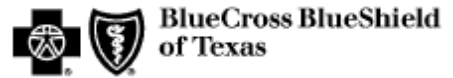


Schedule of Coverage



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 PPOSM HSA 006H

Blue Choice PPOSM 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

Applies to all Eligible Expenses

\$4,000 Individual /
\$8,000 Family

\$8,000 Individual /
\$16,000 Family

Out-of-Pocket Maximum

\$4,000 Individual /
\$8,000 Family

Unlimited

Inpatient Hospital Expenses

Inpatient Hospital Expenses

All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units.

Penalty for failure to obtain Prior Authorization for services

In-Network Benefits

No Charge after Calendar Year Deductible

None

Out-of-Network Benefits

30% of Allowable Amount after Calendar Year Deductible

\$250

Medical/Surgical Expenses

Physician office visit/consultation, including lab and x-ray

Lab & x-ray in other outpatient facilities, excluding Certain Diagnostic Procedures

Inpatient visits and Certain Diagnostic Procedures

Home Infusion Therapy

Physician surgical services performed in any setting

In-Network Benefits

No Charge after Calendar Year Deductible

No Charge after Calendar Year Deductible

No Charge after Calendar Year Deductible

No Charge after Calendar Year Deductible

No Charge after Calendar Year Deductible

Out-of-Network Benefits

30% of Allowable Amount after Calendar Year Deductible

30% of Allowable Amount after Calendar Year Deductible

30% of Allowable Amount after Calendar Year Deductible

30% of Allowable Amount after Calendar Year Deductible

30% of Allowable Amount after Calendar Year Deductible

Extended Care Expenses

Certain Services will require Prior Authorization

Skilled Nursing Facility

Calendar Year maximum

Home Health Care

Calendar Year maximum

Hospice Care

Calendar Year maximum

In-Network Benefits

No Charge after Calendar Year Deductible

25 days per Calendar Year*

No Charge after Calendar Year Deductible

60 visits per Calendar Year*

No Charge after Calendar Year Deductible

Unlimited

Out-of-Network Benefits

30% of Allowable Amount after Calendar Year Deductible

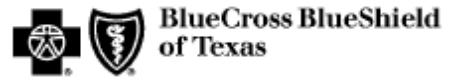
30% of Allowable Amount after Calendar Year Deductible

30% 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

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Schedule of Coverage

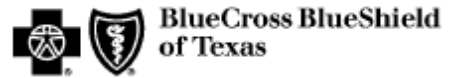


Special Provisions Expenses	In-Network Benefits	Out-of-Network Benefits
Behavioral Health Services		
Treatment of Chemical Dependency (Substance Use Disorder (SUD))		
Certain Services will require Prior Authorization		
Inpatient Services		
Inpatient treatment must be provided in a Chemical Dependency (SUD) Treatment Center / Hospital (facility)	No Charge after Calendar Year Deductible	30% 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	No Charge after Calendar Year Deductible	30% of Allowable Amount after Calendar Year Deductible
Outpatient Services		
Behavioral Health Practitioner expenses (office setting)	No Charge after Calendar Year Deductible	30% of Allowable Amount after Calendar Year Deductible
Other outpatient services	No Charge after Calendar Year Deductible	30% of Allowable Amount after Calendar Year Deductible
Serious Mental Illness		
Certain Services will require Prior Authorization		
Inpatient Services		
Hospital services (facility)	No Charge after Calendar Year Deductible	30% 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	No Charge after Calendar Year Deductible	30% of Allowable Amount after Calendar Year Deductible
Outpatient Services		
Behavioral Health Practitioner expenses (office setting)	No Charge after Calendar Year Deductible	30% of Allowable Amount after Calendar Year Deductible
Other outpatient services	No Charge after Calendar Year Deductible	30% of Allowable Amount after Calendar Year Deductible
Mental Health Care		
Certain Services will require Prior Authorization		
Inpatient Services		
Hospital services (facility)	No Charge after Calendar Year Deductible	30% 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	No Charge after Calendar Year Deductible	30% of Allowable Amount after Calendar Year Deductible
Outpatient Services		
Behavioral Health Practitioner expenses (office setting)	No Charge after Calendar Year Deductible	30% of Allowable Amount after Calendar Year Deductible
Other outpatient services	No Charge after Calendar Year Deductible	30% of Allowable Amount after Calendar Year Deductible

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Schedule of Coverage



Emergency Room/Treatment Room		
Emergency Care (including Accidental Injury & Emergency and Non-Emergency Care for Behavioral Health Services)	<i>No Charge after Calendar Year Deductible</i>	
Facility charges (excluding Certain Diagnostic Procedures)	<i>No Charge after Calendar Year Deductible</i>	
Physician charges	<i>No Charge after Calendar Year Deductible</i>	
Non-Emergency Care		
Facility charges (excluding Certain Diagnostic Procedures)	<i>No Charge after Calendar Year Deductible</i>	<i>30% of Allowable Amount after Calendar Year Deductible</i>
Physician charges	<i>No Charge after Calendar Year Deductible</i>	<i>30% of Allowable Amount after Calendar Year Deductible</i>
Urgent Care Services		
	<i>No Charge after Calendar Year Deductible</i>	<i>30% of Allowable Amount after Calendar Year Deductible</i>
Ambulance Services		
	<i>No Charge after Calendar Year Deductible</i>	
Retail Health Clinics		
	<i>No Charge after Calendar Year Deductible</i>	<i>30% of Allowable Amount after Calendar Year Deductible</i>
Virtual Visits		
	<i>No Charge after Calendar Year Deductible</i>	<i>Not Covered</i>
Preventive Care Services		
	<i>No Charge</i>	<i>30% of Allowable Amount after Calendar Year Deductible</i>
Speech and Hearing Services		
Services to restore loss of or correct an impaired speech or hearing function with hearing aids <i>Benefits for Autism Spectrum Disorder will not apply towards and are not subject to any speech services visits maximum.</i>	<i>Covered as any other sickness</i>	<i>Covered as any other sickness</i>
Hearing Aids	<i>No Charge after Calendar Year Deductible</i>	<i>30% of Allowable Amount after Calendar Year Deductible</i>
Hearing Aids maximum	<i>Limited to one hearing aid per ear each 36-month period*</i>	
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:	<i>Maximum benefit of 1 test every 5 years*</i>	
<ul style="list-style-type: none"> • Computed tomography (CT) scanning measuring coronary artery calcification. 	<i>No Charge after Calendar Year Deductible</i>	<i>30% of Allowable Amount after Calendar Year Deductible</i>
<ul style="list-style-type: none"> • Ultrasonography measuring carotid intima-media thickness and plaque. 	<i>No Charge after Calendar Year Deductible</i>	<i>30% of Allowable Amount after Calendar Year Deductible</i>
Physical Medicine Services		
Physical Medicine Services (includes, but is not limited to physical, occupational, and manipulative therapy) Calendar Year maximum	<i>No Charge after Calendar Year Deductible</i>	<i>30% of Allowable Amount after Calendar Year Deductible</i>
	<i>35 visits each Calendar Year*</i>	
	<i>Benefits for Autism Spectrum Disorder will not apply towards and are not subject to any physical medicine services visits maximum.</i>	

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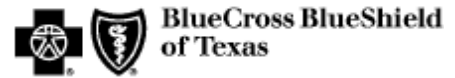
Schedule of Coverage



Prior Authorization Requirements	In-Network Benefits	Out-of-Network Benefits
<i>Inpatient Admissions</i> Penalty for failure to obtain Prior Authorization for inpatient admissions shown in the Utilization Management section of the Benefit Booklet	<i>None</i>	\$250
<i>Outpatient Services</i> Penalty for failure to obtain Prior Authorization for outpatient services shown in the Utilization Management section of the Benefit Booklet	<i>None</i>	<i>50% of Allowable Amount, not to exceed \$500</i>

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Schedule of Coverage



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 One Copayment Amount per 30-day supply, up to a 30-day supply	Preferred Participating Pharmacy		Participating Pharmacy	Non-Participating Pharmacy
	<i>Participant pays...</i>		<i>Participant pays...</i>	
	No Charge after Calendar Year Deductible – Tier 1		No Charge after Calendar Year Deductible – Tier 1	
	No Charge after Calendar Year Deductible – Tier 2		No Charge after Calendar Year Deductible – Tier 2	
	No Charge after Calendar Year Deductible – Tier 3		No Charge after Calendar Year Deductible – Tier 3	
	No Charge after Calendar Year Deductible – Tier 4		No Charge after Calendar Year Deductible – Tier 4	
			50% of Allowable Amount plus Participating Pharmacy Coinsurance Amount* after Calendar Year Deductible	
Extended Prescription Drug Supply Program One Copayment Amount per 30-day supply, no more than a 90-day supply	Preferred Participating Pharmacy		Participating Pharmacy	Non-Participating Pharmacy
	No Charge after Calendar Year Deductible – Tier 1			
	No Charge after Calendar Year Deductible – Tier 2			
	No Charge after Calendar Year Deductible – Tier 3		Not Covered	Not Covered
	No Charge after Calendar Year Deductible – Tier 4			
Mail-Order Program One Copayment Amount per 90-day supply, up to a 90-day supply	Mail-Order Program			Other Pharmacy
	No Charge after Calendar Year Deductible – Tier 1			
	No Charge after Calendar Year Deductible – Tier 2			
	No Charge after Calendar Year Deductible – Tier 3			Not Covered
	No Charge after Calendar Year Deductible – Tier 4			
Specialty Drugs Available In-Network through Specialty Pharmacy Program One Copayment Amount per 30-day supply - limited to a 30-day supply	Specialty Pharmacy Provider			Other Pharmacy
	No Charge after Calendar Year Deductible – Tier 5			50% of Allowable Amount plus Participating Pharmacy Coinsurance Amount*
	No Charge after Calendar Year Deductible – Tier 6			

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Schedule of Coverage



Select Vaccinations obtained through Pharmacies**	Pharmacy Vaccine Network Pharmacy	Other Pharmacy
	<i>No Charge</i>	<i>Not Covered</i>

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.

* 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.

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