



**PREFERRED PROVIDER BENEFIT PLAN (PPO) – M09  
BLUECHOICE NETWORK**

**PLAN 1: CoPAY PLAN (M09)  
BENEFIT HIGHLIGHTS**

This is a general summary of your benefits. Please refer to your benefit booklet for additional details and a description of the plan requirements and benefit design.  
This plan does not cover all health care expenses. Upon receipt of your benefit booklet, carefully review the plan's limitations and exclusions.

Overall Payment Provisions	PPO (In-Network)	Non-PPO (Out-of-Network)
<b>Calendar Year Deductible (Combined)</b> Applies to all Eligible Expenses (unless otherwise indicated)	<b>\$1,000</b> Individual / <b>\$3,000</b> Family	
4th quarter Deductible carryover applies		Yes
Deductible credit from prior carrier (applied on initial group enrollment only)		Yes
<b>Copayment Amounts Required</b>		
Physician office visit/consultation	<b>\$25</b> Copayment Amount	
Urgent Care center visit	<b>\$50</b> Copayment Amount	
Outpatient Hospital Emergency Room visit	<b>\$100</b> Copayment Amount	<b>\$100</b> Copayment Amount
<b>Coinsurance Stop-Loss Amount</b> Deductibles are not applied to Coinsurance Stop-Loss Amount. Your benefit booklet will provide more details.	<b>\$3,000</b> Individual / <b>\$9,000</b> Family	<b>\$6,000</b> Individual / <b>\$18,000</b> Family
	Network Coinsurance Stop-Loss Amount <b>will only</b> apply toward Network Coinsurance Stop-Loss Amount	Out-of-Network Coinsurance Stop-Loss Amount <b>will also</b> apply toward Network Coinsurance Stop-Loss Amount
Credit for Coinsurance Stop-Loss Amount from prior carrier (applied on initial group enrollment only)	Yes	Yes
<b>Maximum Lifetime Benefits</b> Per individual	\$5,000,000*	
<b>Inpatient Hospital Expenses</b>		
<b>Inpatient Hospital Expenses (must be preauthorized)</b>		
Inpatient Hospital Expenses	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Penalty for failure to preauthorize	None	\$250
<b>Medical/Surgical Expenses</b>		
<b>Medical / Surgical Expenses</b>		
Physician office visit/consultation, including lab & x-ray	100% of Allowable Amount after Copayment Amount <b>\$25</b>	70% of Allowable Amount after Calendar Year Deductible
Physician surgical services in any setting	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Lab & x-ray in other outpatient facilities (excluding Certain Diagnostic Procedures)	100% of Allowable Amount	70% of Allowable Amount after Calendar Year Deductible
Certain Diagnostic Procedures: Bone Scan, Cardiac Stress Test, CT Scan (with or without contrast), Ultrasound, MRI, Myelogram, PET Scan	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Home Infusion Therapy (must be preauthorized)	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
In Vitro Fertilization Services	Declined	
All other outpatient services and supplies	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible

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



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BENEFIT HIGHLIGHTS**

Extended Care Expenses	PPO (In-Network)	Non-PPO (Out-of-Network)
<b>Extended Care Expenses</b> (must be preauthorized)	100% of Allowable Amount	70% of Allowable Amount after Calendar Year Deductible
Skilled Nursing Facility	\$10,000 Calendar Year maximum*	
Home Health Care	\$10,000 Calendar Year maximum*	
Hospice Care	\$20,000 lifetime maximum*	
<b>Special Provisions Expenses</b>		
<b>Treatment of Chemical Dependency</b> (must be preauthorized)	Three separate series of treatments for each covered individual*	
Inpatient treatment must be provided in a Chemical Dependency Treatment Center		
All other outpatient treatment	Covered as any other sickness	Covered as any other sickness
<b>Serious Mental Illness</b> (must be preauthorized)		
<b>Inpatient Services</b>	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Hospital services (facility)		
Physician services	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Calendar Year Maximum	45 inpatient days/45 inpatient Physician visits each Calendar Year*	
<b>Outpatient Services</b>		
Physician office visit/consultation, including lab & x-ray	100% of Allowable Amount after <b>\$25</b> Copayment Amount	70% of Allowable Amount after Calendar Year Deductible
Other outpatient services, including psychological testing	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Calendar Year Maximum	60 outpatient visits each Calendar Year*	
<b>Mental Health Care</b> (must be preauthorized)		
<b>Inpatient Services</b>	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Hospital services (facility)		
Physician services	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Calendar Year Maximum	30 inpatient days/30 inpatient Physician visits each Calendar Year*	
<b>Outpatient Services</b>		
Physician office visit/consultation, including lab & x-ray	100% of Allowable Amount after <b>\$25</b> Copayment Amount	70% of Allowable Amount after alendar Year Deductible
Other outpatient services, including psychological testing	80% of Allowable Amount after calendar Year Deductible	60% of Allowable Amount after calendar Year Deductible
Calendar Year Maximum	30 visits each Calendar Year*	
<b>Emergency Care/Outpatient Hospital Emergency Room</b>		
<b>Accidental Injury &amp; Medical Emergency Care (within 48 hours)</b>	80% of Allowable Amount after <b>\$100</b> Copayment Amount (Copayment Amount waived if admitted)	
Facility charges		
Physician charges	80% of Allowable Amount after Calendar Year Deductible	
<b>Non-Emergency Situations (after 48 hours)</b>		
Facility charges	80% of Allowable Amount after <b>\$100</b> Copayment Amount (Copayment Amount waived if admitted)	60% of Allowable Amount after <b>\$100</b> Copayment Amount & Calendar Year Deductible (Copayment Amount waived if admitted)
Physician charges	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible

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



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**PLAN 1: CoPAY PLAN (M09)  
BENEFIT HIGHLIGHTS**

Special Provisions Expenses, cont.	PPO (In-Network)	Non-PPO (Out-of-Network)
<b>Urgent Care Services</b>		
Urgent Care center visit, including all lab & x-ray services, except Certain Diagnostic Procedures	100% of Allowable Amount after <b>\$50</b> Copayment Amount	70% of Allowable Amount after Calendar Year Deductible
Certain Diagnostic Procedures and all services and supplies	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
<b>Preventive Care</b>		
Routine annual physicals, well-baby care, immunizations (after 6th birthdate), vision and hearing exams	100% of Allowable Amount after <b>\$25</b> Copayment Amount	70% of allowable Amount after Calendar Year Deductible
Immunizations (birth through the day of the 6th birthdate)	100% of Allowable Amount	100% of Allowable Amount
<b>Speech and Hearing Services</b>		
Services to restore loss of or correct an impaired speech or hearing function	Covered same as any other sickness	Covered same 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 Benefit	Hearing aids are subject to a \$1,000 maximum amount each 36-month period*	
<b>Physical Medicine Services</b>		
Physical Medicine Services (includes but is not limited to physical, occupational, and manipulative therapy) Calendar Year Maximum	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible \$1,500 maximum benefit each Calendar Year*

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

Prescription Drug Program	Participating Pharmacy	Non-Participating Pharmacy (member files claim)
<b>Prescription Drugs</b>		
<b>Retail Prescription**</b> (All Copayment Amounts are per 30-day supply and will not apply to Coinsurance Stop-Loss Amount)		
Generic	<b>\$20</b> Copayment Amount	80% of Allowable Amount minus Copayment Amount
Preferred Brand Name	<b>\$35</b> Copayment Amount	80% of Allowable Amount minus Copayment Amount
Non-Preferred Brand Name	<b>\$50</b> Copayment Amount	80% of Allowable Amount minus Copayment Amount
<b>Mail Service Prescription**</b> (All Copayment Amounts are per 30-day supply and will not apply to Coinsurance Stop-Loss Amount)		
Generic	<b>\$20</b> Copayment Amount	
Preferred Brand Name	<b>\$35</b> Copayment Amount	
Non -Preferred Brand Name	<b>\$50</b> Copayment Amount	

\*\*Generic Incentive-Members electing to purchase Preferred/Non-Preferred Brand Name Drugs when a Generic equivalent is available, will be required to pay the difference between the cost of the Generic and Preferred/Non-Preferred Brand Name Drug, plus the Preferred Brand Name Copayment Amount.

**Diabetes Supplies** are available under the Prescription Drug Program portion of your plan. Diabetes Supplies include insulin and insulin analog preparations, insulin syringes necessary for self-administration, prescriptive and non-prescriptive oral agents, all required test strips and tablets which test for glucose, ketones, and protein, lancets and lancet devices, biohazard disposable containers, glucagon emergency kits, and other injection aids. All provisions of this portion of the plan will apply including Copayment Amounts and any pricing differences that may apply to the items dispensed.

**Flu vaccinations** are available through certain pharmacies for BCBSTX members. You will be charged \$15.00 Copayment for each vaccination received. Additional information is available on our website at [www.bcbstx.com](http://www.bcbstx.com).



**PREFERRED PROVIDER BENEFIT PLAN (PPO) – M03  
BLUECHOICE NETWORK**

**PLAN 2: CoPAY PLAN (M03)  
BENEFIT HIGHLIGHTS**

This is a general summary of your benefits. Please refer to your benefit booklet for additional details and a description of the plan requirements and benefit design.  
This plan does not cover all health care expenses. Upon receipt of your benefit booklet, carefully review the plan's limitations and exclusions.

Overall Payment Provisions	PPO (In-Network)	Non-PPO (Out-of-Network)
<b>Calendar Year Deductible (Combined)</b>		
Applies to all Eligible Expenses (unless otherwise indicated)	<b>\$500</b> Individual / <b>\$1,500</b> Family	
4th quarter Deductible carryover applies	Yes	
Deductible credit from prior carrier (applied on initial group enrollment only)	Yes	
<b>Copayment Amounts Required</b>		
Physician office visit/consultation	<b>\$15</b> Copayment Amount	
Urgent Care center visit	<b>\$40</b> Copayment Amount	
Outpatient Hospital Emergency Room visit	<b>\$100</b> Copayment Amount	<b>\$100</b> Copayment Amount
<b>Coinsurance Stop-Loss Amount</b>		
Deductibles are not applied to Coinsurance Stop-Loss Amount. Your benefit booklet will provide more details.	<b>\$2,000</b> Individual / <b>\$6,000</b> Family	<b>\$4,000</b> Individual / <b>\$12,000</b> Family
	Network Coinsurance Stop-Loss Amount <b>will only</b> apply toward Network Coinsurance Stop-Loss Amount	Out-of-Network Coinsurance Stop-Loss Amount <b>will also</b> apply toward Network Coinsurance Stop-Loss Amount
Credit for Coinsurance Stop-Loss Amount from prior carrier (applied on initial group enrollment only)	Yes	Yes
<b>Maximum Lifetime Benefits</b>		
Per individual	\$5,000,000*	
<b>Inpatient Hospital Expenses</b>		
<b>Inpatient Hospital Expenses (must be preauthorized)</b>		
Inpatient Hospital Expenses	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Penalty for failure to preauthorize	None	\$250
<b>Medical/Surgical Expenses</b>		
<b>Medical / Surgical Expenses</b>		
Physician office visit/consultation, including lab & x-ray	100% of Allowable Amount after <b>\$15</b> Copayment Amount	70% of Allowable Amount after Calendar Year Deductible
Physician surgical services in any setting	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Lab & x-ray in other outpatient facilities (excluding Certain Diagnostic Procedures)	100% of Allowable Amount	70% of Allowable Amount after Calendar Year Deductible
Certain Diagnostic Procedures: Bone Scan, Cardiac Stress Test, CT Scan (with or without contrast), Ultrasound, MRI, Myelogram, PET Scan	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Home Infusion Therapy (must be preauthorized)	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
In Vitro Fertilization Services	Declined	
All other outpatient services and supplies	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible

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



**PREFERRED PROVIDER BENEFIT PLAN (PPO) – M03  
BLUECHOICE NETWORK**

**PLAN 2: CoPAY PLAN (M03)  
BENEFIT HIGHLIGHTS**

Extended Care Expenses	PPO (In-Network)	Non-PPO (Out-of-Network)
<b>Extended Care Expenses</b> (must be preauthorized)	100% of Allowable Amount	70% of Allowable Amount after Calendar Year Deductible
Skilled Nursing Facility	\$10,000 Calendar Year maximum*	
Home Health Care	\$10,000 Calendar Year maximum*	
Hospice Care	\$20,000 lifetime maximum*	
<b>Special Provisions Expenses</b>		
<b>Treatment of Chemical Dependency</b> (must be preauthorized)	Three separate series of treatments for each covered individual*	
Inpatient treatment must be provided in a Chemical Dependency Treatment Center		
All other outpatient treatment	Covered as any other sickness	Covered as any other sickness
<b>Serious Mental Illness</b> (must be preauthorized)		
<b>Inpatient Services</b>	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Hospital services (facility)		
Physician services	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Calendar Year Maximum	45 inpatient days/45 inpatient Physician visits each Calendar Year*	
<b>Outpatient Services</b>		
Physician office visit/consultation, including lab & x-ray	100% of Allowable Amount after <b>\$15</b> Copayment Amount	70% of Allowable Amount after Calendar Year Deductible
Other outpatient services, including psychological testing	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Calendar Year Maximum	60 outpatient visits each Calendar Year*	
<b>Mental Health Care</b> (must be preauthorized)		
<b>Inpatient Services</b>	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Hospital services (facility)		
Physician services	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
Calendar Year Maximum	30 inpatient days/30 inpatient Physician visits each Calendar Year*	
<b>Outpatient Services</b>		
Physician office visit/consultation, including lab & x-ray	100% of Allowable Amount after <b>\$15</b> Copayment Amount	70% of Allowable Amount after alendar Year Deductible
Other outpatient services, including psychological testing	80% of Allowable Amount after calendar Year Deductible	60% of Allowable Amount after calendar Year Deductible
Calendar Year Maximum	30 visits each Calendar Year*	
<b>Emergency Care/Outpatient Hospital Emergency Room</b>		
<b>Accidental Injury &amp; Medical Emergency Care (within 48 hours)</b>	80% of Allowable Amount after <b>\$100</b> Copayment Amount (Copayment Amount waived if admitted)	
Facility charges		
Physician charges	80% of Allowable Amount after Calendar Year Deductible	
<b>Non-Emergency Situations (after 48 hours)</b>		
Facility charges	80% of Allowable Amount after <b>\$100</b> Copayment Amount (Copayment Amount waived if admitted)	60% of Allowable Amount after <b>\$100</b> Copayment Amount & Calendar Year Deductible (Copayment Amount waived if admitted)
Physician charges	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible

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



**PREFERRED PROVIDER BENEFIT PLAN (PPO) – M03  
BLUECHOICE NETWORK**

**PLAN 2: CoPAY PLAN (M03)  
BENEFIT HIGHLIGHTS**

Special Provisions Expenses, cont.	PPO (In-Network)	Non-PPO (Out-of-Network)
<b>Urgent Care Services</b>		
Urgent Care center visit, including all lab & x-ray services, except Certain Diagnostic Procedures	100% of Allowable Amount after <b>\$40</b> Copayment Amount	70% of Allowable Amount after Calendar Year Deductible
Certain Diagnostic Procedures and all services and supplies	80% of Allowable Amount after Calendar Year Deductible	60% of Allowable Amount after Calendar Year Deductible
<b>Preventive Care</b>		
Routine annual physicals, well-baby care, immunizations (after 6th birthdate), vision and hearing exams	100% of Allowable Amount after <b>\$15</b> Copayment Amount	70% of allowable Amount after Calendar Year Deductible
Immunizations (birth through the day of the 6th birthdate)	100% of Allowable Amount	100% of Allowable Amount
<b>Speech and Hearing Services</b>		
Services to restore loss of or correct an impaired speech or hearing function	Covered same as any other sickness	Covered same 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 Benefit	Hearing aids are subject to a \$1,000 maximum amount each 36-month period*	
<b>Physical Medicine Services</b>		
Physical Medicine Services (includes but is not limited to physical, occupational, and manipulative therapy) Calendar Year Maximum	80% of Allowable Amount after Calendar Year Deductible \$1,500 maximum benefit each Calendar Year*	60% of Allowable Amount after Calendar Year Deductible

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

Prescription Drug Program	Participating Pharmacy	Non-Participating Pharmacy (member files claim)
<b>Prescription Drugs</b>		
<b>Retail Prescription**</b> (All Copayment Amounts are per 30-day supply and will not apply to Coinsurance Stop-Loss Amount)		
Generic	<b>\$15</b> Copayment Amount	80% of Allowable Amount minus Copayment Amount
Preferred Brand Name	<b>\$30</b> Copayment Amount	80% of Allowable Amount minus Copayment Amount
Non-Preferred Brand Name	<b>\$45</b> Copayment Amount	80% of Allowable Amount minus Copayment Amount
<b>Mail Service Prescription**</b> (All Copayment Amounts are per 30-day supply and will not apply to Coinsurance Stop-Loss Amount)		
Generic	<b>\$15</b> Copayment Amount	
Preferred Brand Name	<b>\$30</b> Copayment Amount	
Non -Preferred Brand Name	<b>\$45</b> Copayment Amount	

\*\***Generic Incentive**-Members electing to purchase Preferred/Non-Preferred Brand Name Drugs when a Generic equivalent is available, will be required to pay the difference between the cost of the Generic and Preferred/Non-Preferred Brand Name Drug, plus the Preferred Brand Name Copayment Amount.

**Diabetes Supplies** are available under the Prescription Drug Program portion of your plan. Diabetes Supplies include insulin and insulin analog preparations, insulin syringes necessary for self-administration, prescriptive and non-prescriptive oral agents, all required test strips and tablets which test for glucose, ketones, and protein, lancets and lancet devices, biohazard disposable containers, glucagon emergency kits, and other injection aids. All provisions of this portion of the plan will apply including Copayment Amounts and any pricing differences that may apply to the items dispensed.

**Flu vaccinations** are available through certain pharmacies for BCBSTX members. You will be charged \$15.00 Copayment for each vaccination received. Additional information is available on our website at [www.bcbstx.com](http://www.bcbstx.com).



**BLUEEDGE HSA  
EMBEDDED DEDUCTIBLE (PLAN MH2)  
BLUECHOICE NETWORK**

**PLAN 3: HSA PLAN (MH2)  
BENEFIT HIGHLIGHTS**

This is a general summary of your benefits. Please refer to your benefit booklet for additional details and a description of the plan requirements and benefit design. This plan does not cover all health care expenses. Upon receipt of your benefit booklet, carefully review the plan's limitations and exclusions.

Overall Payment Provisions	PPO (In-Network)	Non-PPO (Out-of-Network)
<p><b>Calendar Year Deductible</b> Applies to all Eligible Expenses (unless otherwise indicated)</p> <p>Family coverage: When one family member meets the individual Deductible, benefits become available under the plan for that individual.</p> <p>NOTE: The individual Deductible amount must be equal to or greater than the minimum family Deductible amount. This qualification is established by the U. S. Treasury for a plan to be considered a qualified HSA plan.</p> <p>4th quarter Deductible carryover provision does not apply</p> <p>Deductible credit from prior carrier (applied on initial group enrollment only)</p>	<p><b>\$3,000</b> Individual / <b>\$6,000</b> Family</p>	<p><b>\$6,000</b> Individual / <b>\$12,000</b> Family</p>
<p><b>Out-of-Pocket Maximum</b> Deductible, Coinsurance Amounts, and Copayments (if any) apply to Out-of-Pocket Maximum</p> <p>Credit for Out-of-Pocket Maximum from prior carrier (applied on initial group enrollment only)</p>	<p><b>\$3,000</b> Individual / <b>\$6,000</b> Family</p> <p>Network Deductible &amp; Out-of-Pocket Maximum <b>will only</b> apply toward Network Deductible &amp; Out-of-Pocket Maximum</p>	<p><b>\$12,000</b> Individual / <b>\$24,000</b> Family</p> <p>Out-of-Network Deductible &amp; Out-of-Pocket Maximum <b>will also</b> apply toward Network Deductible &amp; Out-of-Pocket Maximum</p>
<p><b>Maximum Lifetime Benefits</b> Per individual <span style="float: right;">\$5,000,000*</span></p>		
<p><b>Inpatient Hospital Expenses (must be preauthorized)</b></p>		
<p>Inpatient Hospital Expenses</p> <p>Penalty for failure to preauthorize</p>	<p>100% of Allowable Amount after Calendar Year Deductible</p> <p>None</p>	<p>70% of Allowable Amount after Calendar Year Deductible</p> <p>\$250</p>
<p><b>Medical / Surgical Expenses</b></p>		
<p>Physician office visit/consultation, including lab &amp; x-ray</p> <p>Physician surgical services in any setting</p> <p>Lab &amp; x-ray in other outpatient facilities &amp; Certain Diagnostic Procedures: Bone Scan, Cardiac Stress Test, CT Scan (with or without contrast), Ultrasound, MRI, Myelogram, PET Scan.</p> <p>Home Infusion Therapy (must be preauthorized)</p> <p>In Vitro Fertilization Services</p> <p>All other outpatient services and supplies</p>	<p>100% of Allowable Amount after Calendar Year Deductible</p> <p>100% of Allowable Amount after Calendar Year Deductible</p> <p>100% of Allowable Amount after Calendar Year Deductible</p> <p>100% of Allowable Amount after Calendar Year Deductible</p> <p>Declined</p> <p>100% of Allowable Amount after Calendar Year Deductible</p>	<p>70% of Allowable Amount after Calendar Year Deductible</p> <p>70% of Allowable Amount after Calendar Year Deductible</p> <p>70% of Allowable Amount after Calendar Year Deductible</p> <p>70% of Allowable Amount after Calendar Year Deductible</p> <p>70% of Allowable Amount after Calendar Year Deductible</p>

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



**BLUEEDGE HSA  
EMBEDDED DEDUCTIBLE (PLAN MH2)  
BLUECHOICE NETWORK**

**PLAN 3: HSA PLAN (MH2)  
BENEFIT HIGHLIGHTS**

Extended Care Expenses	PPO (In-Network)	Non-PPO (Out-of-Network)
<b>Extended Care Expenses (must be preauthorized)</b>  Skilled Nursing Facility Home Health Care Hospice Care	100% of Allowable Amount after Calendar Year Deductible  \$10,000 Calendar Year maximum* \$10,000 Calendar Year maximum* \$20,000 lifetime maximum*	70% of Allowable Amount after Calendar Year Deductible
<b>Special Provisions Expenses</b>		
<b>Treatment of Chemical Dependency (must be preauthorized)</b>  Inpatient treatment must be provided in a Chemical Dependency Treatment Center All other outpatient treatment	Three separate series of treatments for each covered individual* Covered as any other physical illness Covered as any other physical illness	Covered as any other physical illness
<b>Serious Mental Illness (must be preauthorized)</b>		
<b>Inpatient Services</b> Hospital services (facility)  Physician services  Calendar Year Maximum	100% of Allowable Amount after Calendar Year Deductible  100% of Allowable Amount after Calendar Year Deductible  45 inpatient days/45 inpatient Physician visits each Calendar Year*	70% of Allowable Amount after Calendar Year Deductible  70% of Allowable Amount after Calendar Year Deductible
<b>Outpatient Services</b> Services performed in a Physician's office, including lab & x-ray  Other outpatient services and psychological testing  Calendar Year Maximum	100% of Allowable Amount after Calendar Year Deductible  100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible  70% of Allowable Amount after Calendar Year Deductible  60 outpatient visits each Calendar Year*
<b>Mental Health Care (must be preauthorized)</b>		
<b>Inpatient Services</b> Hospital services (facility)  Physician services  Calendar Year Maximum	100% of Allowable Amount after Calendar Year Deductible  100% of Allowable Amount after Calendar Year Deductible  30 inpatient days/30 inpatient Physician visits each Calendar Year*	70% of Allowable Amount after Calendar Year Deductible  70% of Allowable Amount after Calendar Year Deductible
<b>Outpatient Services</b> Services performed in a Physician's office, including lab & x-ray  Other outpatient services and psychological testing  Calendar Year Maximum	100% of Allowable Amount after Calendar Year Deductible  100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible  70% of Allowable Amount after Calendar Year Deductible  30 visits each Calendar Year*

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



**BLUEEDGE HSA  
EMBEDDED DEDUCTIBLE (PLAN MH2)  
BLUECHOICE NETWORK**

**PLAN 3: HSA PLAN (MH2)  
BENEFIT HIGHLIGHTS**

Special Provisions Expenses, cont.	PPO (In-Network)	Non-PPO (Out-of-Network)
<b>Emergency Care/Outpatient Hospital Emergency Room</b>		
Accidental Injury & Medical Emergency Care (within 48 hours) Facility charges	100% of Allowable Amount after Calendar Year Deductible	
Physician charges	100% of Allowable Amount after Calendar Year Deductible	
<b>Non-Emergency Situations (after 48 hours)</b> Facility charges	100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
Physician charges	100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
<b>Urgent Care</b>		
Each Urgent Care center visit, including all lab & x-ray services, Certain Diagnostic Procedures, and all other services and supplies	100% of Allowable Amount after Calendar Year Deductible	70% of allowable Amount after Calendar Year Deductible
<b>Preventive Care</b>		
Routine annual physical exam office visit, well-baby exam office visit, immunizations (after 6th birthdate), & vision and hearing exams	100% of Allowable Amount	70% of allowable Amount
Immunizations (birth to the day of the 6th birthdate)	100% of Allowable Amount	100% of Allowable Amount
<b>Speech and Hearing Services</b>		
Services to restore loss of or correct an impaired speech or hearing function with hearing aids	Covered same as any other sickness	Covered same as any other sickness
Hearing Aids	100% of Allowable Amount after Calendar Year Deductible	100% of Allowable Amount after Calendar Year Deductible
Hearing Aids Maximum Benefit	Hearing aids are subject to a \$1,000 maximum amount each 36-month period*	
<b>Physical Medicine Services</b>		
Physical Medicine Services (includes but is not limited to physical, occupational, and manipulative therapy) Calendar Year Maximum	100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
	\$1,500 maximum benefit each Calendar Year*	

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

Prescription Drug Program	Participating Pharmacy	Non-Participating Pharmacy (member files claim)
<b>Prescription Drugs*</b>		
<b>Retail Pharmacy</b> (Dispensing is limited to a 30-day supply, no more than a 90-day supply)	100% of Allowable Amount after the Calendar Year Deductible	
<b>Mail Service Pharmacy</b> (Dispensing is limited to a 30-day supply, no more than a 90-day supply)	100% of Allowable Amount after the Calendar Year Deductible	

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



## EMPLOYEE INFORMATION

The following applies to dependent coverage:

- Dependent children are covered for maternity benefits.
- Automatic coverage for newborns for the first 31 days following birth. Infants not enrolled for coverage within the first 31 days after birth will not be eligible for coverage until the following open enrollment period or special enrollment event.

**Payments:** Network providers agree to accept amounts negotiated with BCBSTX and are paid according to this BCBSTX determined Allowable Amount. Covered individuals are responsible for any required Deductibles, Coinsurance or Out-of-Pocket Amounts, and Copayments. Plan benefits paid to Out-of-Network providers are based on the BCBSTX-determined Allowable Amount. These providers may balance bill covered individuals for charges in excess of the BCBSTX Allowable Amount. The covered individual will be responsible for charges in excess of the Allowable Amount in addition to any applicable Deductibles, Coinsurance or Out-of-Pocket Amounts, and Copayments. For cost savings information, refer to the section on ParPlan Providers and the definition of Allowable Amount in the benefit booklet.

**Preexisting Conditions:** This term is defined in the benefit booklet. Conditions determined to be preexisting are excluded for 12 months. Appropriate credit will be given for time served under another health benefit plan as defined under the law.

**Replacement of Medical Coverage:** In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Texas State law, the following provisions apply to each eligible Participant who has health coverage under the employer's plan immediately prior to the effective date of the health contract between the employer and BCBSTX (the Contract Date):

- Benefits for eligible expenses incurred for any service or supplies prior to the contract date, are not covered under the contract.
- Eligible Expenses for services or supplies incurred on or after the effective date will be considered for benefits subject to all applicable contract provisions.

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## HSA INFORMATION

**HSA Deductible (Embedded):** The benefits of the HSA Plan will be available after satisfaction of the applicable Deductible. The Deductible will be increased in the future in direct proportion to the increase as determined from the cost-of-living adjustments based on the Consumer Price Index (CPI-U). The Deductibles are explained as follows:

1. The individual Deductible amount as shown on this Benefits Highlights under "Calendar Year Deductible," must be satisfied by each Participant under your coverage each Calendar Year. This Deductible, unless otherwise indicated, will apply to all combined Inpatient Hospital Expenses, Medical-Surgical Expenses, Extended Care Expenses, and Special Provisions Expenses you incur during a Calendar Year. This Deductible must be satisfied by each Participant under your coverage each Calendar Year before any benefits are available under the Plan.
2. If you have several covered Dependents, all charges used to apply toward a "per individual" Deductible amount will be applied toward the "per family" Deductible amount shown on this Benefits Highlights. When that family Deductible amount is reached, no further individual Deductibles will have to be satisfied for the remainder of that Calendar Year. No Participant will contribute more than the individual Deductible amount to the "per family" Deductible amount.

**HSA Out-of-Pocket Maximum:** Most of your Eligible Expense payment obligations are applied to the Out-of-Pocket Maximum. The Out-of-Pocket Maximum will be increased in the future in direct proportion to the increase as determined from the cost-of-living adjustments based on the Consumer Price Index (CPI-U).

1. The Out-of-Pocket Maximum **will not** include:
  - Services, supplies, or charges limited or excluded by the Plan;
  - Expenses not covered because a benefit maximum has been reached;
  - Any Eligible Expense paid by the Primary Plan when BCBSTX is the Secondary Plan for purposes of coordination of benefits;
  - Penalties for failing to obtain preauthorization;
2. When the Out-of-Pocket Maximum amount for the In-Network or Out-of-Network Benefits level for a Participant in a Calendar Year equals the "per individual" "Out-of-Pocket Maximum" shown on this Benefits Highlights for that level, the benefit percentages automatically increase to 100% for purposes of determining the benefits available for additional Eligible Expenses incurred by that Participant for the remainder of that Calendar Year for that level.
3. When the Out-of-Pocket Maximum amount for the In-Network or Out-of-Network Benefits level for all Participants under your coverage in a Calendar Year equals the "per family" "Out-of-Pocket Maximum" shown on this Benefits Highlights for that level, the benefit percentages automatically increase to 100% for purposes of determining the benefits available for additional Eligible Expenses incurred by all family Participants for the remainder of the Calendar Year for that level. No Participant will be required to contribute more than the individual Out-of-Pocket Maximum to the family Out-of-Pocket Maximum.

± Please be reminded that Health Savings Accounts (HSA's) have tax and legal ramifications. Blue Cross and Blue Shield of Texas does not provide legal or tax advice, and nothing herein should be construed as legal or tax advice. These materials, and any tax-related statements in them, are not intended or written to be used, and cannot be used or relied on, for the purpose of avoiding tax penalties. Tax-related statements, if any, may have been written in connection with the promotion or marketing of the transaction(s) or matter(s) addressed by these materials. You should seek advice based on your particular circumstances from an independent tax advisor regarding the tax consequences of specific health insurance plans or products.