



**BlueCross BlueShield  
of Texas**



## **Your Health Care Benefits Program**

Managed Health Care  
Pharmacy Benefits

## CERTIFICATE OF COVERAGE

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association  
(herein called "BCBSTX" or "Carrier")

**Hereby certifies** that it has issued a Group **Managed Health Care, and Pharmacy Benefits** Contract (herein called the "Plan"). Subject to the provisions of the Plan, each Employee (Subscriber) to whom a Blue Cross and Blue Shield Identification Card is issued, together with his eligible Dependents for whom application is initially made and accepted, shall have coverage under the Plan, beginning on the Effective Date shown on the Identification Card, if the Employer makes timely payment of total premium due to the Carrier. Issuance of this Benefit Booklet by BCBSTX does not waive the eligibility and Effective Date provisions stated in the Plan. Any reference to "applicable law" will include applicable laws and rules, including but not limited to statutes, ordinances, and administrative decisions and regulations.



James Springfield  
President of Blue Cross and Blue Shield of Texas

The Schedule(s) of Coverage enclosed with this Benefit Booklet indicate benefit percentages, Deductibles, Copayment Amounts, maximums, and other benefit and payment issues that apply to the Plan.

The Schedule(s) of Coverage specify benefits for:

Managed Health Care (In-Network) and (Out-of-Network) coverage

Pharmacy Benefit coverage

### NOTICE OF SEPARATE AVAILABLE COVERAGE

This notice is required by Texas legislation to be provided to you. It is to inform you, the Employee, that your Employer has selected this health benefit coverage. BCBSTX does not offer a rider or separate insurance contract through your Employer that would provide coverage in addition to the coverage under this Contract.

**THE INSURANCE CONTRACT UNDER WHICH THIS BENEFIT BOOKLET IS ISSUED IS NOT A CONTRACT OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.**



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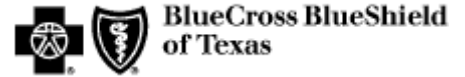








## Schedule of Coverage



### (Blue Choice Bronze PPO<sup>SM</sup> 806)

### Blue Choice PPO<sup>SM</sup> Network

| Prior Authorization Requirements                                                                                                         | In-Network | Out-of-Network |
|------------------------------------------------------------------------------------------------------------------------------------------|------------|----------------|
| <b>Inpatient Admissions</b>                                                                                                              |            |                |
| 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.

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## Schedule of Coverage

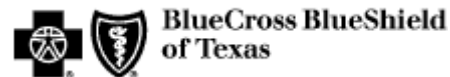


The following chart summarizes the pharmacy benefits available under your coverage. To get the most out of your coverage, it is important that you carefully read the **PHARMACY BENEFITS** section of your Benefit Booklet so you are aware of plan requirements, provisions, limitations and exclusions.

| Pharmacy Benefits                                              |                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                           |                                                                                                        |
|----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------|
| Retail Pharmacy                                                | Preferred Participating Pharmacy                                                                                                                                                                                                                                                          | Participating Pharmacy                                                                                                                                                                                                                                                                    | Non-Participating Pharmacy                                                                             |
| One Copayment Amount per 30-day supply, up to a 30-day supply. | 100% of Allowable Amount after Calendar Year Deductible – Tier 1<br><br>100% of Allowable Amount after Calendar Year Deductible – Tier 2<br><br>100% of Allowable Amount after Calendar Year Deductible – Tier 3<br><br>100% of Allowable Amount* after Calendar Year Deductible – Tier 4 | 100% of Allowable Amount after Calendar Year Deductible – Tier 1<br><br>100% of Allowable Amount after Calendar Year Deductible – Tier 2<br><br>100% of Allowable Amount after Calendar Year Deductible – Tier 3<br><br>100% of Allowable Amount* after Calendar Year Deductible – Tier 4 | 50% of Allowable Amount minus Participating Pharmacy Copayment Amount * after Calendar Year Deductible |
| 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. | 100% of Allowable Amount after Calendar Year Deductible – Tier 1<br><br>100% of Allowable Amount after Calendar Year Deductible – Tier 2<br><br>100% of Allowable Amount after Calendar Year Deductible – Tier 3<br><br>100% of Allowable Amount* after Calendar Year Deductible – 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  | 100% of Allowable Amount after Calendar Year Deductible – Tier 1<br><br>100% of Allowable Amount after Calendar Year Deductible – Tier 2<br><br>100% of Allowable Amount after Calendar Year Deductible – Tier 3<br><br>100% of Allowable Amount* after Calendar Year Deductible – Tier 4 |                                                                                                                                                                                                                                                                                           | XXXXXXXXXXXXXX                                                                                         |
| Specialty Drugs                                                | Specialty Pharmacy Provider                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                           | Other Pharmacy                                                                                         |

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## Schedule of Coverage



|                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                          |                                                                               |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|
| 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 – Tier 5<br><br>100% of Allowable Amount after Calendar Year Deductible – Tier 6 | 50% of Allowable Amount minus Copayment Amount after Calendar Year Deductible |
| <b>Select Vaccinations obtained through Pharmacies**</b>                                                                                                                                                                                                                                                                                                                                                                                                | <b>Pharmacy Vaccine Network Pharmacy</b>                                                                                                 | <b>Other Pharmacy</b>                                                         |
|                                                                                                                                                                                                                                                                                                                                                                                                                                                         | \$0 Copayment Amount                                                                                                                     | 50% of Allowable Amount minus Copayment Amount after Calendar Year Deductible |
| <p>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.</p> <p>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.</p> |                                                                                                                                          |                                                                               |

\*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.































































































































































































































































































