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 Gold PPO℠ 820) **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		
Deductibles		
• Calendar Year Deductible Applies to all Eligible Expenses	$1,500 Individual/$4,500 Family	$3,000 Individual/$9,000 Family
Out-of-Pocket Maximum	$5,000 Individual/$10,000 Family	Unlimited Individual/Unlimited Family
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	$40 Primary Care Copayment Amount	
Specialty Copayment Amount for office visit/consultation when services rendered by a Specialty Care Provider.	$80 Specialty Copayment Amount	
Telehealth and Telemedicine Services Copayment Amount	$40/$80 Copayment Amount	
Virtual Visits Copayment Amount	$40 Copayment Amount	
Urgent Care center visit	$100 Copayment Amount	
Infusion Therapy in the home, office, or in an Infusion Suite	$50 Outpatient Infusion Therapy Copayment Amount	
Outpatient Infusion Therapy - Hospital Setting	$500 Outpatient Infusion Therapy Copayment Amount	
Outpatient Hospital emergency room visit	$500 outpatient Hospital emergency room visit Copayment Amount	$500 outpatient Hospital emergency room visit Copayment Amount
Imaging Services	$250 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.	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Penalty for failure to prior authorize services	None	$250

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

*****After the age of 3, when services under the individualized family service plan are completed, Eligible Expenses, as otherwise covered under the Policy, will be available. All contractual provisions of the Policy will apply, including but not limited to, defined terms, limitations and exclusions, and benefit maximum.

Schedule of Coverage

BlueCross BlueShield of Texas

(Blue Choice Gold PPO℠ 820) **Blue Choice PPO℠ Network**

Medical/Surgical Expenses	In-Network Benefits	Out-of-Network Benefits
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.	100% of Allowable Amount after $40 Primary Care Copayment Amount	60% of Allowable Amount after Calendar Year Deductible
Specialty office visit/consultation when services rendered by a Specialty Care Provider.	100% of Allowable Amount after $80 Specialty Copayment Amount	60% of Allowable Amount after Calendar Year Deductible
Outpatient Surgery facility charges	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Lab & x-ray	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Inpatient visits	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Imaging Services	100% of Allowable Amount after $250 Copay Amount	60% of Allowable Amount after Calendar Year Deductible
Home Infusion Therapy	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Infusion Therapy in the home, office, or in an Infusion Suite	100% of Allowable Amount after $50 Outpatient Infusion Therapy Copayment Amount	60% of Allowable Amount after Calendar Year Deductible
Outpatient Infusion Therapy Drug (non-maintenance)	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Outpatient Infusion Therapy - Hospital Setting	100% of Allowable Amount after $500 Outpatient Infusion Therapy Copayment Amount	60% of Allowable Amount after Calendar Year Deductible
Physician surgical services performed in any setting	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Extended Care Expenses	**In-Network Benefits**	**Out-of-Network Benefits**
	80% of Allowable Amount after Calendar Year Deductible	60% 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 Hospice Care that is provided in a Hospital will include charges as described in Inpatient Hospital Expense	Unlimited	

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

*****After the age of 3, when services under the individualized family service plan are completed, Eligible Expenses, as otherwise covered under the Policy, will be available. All contractual provisions of the Policy will apply, including but not limited to, defined terms, limitations and exclusions, and benefit maximum.

Schedule of Coverage

BlueCross BlueShield of Texas

(Blue Choice Gold PPO℠ 820) **Blue Choice PPO℠ Network**

Special Provisions	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)	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Penalty for failure to prior authorize inpatient services (facility) same as for medical services	None	$250
Behavioral Health Practitioner services	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Outpatient Services Behavioral Health Practitioner expenses (office setting)	100% of Allowable Amount after $40 Copayment Amount	60% of Allowable Amount after Calendar Year Deductible
Other outpatient services	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Mental Health Care (Including Serious Mental Illness) Certain Services will require Prior Authorization		
Inpatient Services Hospital services (facility)	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Penalty for failure to prior authorize inpatient services (facility) same as for medical services	None	$250
Behavioral Health Practitioner services	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Outpatient Services Behavioral Health Practitioner expenses (office setting)	100% of Allowable Amount after $40 Copayment Amount	60% of Allowable Amount after Calendar Year Deductible
Other outpatient services	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Emergency Room		
Emergency Care (including Emergency Care for Accidental Injury and Emergency and Non-Emergency Care for Behavioral Health Services)		
Facility charges (excluding Certain Diagnostic Procedures)	80% of Allowable Amount after $500 outpatient Hospital emergency room Copayment Amount (waived if admitted, and Inpatient Hospital Expenses will apply) after Calendar Year Deductible	
Physician charges	80% of Allowable Amount after Calendar Year Deductible	
Lab & x-ray charges	80% 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

*****After the age of 3, when services under the individualized family service plan are completed, Eligible Expenses, as otherwise covered under the Policy, will be available. All contractual provisions of the Policy will apply, including but not limited to, defined terms, limitations and exclusions, and benefit maximum.

Schedule of Coverage

BlueCross BlueShield of Texas

(Blue Choice Gold PPO℠ 820) **Blue Choice PPO℠ Network**

Non-Emergency Care		
Facility charges (excluding Certain Diagnostic Procedures)	80% of Allowable Amount after $500 outpatient Hospital emergency room Copayment Amount (waived if admitted, and Inpatient Hospital Expenses will apply) after Calendar Year Deductible	60% of Allowable Amount after $500 outpatient Hospital emergency room Copayment Amount (waived if admitted, and Inpatient Hospital Expenses will apply) after Calendar Year Deductible
Physician charges	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Lab & x-ray charges	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Urgent Care Services		
Urgent Care center visit	100% of Allowable Amount after $100 Copayment Amount	60% of Allowable Amount after Calendar Year Deductible (Urgent Care Copayment Amount will apply to Accidental Injury and Emergency Care services provided Out-of-Network)
Services received during an Urgent Care visit	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Ambulance Services	80% of Allowable Amount after Calendar Year Deductible	
Retail Health Clinic		
	Paid as any other Primary Care Copayment Amount	60% of Allowable Amount after Calendar Year Deductible
Telehealth and Telemedicine Services		
	100% of Allowable Amount after $40/$80 Copayment Amount	60% of Allowable Amount after Calendar Year Deductible
Virtual Visits		
	100% of Allowable Amount after $40 Copayment Amount	XXXXXXXXXX
Preventive Care Services		
	100% of Allowable Amount	60% 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	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Hearing Aids maximum	Limited to one hearing aid per ear each 36-month period*	

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

*****After the age of 3, when services under the individualized family service plan are completed, Eligible Expenses, as otherwise covered under the Policy, will be available. All contractual provisions of the Policy will apply, including but not limited to, defined terms, limitations and exclusions, and benefit maximum.

Schedule of Coverage

BlueCross BlueShield of Texas

(Blue Choice Gold PPO℠ 820) **Blue Choice PPO℠ Network**

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	100% of Allowable Amount after $250 Copayment Amount	60% of Allowable Amount after Calendar Year Deductible
• Ultrasonography measuring carotoid intima-media thickness and plaque.	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Habilitation Services		
Habilitation Services (includes, but is not limited to physical, occupational, and manipulative therapy)	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Calendar Year maximum	35 visits each Calendar Year* The visit limit does not apply to an individualized family service plan as issued by the Texas Interagency Council on Early Childhood Intervention as provided for in the benefit for **Certain Therapies for Children with Developmental Delays***** This limit does not apply to services associated with Autism Spectrum Disorder This limit does not apply to services associated with Acquired Brain Injury This limit does not apply to services associated with Behavioral Health Services	
Rehabilitation Services		
Rehabilitation Services (includes, but is not limited to physical, occupational, and manipulative therapy)	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Calendar Year maximum	35 visits each Calendar Year The visit limit does not apply to an individualized family service plan as issued by the Texas Interagency Council on Early Childhood Intervention as provided for in the benefit for **Certain Therapies for Children with Developmental Delays***** This limit does not apply to services associated with Autism Spectrum Disorder This limit does not apply to services associated with Acquired Brain Injury This limit does not apply to services associated with Behavioral Health Services	
Prior Authorization Requirements	**In-Network**	**Out-of-Network**
Inpatient Admissions		
Penalty for failure to prior authorize inpatient admissions shown in the Prior Authorization Requirements section of the Benefit Booklet	None	$250

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

*****After the age of 3, when services under the individualized family service plan are completed, Eligible Expenses, as otherwise covered under the Policy, will be available. All contractual provisions of the Policy will apply, including but not limited to, defined terms, limitations and exclusions, and benefit maximum.

Schedule of Coverage

BlueCross BlueShield of Texas

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.	$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 minus Participating Pharmacy Copayment Amount *
Extended Prescription Drug Supply Program	**Preferred Participating Pharmacy**	**Participating Pharmacy**	**Non-Participating Pharmacy**
One Copayment Amount per 30-day supply, up to a 90-day supply.	$0 Copayment Amount – Tier 1 $10 Copayment Amount – Tier 2 $50 Copayment Amount – Tier 3 $100 Copayment Amount* – Tier 4	**XXXXXXXXXXXXXX**	**XXXXXXXXXXXXXX**
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		**XXXXXXXXXXXXXX**
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		50% of Allowable Amount minus Copayment Amount
	$250 Copayment Amount – Tier 6		
Select Vaccinations obtained through Pharmacies**	**Pharmacy Vaccine Network Pharmacy**		**Other Pharmacy**
	$0 Copayment Amount		50% of Allowable Amount minus Copayment Amount
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 in 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.			

Schedule of Coverage

BlueCross BlueShield of Texas

*If you receive a 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.