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.

Plan RMH3 — ***BlueChoice 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*	*$5,000 Individual / $10,000 Family*	*$10,000 Individual / $20,000 Family*
Out-of-Pocket Maximum	*$5,000 Individual / $10,000 Family*	*$20,000 Individual / $40,000 Family*
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.	*100% of Allowable Amount after Calendar Year Deductible*	*70% of Allowable Amount after Calendar Year Deductible*
Penalty for failure to preauthorize services	*None*	*$250*
Medical/Surgical Expenses	***In-Network Benefits***	***Out-of-Network Benefits***
Physician office visit/consultation, including lab and x-ray	*100% of Allowable Amount after Calendar Year Deductible*	*70% of Allowable Amount after Calendar Year Deductible*
Lab & x-ray in other outpatient facilities, excluding Certain Diagnostic Procedures	*100% of Allowable Amount after Calendar Year Deductible*	*70% of Allowable Amount after Calendar Year Deductible*
Inpatient visits and Certain Diagnostic Procedures	*100% of Allowable Amount after Calendar Year Deductible*	*70% of Allowable Amount after Calendar Year Deductible*
Home Infusion Therapy	*100% of Allowable Amount after Calendar Year Deductible*	*70% of Allowable Amount after Calendar Year Deductible*
Physician surgical services performed in any setting	*100% of Allowable Amount after Calendar Year Deductible*	*70% of Allowable Amount after Calendar Year Deductible*
Extended Care Expenses	***In-Network Benefits***	***Out-of-Network Benefits***
	100% of Allowable Amount after Calendar Year Deductible	*70% 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	*Unlimited*	
Special Provisions Expenses	***In-Network Benefits***	***Out-of-Network Benefits***
Behavioral Health Services		

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

Treatment of Chemical Dependency

Certain Services will require Preauthorization

Inpatient Services		
Inpatient treatment must be provided in a Chemical Dependency Treatment Center / Hospital (facility)	*100% of Allowable Amount after Calendar Year Deductible*	*70% of Allowable Amount after Calendar Year Deductible*
Penalty for failure to preauthorize inpatient services (facility)	*None*	*$250*
Behavioral Health Practitioner services	*100% of Allowable Amount after Calendar Year Deductible*	*70% of Allowable Amount after Calendar Year Deductible*
Outpatient Services		
Behavioral Health Practitioner expenses (office setting)	*100% of Allowable Amount after Calendar Year Deductible*	*70% of Allowable Amount after Calendar Year Deductible*
Other outpatient services	*100% of Allowable Amount after Calendar Year Deductible*	*70% of Allowable Amount after Calendar Year Deductible*

Serious Mental Illness

Certain Services will require Preauthorization.

Inpatient Services		
Hospital services (facility)	*100% of Allowable Amount after Calendar Year Deductible*	*70% of Allowable Amount after Calendar Year Deductible*
Penalty for failure to preauthorize inpatient services (facility)	*None*	*$250*
Behavioral Health Practitioner services	*100% of Allowable Amount after Calendar Year Deductible*	*70% of Allowable Amount after Calendar Year Deductible*
Outpatient Services		
Behavioral Health Practitioner expenses (office setting)	*100% of Allowable Amount after Calendar Year Deductible*	*70% of Allowable Amount after Calendar Year Deductible*
Other outpatient services	*100% of Allowable Amount after Calendar Year Deductible*	*70% of Allowable Amount after Calendar Year Deductible*

Mental Health Care

Certain Services will require Preauthorization

Inpatient Services		
Hospital services (facility)	*100% of Allowable Amount after Calendar Year Deductible*	*70% of Allowable Amount after Calendar Year Deductible*
Penalty for failure to preauthorize inpatient services (facility)	*None*	*$250*
Behavioral Health Practitioner services	*100% of Allowable Amount after Calendar Year Deductible*	*70% of Allowable Amount after Calendar Year Deductible*
Outpatient Services		
Behavioral Health Practitioner expenses (office setting)	*100% of Allowable Amount after Calendar Year Deductible*	*70% of Allowable Amount after Calendar Year Deductible*
Other outpatient services	*100% of Allowable Amount after Calendar Year Deductible*	*70% of Allowable Amount after Calendar Year Deductible*

Emergency Room/Treatment Room

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Accidental Injury & Emergency Care(including Accidental Injury & Emergency Care for Behavioral Health Services)		
Facility charges (excluding Certain Diagnostic Procedures)	*100% of Allowable Amount after Calendar Year Deductible*	
Physician charges	*100% of Allowable Amount after Calendar Year Deductible*	
Non-Emergency Care (including Non-Emergency Care for Behavioral Health Services)		
Facility charges (excluding Certain Diagnostic Procedures)	*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*
Urgent Care Services		
Urgent Care center visit, including lab & x-ray services and Certain Diagnostic Procedures	*100% of Allowable Amount after Calendar Year Deductible*	*70% of Allowable Amount after Calendar Year Deductible*
Ambulance Services	*100% of Allowable Amount after Calendar Year Deductible*	
Preventive Care Services		
	100% of Allowable Amount	*70% of Allowable Amount*
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*
Hearing Aids	*100% of Allowable Amount after Calendar Year Deductible*	*70% 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.	*100% of Allowable Amount after Calendar Year Deductible*	*70% of Allowable Amount after Calendar Year Deductible*
• Ultrasonography measuring carotoid intima-media thickness and plaque.	*100% of Allowable Amount after Calendar Year Deductible*	*70% of Allowable Amount after Calendar Year Deductible*
Physical Medicine Services		
Physical Medicine Services (includes, but is not limited to physical, occupational, and manipulative therapy)	*100% of Allowable Amount after Calendar Year Deductible*	*70% of Allowable Amount after Calendar Year Deductible*
Calendar Year maximum	*35 visits each Calendar Year**	

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

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	***Participating Pharmacy***	***Non-Participating Pharmacy (member files claims)***
Retail Pharmacy		
One Copayment Amount per 30-day supply, no more than a 90-day supply	*100% of Allowable Amount after Calendar Year Deductible*	
Mail-Order Program	***Mail Order Program***	***Other Pharmacy***
One Copayment Amount per 30-day supply, up to a 90-day supply	*100% of Allowable Amount after Calendar Year Deductible*	*XXXXXXXXXXXXXXXXXXXXX*
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	*100% of Allowable Amount after Calendar Year Deductible*	
Vaccinations obtained through Pharmacies*	***Select Participating Pharmacies***	***Non-Participating Pharmacy (member files claims)***
	Flu vaccine - $0 Copayment Amount	*100% of Allowable Amount minus Copayment Amount after Calendar Year Deductible*

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.

** 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. Childhood immunizations subject to state regulations are not available under this pharmacy benefit. Refer to your BCBSTX medical coverage for benefits available for childhood immunizations.

Preferred Drug List 1 applies.

Pharmacy Network A applies.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bcbstx.com/member/policy-forms/ or by calling 1-800-521-2227.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For Network **$5,000** Individual/**$10,000** Family. For Out-of-Network **$10,000** Individual/**$20,000** Family. Preventive care does not apply to the Network deductible.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. For Network **$5,000** Individual/**$10,000** Family. For Out-of-Network **$20,000** Individual/**$40,000** Family.	The **out-of-pocket** limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Pre-authorization penalties, premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Does this plan use a network of providers?	Yes. See www.bcbstx.com or call **1-800-810-2583** for a list of Network Providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the health plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- The plan may encourage you to use Network **providers** by charging you lower **deductibles**, **copayments**, and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No Charge	30% coinsurance	---none---
	Specialist visit	No Charge	30% coinsurance	
	Other practitioner office visit	No Charge	30% coinsurance	
	Preventive care/screening/immunization	No Charge	30% coinsurance	There is No Charge for Out-of-Network immunizations from birth through the day of the 6th birthday.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	30% coinsurance	---none---
	Imaging (CT/PET scans, MRIs)	No Charge	30% coinsurance	

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbstx.com/member/rx_drugs.html	Generic drugs	No Charge	No Charge	Benefit payments are based on a 30-day supply for retail and mail order. With appropriate Prescription Order, up to a 90-day supply. Preferred Drug List 1 applies.
	Preferred brand drugs	No Charge	No Charge	
	Non-preferred brand drugs	No Charge	No Charge	
	Specialty drugs	No Charge	No Charge	Benefit payments are based on a 30-day supply for retail only, no mail order. With appropriate Prescription Order, up to a 90-day supply. Preferred Drug List 1 applies.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge	30% coinsurance	---none---
	Physician/surgeon fees	No Charge	30% coinsurance	
If you need immediate medical attention	Emergency room services	No Charge	No Charge	---none---
	Emergency medical transportation	No Charge	No Charge	
	Urgent care	No Charge	30% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	30% coinsurance	Preauthorization is required and there is a $250 penalty if Out-of-Network is not preauthorized.
	Physician/surgeon fee	No Charge	30% coinsurance	---none---

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/behavioral health outpatient services	No Charge	30% coinsurance	Certain services must be preauthorized; refer to benefit booklet for details.
	Mental/behavioral health inpatient services	No Charge	30% coinsurance	All services must be preauthorized; $250 penalty for failure to preauthorize Out-of-Network
	Substance use disorder outpatient services	No Charge	30% coinsurance	Certain services must be preauthorized; refer to benefit booklet for details.
	Substance use disorder inpatient services	No Charge	30% coinsurance	All services must be preauthorized; $250 penalty for failure to preauthorize Out-of-Network
If you are pregnant	Prenatal and postnatal care	No Charge	30% coinsurance	---none---
	Delivery and all inpatient services	No Charge	30% coinsurance	Preauthorization is only required if extension of minimum length of stay is requested.
If you need help recovering or have other special health needs	Home health care	No Charge	30% coinsurance	Limited to 60 visits per calendar year. Preauthorization is required.
	Rehabilitation services	No Charge	30% coinsurance	Limited to combined 35 visits per year, including Chiropractic.
	Habilitation services	No Charge	30% coinsurance	
	Skilled nursing care	No Charge	30% coinsurance	Limited to 25 days per calendar year. Preauthorization is required.
	Durable medical equipment	No Charge	30% coinsurance	---none---
	Hospice service	No Charge	30% coinsurance	Preauthorization is required.

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	No Charge	30% coinsurance	---none---
	Glasses	Not Covered	Not Covered	
	Dental check-up	Not Covered	Not Covered	

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Long term care
- Private duty nursing
- Termination of pregnancy
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Hearing aids
- Infertility treatment (Invitro and artificial insemination are not covered unless shown in your plan document)
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care (Only covered in connection with diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact the plan at 1-800-521-2227. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact Blue Cross and Blue Shield of Texas at 1-800-521-2227 or visit www.bcbstx.com, or contact U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-521-2227.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-521-2227.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-521-2227.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-521-2227.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About These Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under the plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $2,340
- **Patient pays** $5,200

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$5,000
Copays	$0
Coinsurance	$0
Limits or exclusions	$200
Total	**$5,200**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $320
- **Patient pays** $5,080

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$5,000
Copays	$0
Coinsurance	$0
Limits or exclusions	$80
Total	**$5,080**

Questions and answers about Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No**. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No**. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes**. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes**. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.