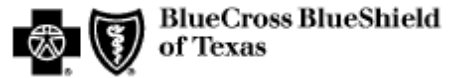


Schedule of Coverage



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.

Blue Choice PPOSM 006

Blue Choice 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.

Participant pays...

Participant pays...

Calendar Year Deductibles

Calendar Year Deductible

Three-month Deductible carryover applies

Applies to all Eligible Expenses

\$500 Individual /
\$1,500 Family

\$1,000 Individual /
\$3,000 Family

Out-of-Pocket Maximum

\$3,000 Individual /
\$9,000 Family

Unlimited

Copayment Amounts Required

Primary Care Copayment Amount for 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

\$30 Copayment Amount

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

\$60 Copayment Amount

Retail Health Clinic Copayment Amount

\$30 Copayment Amount

Virtual Visits Copayment Amount

\$0 Copayment Amount

Urgent Care center visit

\$75 Copayment Amount

Outpatient Hospital emergency room/treatment room visit

\$500 outpatient Hospital emergency
room/treatment room visit Copayment
Amount

\$500 outpatient Hospital emergency
room/treatment room visit Copayment
Amount

Infusion Therapy in the home, office, or an infusion suite

\$50 Copayment Amount

Outpatient Infusion Therapy – Hospital Setting

\$500 Copayment Amount

Inpatient Hospital Expenses

In-Network Benefits

Out-of-Network Benefits

Inpatient Hospital Expenses

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

20% of Allowable Amount after Calendar Year Deductible

40% of Allowable Amount after Calendar Year Deductible

Penalty for failure to obtain Prior Authorization for services

None

\$250

Medical/Surgical Expenses

In-Network Benefits

Out-of-Network Benefits

Primary Care 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

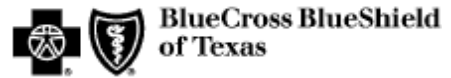
No Charge after \$30 Copayment Amount

40% of Allowable Amount after Calendar Year Deductible

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

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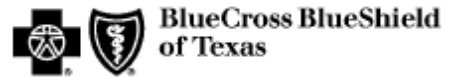
Schedule of Coverage



Specialty office visit/consultation, including lab and x-ray when services rendered by a Specialty Care Provider Lab & x-ray in other outpatient facilities, excluding Certain Diagnostic Procedures	No Charge after \$60 Copayment Amount No Charge after Calendar Year Deductible	40% of Allowable Amount after Calendar Year Deductible 40% of Allowable Amount after Calendar Year Deductible
Inpatient visits and Certain Diagnostic Procedures	20% of Allowable Amount after Calendar Year Deductible	40% of Allowable Amount after Calendar Year Deductible
Infusion Therapy in the home, office, or in an infusion suite	No Charge after \$50 Copayment Amount	40% of Allowable Amount after Calendar Year Deductible
Outpatient Infusion Therapy – Hospital Setting	No Charge after \$500 Copayment Amount	40% of Allowable Amount after Calendar Year Deductible
Physician surgical services performed in any setting	20% of Allowable Amount after Calendar Year Deductible	40% of Allowable Amount after Calendar Year Deductible
Extended Care Expenses		
	In-Network Benefits	Out-of-Network Benefits
Certain Services will require Prior Authorization		
Skilled Nursing Facility	20% of Allowable Amount after Calendar Year Deductible	40% of Allowable Amount after Calendar Year Deductible
Calendar Year maximum	25 days per Calendar Year*	
Home Health Care	20% of Allowable Amount after Calendar Year Deductible	40% of Allowable Amount after Calendar Year Deductible
Calendar Year maximum	60 visits per Calendar Year*	
Hospice Care	No Charge after Calendar Year Deductible	40% of Allowable Amount after Calendar Year Deductible
Calendar Year maximum	Unlimited	
Special Provisions Expenses		
	In-Network Benefits	Out-of-Network Benefits
Behavioral Health Services		
Treatment of Chemical Dependency (Substance Use Disorder (SUD))		
Certain Services will require Prior Authorization		
Inpatient Services		
Inpatient treatment must be provided in a Chemical Dependency (SUD) Treatment Center / Hospital (facility)	20% of Allowable Amount after Calendar Year Deductible	40% of Allowable Amount after Calendar Year Deductible
Penalty for failure to obtain Prior Authorization for inpatient services (facility) same as for medical services	None	\$250
Behavioral Health Practitioner services	20% of Allowable Amount after Calendar Year Deductible	40% of Allowable Amount after Calendar Year Deductible
Outpatient Services		
Behavioral Health Practitioner expenses (office setting)	No Charge after \$30 Copayment Amount	40% of Allowable Amount after Calendar Year Deductible
Other outpatient services	20% of Allowable Amount after Calendar Year Deductible	40% of Allowable Amount after Calendar Year Deductible

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Schedule of Coverage



Serious Mental Illness

Certain Services will require Prior Authorization

Inpatient Services

Hospital services (facility)

20% of Allowable Amount after Calendar Year Deductible

40% of Allowable Amount after Calendar Year Deductible

Penalty for failure to obtain Prior Authorization for inpatient services (facility) same as for medical services

None

\$250

Behavioral Health Practitioner services

20% of Allowable Amount after Calendar Year Deductible

40% of Allowable Amount after Calendar Year Deductible

Outpatient Services

Behavioral Health Practitioner expenses (office setting)

No Charge after \$30 Copayment Amount

40% of Allowable Amount after Calendar Year Deductible

Other outpatient services

20% of Allowable Amount after Calendar Year Deductible

40% of Allowable Amount after Calendar Year Deductible

Mental Health Care

Certain Services will require Prior Authorization

Inpatient Services

Hospital services (facility)

20% of Allowable Amount after Calendar Year Deductible

40% of Allowable Amount after Calendar Year Deductible

Penalty for failure to obtain Prior Authorization for inpatient services (facility) same as for medical services

None

\$250

Behavioral Health Practitioner services

20% of Allowable Amount after Calendar Year Deductible

40% of Allowable Amount after Calendar Year Deductible

Outpatient Services

Behavioral Health Practitioner expenses (office setting)

No Charge after \$30 Copayment Amount

40% of Allowable Amount after Calendar Year Deductible

Other outpatient services

20% of Allowable Amount after Calendar Year Deductible

40% of Allowable Amount after Calendar Year Deductible

Emergency Room/Treatment Room

Emergency Care (including Accidental Injury & Emergency and Non-Emergency Care for Behavioral Health Services)

Facility charges
(excluding Certain Diagnostic Procedures)

20% of Allowable Amount after \$500 outpatient Hospital emergency room/treatment room Copayment Amount (waived if admitted, and Inpatient Hospital Expenses will apply) after Calendar Year Deductible

Physician charges

20% of Allowable Amount after Calendar Year Deductible

Non-Emergency Care

Facility charges
(excluding Certain Diagnostic Procedures)

20% of Allowable Amount after \$500 outpatient Hospital emergency room/treatment room Copayment Amount (waived if admitted, and Inpatient Hospital Expenses will apply) and after Calendar Year Deductible

40% of Allowable Amount after \$500 outpatient Hospital emergency room/treatment room Copayment Amount (waived if admitted, and Inpatient Hospital Expenses will apply) and after Calendar Year Deductible

Physician charges

20% of Allowable Amount after Calendar Year Deductible

40% of Allowable Amount after Calendar Year Deductible

Urgent Care Services

Urgent Care center visit, including lab & x-ray services
(excluding Certain Diagnostic Procedures)

No Charge after \$75 Copayment Amount

40% of Allowable Amount after Calendar Year Deductible

Services received during an Urgent Care visit - Certain Diagnostic Procedures

20% of Allowable Amount after Calendar Year Deductible

40% of Allowable Amount after Calendar Year Deductible

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

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Schedule of Coverage

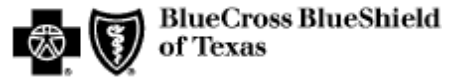


Ambulance Services	20% of Allowable Amount after Calendar Year Deductible	
Retail Health Clinics	No Charge after \$30 Copayment Amount	40% of Allowable Amount after Calendar Year Deductible
Virtual Visits	No Charge after \$0 Copayment Amount	Not Covered
Preventive Care Services	No Charge	40% of Allowable Amount after Calendar Year Deductible
Speech and Hearing Services		
Services to restore loss of or correct an impaired speech or hearing function with hearing aids Benefits for Autism Spectrum Disorder will not apply towards and are not subject to any speech services visits maximum.	Covered as any other sickness	Covered as any other sickness
Hearing Aids	20% of Allowable Amount after Calendar Year Deductible	40% of Allowable Amount after Calendar Year Deductible
Hearing Aids maximum	Limited to one hearing aid per ear each 36-month period*	
Cardiovascular Tests		
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:	Maximum benefit of 1 test every 5 years*	
Computed tomography (CT) scanning measuring coronary artery calcification.	20% of Allowable Amount after Calendar Year Deductible	40% of Allowable Amount after Calendar Year Deductible
Ultrasonography measuring carotid intima-media thickness and plaque.	20% of Allowable Amount after Calendar Year Deductible	40% of Allowable Amount after Calendar Year Deductible
Physical Medicine Services		
Physical Medicine Services (includes, but is not limited to physical, occupational, and manipulative therapy) Calendar Year maximum	20% of Allowable Amount after Calendar Year Deductible 35 visits each Calendar Year* Benefits for Autism Spectrum Disorder will not apply towards and are not subject to any physical medicine services visits maximum.	40% of Allowable Amount after Calendar Year Deductible
Prior Authorization Requirements	In-Network Benefits	Out-of-Network Benefits
Inpatient Admissions		
Penalty for failure to obtain Prior Authorization for inpatient admissions shown in the Utilization Management section of the Benefit Booklet	None	\$250
Outpatient Services		
Penalty for failure to obtain Prior Authorization for outpatient services shown in the Utilization Management section of the Benefit Booklet	None	50% of Allowable Amount, not to exceed \$500

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Schedule of Coverage



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

Retail Pharmacy	Preferred Participating Pharmacy	Participating Pharmacy	Non-Participating Pharmacy
One Copayment Amount per 30-day supply, up to a 30-day supply	<i>Participant pays...</i>		<i>Participant pays...</i>
	\$0 Copayment Amount – Tier 1	\$10 Copayment Amount – Tier 1	50% of Allowable Amount plus Participating Pharmacy Copayment Amount*
	\$10 Copayment Amount – Tier 2	\$20 Copayment Amount – Tier 2	
	\$50 Copayment Amount – Tier 3	\$70 Copayment Amount – Tier 3	
	\$100 Copayment Amount* – Tier 4	\$120 Copayment Amount* – Tier 4	
Extended Prescription Drug Supply Program	Preferred Participating Pharmacy	Participating Pharmacy	Non-Participating Pharmacy
One Copayment Amount per 30-day supply, no more than a 90-day supply	\$0 Copayment Amount – Tier 1	Not Covered	Not Covered
	\$10 Copayment Amount – Tier 2		
	\$50 Copayment Amount – Tier 3		
	\$100 Copayment Amount* – Tier 4		
Mail-Order Program	Mail-Order Program		Other Pharmacy
One Copayment Amount per 90-day supply, up to a 90-day supply	\$0 Copayment Amount – Tier 1		Not Covered
	\$30 Copayment Amount – Tier 2		
	\$150 Copayment Amount – Tier 3		
	\$300 Copayment Amount* – Tier 4		
Specialty Drugs	Specialty Pharmacy Provider		Other Pharmacy
Available In-Network through Specialty Pharmacy Program			
One Copayment Amount per 30-day supply - limited to a 30-day supply	\$150 Copayment Amount – Tier 5		50% of Allowable Amount plus Participating Pharmacy Copayment Amount*
	\$250 Copayment Amount – Tier 6		
Select Vaccinations obtained through Pharmacies**	Pharmacy Vaccine Network Pharmacy		Other Pharmacy
	No Charge		Not Covered

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, Coinsurance Amounts, and any pricing differences.

The Copayment Amount for insulin included on the Drug List will not exceed \$25 per prescription for a 30-day supply, regardless of the amount or type of insulin needed to fill the prescription.

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Schedule of Coverage



* 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.

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