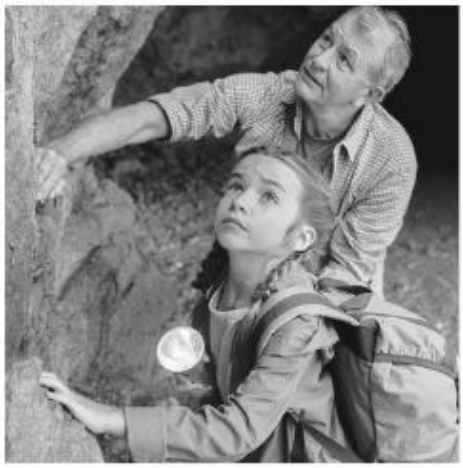
Administered by:

BlueCross BlueShield of Texas






Your Health Care Benefits Program

Managed Health Care
Pharmacy Benefits

Edinburg CISD

Group #219674

January 1, 2025

SCHEDULE OF COVERAGE

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Deductibles		
• Per-Admission Deductible	$300 per-admission Deductible	$900 per-admission Deductible
• Calendar Year Deductible *Three-month Deductible carryover applies* *Applies to all Eligible Expenses*	$1,000 – per individual $3,000 – per family	$3,000 – per individual $9,000 – per family
Out-of-Pocket Maximums *Includes Calendar Year Deductible and Copayment Amounts*	$5,000 – per individual $14,700 – per family	Unlimited – per individual Unlimited – per family
Copayment Amounts Required		
• Physician office visit/consultation	$30 Physician office visit	Does Not Apply
• Telehealth/Telemedicine visit/consultation	$30 Telehealth/Telemedicine visit/consultation	Does Not Apply
• Outpatient Hospital Emergency Room/Treatment Room visit	$150 outpatient Hospital Emergency Room/Treatment Room visit	$150 outpatient Hospital Emergency Room/Treatment Room visit
• Urgent Care Center visit	$75 Urgent Care Center visit	Does Not Apply
• Retail Health Clinic	$30 Retail Health Clinic visit	Does Not Apply
Inpatient Hospital Expenses		
All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units.	70% of Allowable Amount after $300 per-admission Deductible and Calendar Year Deductible	50% of Allowable Amount after $900 per-admission Deductible and Calendar Year Deductible
	No penalty for failure to obtain Prior Authorization for services	$250 penalty for failure to obtain Prior Authorization for services
Medical-Surgical Expenses		
• Office visit/consultation including lab and x-rays • Radiation Therapy and Chemotherapy in the office setting • Physician surgical services in office setting • Inpatient visits and Certain Diagnostic Procedures • Home Infusion Therapy • Physician surgical services in any other setting • Early Detection Tests for Cardiovascular Disease (Limited to 1 test every five years)	100% of Allowable Amount after $30 Copayment Amount 70% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible 50% of Allowable Amount after Calendar Year Deductible
• Independent Lab & X-ray	100% of Allowable Amount	50% of Allowable Amount after Calendar Year Deductible

SCHEDULE OF COVERAGE

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Extended Care Expenses (Certain services will require Prior Authorization.)		
• Skilled Nursing Facility	100% of Allowable Amount	50% of Allowable Amount after Calendar Year Deductible
	25 days maximum per Calendar Year	
• Home Health Care	100% of Allowable Amount	50% of Allowable Amount after Calendar Year Deductible
	60 visits maximum per Calendar Year	
• Hospice Care	100% of Allowable Amount	50% of Allowable Amount after Calendar Year Deductible
	Unlimited	
Mental Health Care/Serious Mental Illness/Treatment of Substance Use Disorder (SUD) (Certain services will require Prior Authorization.)		
Inpatient Services		
• Hospital Services (facility)	70% of Allowable Amount after $300 per-admission Deductible and after Calendar Year Deductible	50% of Allowable Amount after $900 per-admission Deductible and after Calendar Year Deductible
• Behavioral Health Practitioner Services	70% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Outpatient Services		
• Behavioral Health Practitioner Expenses (office setting)	100% of Allowable Amount after $30 Copayment Amount	50% of Allowable Amount after Calendar Year Deductible
• Other Outpatient Services	70% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Emergency Care Accidental Injury & Emergency Care (including Accidental Injury, Emergency and non-emergency Care for Behavioral Health Services)		
• Facility Charges	70% of Allowable Amount after $150 outpatient Hospital emergency room Copayment Amount (waived if admitted)	
• Lab & X-ray without emergency room or treatment room	100% of Allowable Amount	
• Physician Charges	70% of Allowable Amount after Calendar Year Deductible	

SCHEDULE OF COVERAGE

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Emergency Care (Cont'd)		
Non-Emergency Care		
• Facility Charges	70% of Allowable Amount after Calendar Year Deductible and $150 outpatient Hospital emergency room Copayment Amount (waived if admitted)	50% of Allowable Amount after Calendar Year Deductible and $150 outpatient Hospital emergency room Copayment Amount (waived if admitted)
• Physician Charges	70% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Urgent Care Services		
• Urgent Care Center visit - including lab & x-ray services (excluding Certain Diagnostic Procedures)	100% of Allowable Amount after $75 Copayment Amount	50% of Allowable Amount after Calendar Year Deductible
Ambulance Services	70% of Allowable Amount after Calendar Year Deductible	
Retail Health Clinic	100% of Allowable Amount after $30 Copayment Amount	50% of Allowable Amount after Calendar Year Deductible
Telehealth		
• Primary Care telehealth/telemedicine visit/consultation	100% of Allowable Amount after $30 Copayment Amount	50% of Allowable Amount after Calendar Year Deductible
• Primary Care telehealth/telemedicine visit/consultation for treatment of Behavioral Health	100% of Allowable Amount after $30 Copayment Amount	50% of Allowable Amount after Calendar Year Deductible
Preventive Care Services • Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force ("USPSTF") • Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") with respect to the individual involved • Evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") for infants, children, and adolescents	100% of Allowable Amount	50% of Allowable Amount after Calendar Year Deductible

SCHEDULE OF COVERAGE

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Preventive Care Services (Cont'd)		
• With respect to women, such additional preventive care and screenings, not described in the first bullet above, as provided for in comprehensive guidelines supported by the HRSA	100% of Allowable Amount	50% of Allowable Amount after Calendar Year Deductible
• Routine physical examinations, well baby care, immunizations and Newborn Hearing Test after routine lab		
• Routine X-Rays, Routine EKG, Routine Diagnostic Medical Procedures (Independent Lab & X-Ray Provider)		
• Colonoscopy Professional (physician charges)		
• Colonoscopy facility charges		
• Healthy diet counseling and obesity screening/counseling		
• Immunizations Birth up to age 6	100% of Allowable Amount	100% of Allowable Amount
Other Routine Services		
• Routine X-Rays, Routine EKG, Routine Diagnostic Medical Procedures, routine digital rectal exam, routine prostate test	100% of Allowable Amount	50% of Allowable Amount after Calendar Year Deductible
• Annual Hearing Examination	100% of Allowable Amount	100% of Allowable Amount
• Annual Vision Examination		
Speech Therapy*		
• Office visit	100% of Allowable Amount after $30 Copayment Amount	50% of Allowable Amount after Calendar Year Deductible
• All other services	70% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
	35 visits maximum per Calendar Year combined with Physical Therapy and Occupational Therapy	
*Benefits for Autism Spectrum Disorder will not apply towards and are not subject to any speech services visits maximum.		
Hearing Services		
• Office visit	100% of Allowable Amount after $30 Copayment Amount	50% of Allowable Amount after Calendar Year Deductible
• All other services	70% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
	1 per ear per 36-month period for hearing aids	

SCHEDULE OF COVERAGE

Plan Provisions	In-Network Benefits	Out-of-Network Benefits
Chiropractic Services		
• Office visit	100% of Allowable Amount after $30 Copayment Amount	50% of Allowable Amount after Calendar Year Deductible
• All other services	70% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
	35 visits maximum per Calendar Year	
Physical Medicine Services**		
• Office visit/Office services	100% of Allowable Amount after $30 Copayment Amount	50% of Allowable Amount after Calendar Year Deductible
• All other services in the outpatient setting	70% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
	35 visits maximum per Calendar Year combined with Speech Therapy and Occupational Therapy	
**Benefits for Autism Spectrum Disorder will not apply towards and are not subject to any Physical Medicine Services visits maximum.		
Occupational Therapy		
• Office visit/Office services	100% of Allowable Amount after $30 Copayment Amount	50% of Allowable Amount after Calendar Year Deductible
• All other services in the outpatient setting	70% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
	35 visits maximum per Calendar Year combined with Speech Therapy and Physical Therapy	
Cardiac Rehabilitation Services		
• Office visit/Office services	100% of Allowable Amount after $30 Copayment Amount	50% of Allowable Amount after Calendar Year Deductible
• All other services	70% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
	35 visits maximum per Calendar Year	
Allergy		
• Allergy injection with an office visit	100% of Allowable Amount after $30 Copayment Amount	50% of Allowable Amount after Calendar Year Deductible
• Allergy injection without an office visit	70% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Wigs	100% of Allowable Amount (Deductible Waived)	
	Limited to $500 lifetime maximum	

SCHEDULE OF COVERAGE

Plan Provisions Blue Distinction	Blue Distinction+ Designated Center	Blue Distinction Designated Center	In-Network Benefits	Out-of-Network Benefits
Bariatric Surgery	70% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible	Not Covered	Not Covered
	Limited to one surgery per lifetime maximum			

SCHEDULE OF COVERAGE
PHARMACY BENEFITS

Plan Provisions	Participating Pharmacy	Non-Participating Pharmacy
Retail Pharmacy **30-day supply with** **1 Copayment Amount per 30-day supply at a Participating Pharmacy**	$10 Copayment Amount – (Deductible Waived) Generic Drugs $45 Copayment Amount* – Preferred Brand Name Drugs $65 Copayment Amount* – Non-Preferred Brand Name Drugs	50% of Allowable Amount minus Copayment Amount
Extended Retail Prescription Drug Supply (if allowed by the Prescription Order) - one Copayment Amount per 90-day supply, up to a 30-day supply	$10 Copayment Amount – (Deductible Waived) Generic Drugs $45 Copayment Amount* – Preferred Brand Name Drugs $65 Copayment Amount* – Non-Preferred Brand Name Drugs	50% of Allowable Amount minus Copayment Amount
Specialty Pharmacy Program (Prime Specialty Pharmacy Only) **Specialty Drugs - limited to Specialty Pharmacy Provider** Coverage for Specialty Drugs are limited to a 30-day supply. However, some Specialty Drugs have FDA approved dosing regimens exceeding the 30-day supply limited and may be allowed greater than a 30 day-supply, if allowed by your plan benefits.	**Specialty Pharmacy Provider** $10 Copayment Amount – (Deductible Waived) Generic Drugs $45 Copayment Amount* – Preferred Brand Name Drugs $65 Copayment Amount* – Non-Preferred Brand Name Drugs	Not Covered
Mail Service Prescription	**Mail-Order Pharmacy**	
Mail-Order Program **One Copayment Amount per 90-day supply, up to a 90-day supply only**	$25 Copayment Amount – (Deductible Waived) Generic Drugs $112.50 Copayment Amount* – Preferred Brand Name Drugs $162.50 Copayment Amount* – Non-Preferred Brand Name Drugs	Not Covered
Diabetic Supplies (no insulin or diabetic medication purchase required)	$0 Copayment Amount – (Deductible Waived) Generic Drugs $0 Copayment Amount* – Preferred Brand Name Drugs $65 Copayment Amount* – Non-Preferred Brand Name Drugs	Not Covered

SCHEDULE OF COVERAGE

Select Vaccinations Obtained through Participating Pharmacies**	Select Participating Pharmacy - 100% of Allowable Amount Any other Participating Pharmacy - 50% of Allowable Amount minus Copayment Amount	Not Covered
Pharmacy Deductible	\$50 per Individual each Calendar Year	
Prior Authorization Provision	Applies	
Step Therapy Provision	Applies	
Limitations on Quantities Dispensed	Applies	
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, Co-Share Amounts and any pricing differences.		
Contraceptive drugs and devices obtained from a Participating Pharmacy that are identified on the BCBSTX website under Contraceptive - Pharmacy information (referenced in the medical portion of the Plan as part of ***Benefits for Preventive Care Services***) will not be subject to Deductibles, Copayment Amounts and Co-Share Amounts. Additional contraceptive drugs are covered under the Pharmacy portion of the Plan and are subject to the applicable Deductibles, Copayment Amounts, Co-Share Amounts and any pricing differences. Additional contraceptive devices are not covered.		
Tobacco cessation drugs (including both prescription and over-the-counter drugs) prescribed by a Health Care Practitioner are covered at no cost share and will not be subject to Deductibles, Copayment Amounts and Co-Share Amounts for two 90-day treatment regimens per benefit period as required by the United States Preventive Services Task Force as referenced in the Preventive Care subsection of the **PHARMACY BENEFITS** portion of the Plan.		

* 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 this Benefit Booklet for details.

** Select Participating Pharmacies that have 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. Vaccinations at all other participating pharmacy will be payable at the non-participating benefit level. 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. A Select Participating Pharmacy is a Pharmacy that has specifically contracted with BCBSTX to administer vaccinations to Participants. Not all Participating Pharmacies are Select Participating Pharmacies.

NOTE: In the ***How Member Payment is Determined*** subsection of the **PHARMACY BENEFITS** section, an explanation of how the prescription drug products are separated into tiers is shown.

SCHEDULE OF COVERAGE

Dependent Eligibility

Dependent Child Age Limit to age 26.

Dependent children are eligible for Maternity Care benefits.

Preexisting Conditions

Preexisting conditions are covered immediately.