Blue Choice 100%/100%

$5,000 DEDUCTIBLE - $5,000 OPX – 100% after deductible

S609CHC – Blue Choice Silver PPO 025 - HSA

BlueCross BlueShield of Texas

BENEFIT HIGHLIGHTS

Blue Choice

This provides only highlights of the benefit plan. After enrollment, members will receive a Certificate that more fully describes the terms of coverage.

Program Basics	Blue Choice (In-Network)	Non-Blue Choice (Out-of-Network)
Lifetime Benefit Maximum Per individual.	*Unlimited*	
Individual Coverage Deductible Per calendar year.	*$5,000*	*$10,000*
Family Coverage Deductible Per calendar year. Embedded Deductible.	*$12,700*	*$25,400*
Individual Coverage Out-of-Pocket Expense (OPX) Limit The amount of money that any individual will have to pay toward covered health care expenses during any one calendar year, Including the deductible. The following items will not be applied to the out-of-pocket expense limit: • Premium • Claims for uncovered services • Preauthorization Penalties • Charges that exceed the eligible charge	*$5,000*	*$10,000*
Family Coverage Out-of-Pocket Expense (OPX) Limit	*$12,700*	*$25,400*
Employer Contribution The amount of money that the employer contributes into the employee's HSA accounts over the plan's benefit period.	*$300-$600*	
Physician Services		
Physician Office Visits Payment applies for each visit to the physician's office. Surgeries, therapies, and chiropractic/osteopathic manipulation performed in a physician's office may be subject to the deductible and/or coinsurance. Lab and x-ray are no longer included in the Office Visit and pay at Deductible and Coinsurance.	*100% after deductible*	*100% after deductible*
Specialist Office Visits Payment applies for each visit to the physician's office. Surgeries, therapies, and chiropractic/osteopathic manipulation performed in a physician's office may be subject to the deductible and/or coinsurance.	*100% after deductible*	*100% after deductible*
Urgent Care Office Visits For out-of-network services, in-network payment applies for valid urgent care services only; otherwise benefits will be subjected to out-of-network deductible and coinsurance.	*100% after deductible*	
Preventive Care Services that have a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF"). Includes benefits for routine physical examinations, well child care and routine diagnostic tests including, but not limited to: PSA, Pap Smear, Bone Density, and Colonoscopy. Health Education and Counseling services including, but not limited to: Smoking Cessation and Obesity.	*100%*	*100% after deductible*
Maternity Services Payment applies to first prenatal visit (per pregnancy). All other maternity physician covered services are paid the same as Medical / Surgical Services.	*100% after deductible*	*100% after deductible*
Medical / Surgical Services Coverage for surgical procedures, inpatient visits therapies, allergy injections or treatments, and certain diagnostic procedures as well as other physician services.	*100% after deductible*	*100% after deductible*
Hospital Services		
Inpatient Hospital Services Coverage includes services received in a hospital, skilled nursing facility, coordinated home care and hospice, including mental health and substance abuse services. Room allowances based on the hospital's most common semi-private room rates.	*100% after deductible*	*100% after deductible*
Outpatient Hospital Services Coverage for services includes, but is not limited to outpatient or ambulatory surgical procedures, x-ray, lab tests, chemotherapy, radiation therapy, renal dialysis, and mammograms performed in a hospital or ambulatory surgical center, including mental health and substance abuse services. Routine mammograms performed in an in-network outpatient hospital setting are payable at 100%, no deductible will apply.	*100% after deductible*	*100% after deductible*

Blue Choice 100%/100%

$5,000 DEDUCTIBLE - $5,000 OPX – 100% after deductible

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BENEFIT HIGHLIGHTS

	Blue Choice	
	Blue Choice (In-Network)	**Non-Blue Choice** (Out-of-Network)
Outpatient Emergency Care (Accident or Illness)		
Emergency Medical and Emergency Accident. Applies to both in- and out-of-network emergency room visits. The per-occurrence is waived if the member is admitted to the hospital.	*100% after deductible*	
Additional Services		
Pediatric Dental Coverage (Members under age 19)		
See benefit booklet for additional benefit details	*100% after deductible*	*100% after deductible*
Muscle Manipulation Services		
Coverage for spinal and muscle manipulation services provided by a physician or chiropractor. Related office visits are paid the same as other Physician Office Visits. • *Maximum of 35 combined visits for Chiropractic, OT, and PT visits per calendar year.*	*100% after deductible*	*100% after deductible*
Therapy Services – Speech, Occupational and Physical		
Coverage for services provided by a physician or therapist. • *Maximum of 35 combined visits for Chiropractic, OT, and PT visits per calendar year.*	*100% after deductible*	*100% after deductible*
Temporomandibular Joint (TMJ) Dysfunction and Related Disorders	*100% after deductible*	*100% after deductible*
Imaging Services (CT, PET scan, MRI)	*100% after deductible*	*100% after deductible*
Other Covered Services (Please refer to Certificate for details) • Artificial limbs and other prosthetic devices • Blood and blood components • Skilled Nursing (25 day maximum per calendar year) • Ambulance services • Orthotic appliances • Prosthetic appliances • Medical supplies	*100% after deductible*	*100% after deductible*
Prescription Drug Card Prescription Drug benefit paid at 100% after co-payment at participating pharmacy. 90-Day Supply Options - can receive a 90-day supply of maintenance medications through the mail order program or at select retail pharmacies. Mail order and 90-day at retail prescriptions are 3x the retail copay. (Specialty drugs not available through mail order.) Member's covered prescription drug expenses will apply to the medical out-of-pocket maximum.	***Pharmacy*** • *100% after deductible for preferred generic drugs* • *100% after deductible for non-preferred generic drugs* • *100% after deductible for preferred brand drugs* • *100% after deductible for non-preferred brand drugs* • *100% after deductible for specialty drugs*	

****This is a general summary of your benefits.** Please refer to your Summary of Benefits and Coverage (SBC), or you may request a copy of the policy or plan document by calling Customer Service, for additional details and a description of the plan requirements and benefit design. This plan does not cover all health care expenses. Please carefully review the plan's limitations and exclusions.