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.

***Blue Choice PPO℠ Basic* 014**	***Blue Choice PPO℠ 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*	*$1,500 Individual / $4,500 Family* / *$3,000 Individual / $9,000 Family*
Out-of-Pocket Maximum	*$4,500 Individual / $13,500 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	*$35 Copayment Amount*
Specialty Copayment Amount for office visit/consultation when services rendered by a Specialty Care Provider	*$70 Copayment Amount*
Retail Health Clinic Copayment Amount	*$35 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 $35 Copayment Amount* / *40% of Allowable Amount after Calendar Year Deductible*

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Specialty office visit/consultation when services rendered by a Specialty Care Provider	*No Charge after $70 Copayment Amount*	*40% of Allowable Amount after Calendar Year Deductible*
Lab & x-ray in other outpatient facilities, excluding Certain Diagnostic Procedures	*20% 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 $35 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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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 $35 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 $35 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	*No Charge after $75 Copayment Amount*	*40% of Allowable Amount after Calendar Year Deductible*
Services received during an Urgent Care visit - including lab & x-ray and Certain Diagnostic Procedures	*20% of Allowable Amount after Calendar Year Deductible*	*40% of Allowable Amount after Calendar Year Deductible*

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Ambulance Services	*20% of Allowable Amount after Calendar Year Deductible*	
Retail Health Clinics	*No Charge after $35 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	*Covered as any other sickness*	*Covered as any other sickness*
Benefits for Autism Spectrum Disorder will not apply towards and are not subject to any speech services visits maximum.		
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)	*20% of Allowable Amount after Calendar Year Deductible*	*40% of Allowable Amount after Calendar Year Deductible*
Calendar Year maximum	*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.*	
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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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***
	Participant pays…		*Participant pays…*
One Copayment Amount per 30-day supply, up to a 30-day supply	*$0 Copayment Amount – Tier 1* *$10 Copayment Amount – Tier 2* *$50 Copayment Amount – Tier 3* *$100 Copayment Amount* – Tier 4*	*$10 Copayment Amount – Tier 1* *$20 Copayment Amount – Tier 2* *$70 Copayment Amount – Tier 3* *$120 Copayment Amount* – Tier 4*	*50% of Allowable Amount plus Participating Pharmacy Copayment Amount**
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* *$10 Copayment Amount – Tier 2* *$50 Copayment Amount – Tier 3* *$100 Copayment Amount* – Tier 4*	*Not Covered*	*Not Covered*
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* *$30 Copayment Amount – Tier 2* *$150 Copayment Amount – Tier 3* *$300 Copayment Amount* – Tier 4*		*Not Covered*
Specialty Drugs Available In-Network through Specialty Pharmacy Program	***Specialty Pharmacy Provider***		***Other Pharmacy***
One Copayment Amount per 30-day supply - limited to a 30-day supply	*$150 Copayment Amount – Tier 5* *$250 Copayment Amount – Tier 6*		*50% of Allowable Amount plus Participating Pharmacy Copayment Amount**
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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* 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.