <ul style="list-style-type: none"> • Computed tomography (CT) scanning measuring coronary artery calcification. • Ultrasonography measuring carotoid intima-media thickness and plaque. 	<p><i>80% of Allowable Amount after Calendar Year Deductible</i></p> <p><i>Maximum benefit of 1 test every 5 years*</i></p>	<p><i>50% of Allowable Amount after Calendar Year Deductible</i></p>
<p>Physical Medicine Services</p> <p>Physical Medicine Services (includes, but is not limited to physical, occupational, and manipulative therapy)</p> <p>Calendar Year maximum</p>	<p><i>80% of Allowable Amount after Calendar Year Deductible</i></p> <p><i>35 visits each Calendar Year*</i></p>	<p><i>50% of Allowable Amount after Calendar Year Deductible</i></p>

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The following chart summarizes the pharmacy benefits available under your coverage. To get the most out of your coverage, it is important that you carefully read the PHARMACY BENEFITS section of your Benefit Booklet so you are aware of plan requirements, provisions, limitations and exclusions.

Pharmacy Benefits	<i>Participating Pharmacy</i>	<i>Non-Participating Pharmacy (member files claims)</i>
Retail Pharmacy		
One Copayment Amount per 30-day supply, up to a 90-day supply	<i>\$10 Copayment Amount – Generic Drugs</i> <i>\$25 Copayment Amount* – Preferred Brand Name Drug</i> <i>\$50 Copayment Amount* – Non-Preferred Brand Name Drug</i>	<i>80% of Allowable Amount minus Copayment Amount*</i>
Mail-Order Program		
One Copayment Amount per 30-day supply, up to a 90-day supply	<i>\$10 Copayment Amount – Generic Drugs</i> <i>\$25 Copayment Amount* – Preferred Brand Name Drug</i> <i>\$50 Copayment Amount* – Non-Preferred Brand Name Drug</i>	XXXXXXXXXXXXXXXXXXXXXXXXXXXX
Vaccinations obtained through Pharmacies**	<i>Select Participating Pharmacies</i>	<i>Non-Participating Pharmacy (member files claims)</i>
	<i>Flu vaccine – \$0 Copayment Amount</i>	<i>80% of Allowable Amount minus Copayment Amount</i>

Diabetes Supplies are available under the Pharmacy Benefits portion of your Plan. All provisions of this portion of the Plan will apply including any Deductibles, Copayment Amounts, and any pricing differences.

* If you receive a Preferred Brand Name Drug or a Non-Preferred Brand Name Drug when a Generic Drug is available, you may incur additional costs. Refer to the Pharmacy Benefits portion of your booklet for details.

** Each Participating Pharmacy that has contracted with BCBSTX to provide this service may have age, scheduling, or other requirements that will apply, so you are encouraged to contact them in advance. Childhood immunizations subject to state regulations are not available under this pharmacy benefit. Refer to your BCBSTX medical coverage for benefits available for childhood immunizations.

Preferred Drug List 1 applies.

Pharmacy Network A applies.