BlueCross BlueShield of Texas

NORTH EAST ISD

Compare the Plans

Using in-network doctors and hospitals will save you money. Go to **bcbstx.com** and click **Doctors and Hospitals** to look for a provider. Or call Customer Service at the number on your member ID card for help.

	Blue Essentials℠ - HMO Option		Blue Choice PPO℠ - High Option		BlueEdge HSA℠	
	In-Network	**Out-Of-Network**	**In-Network**	**Out-Of-Network**	**In-Network**	**Out-Of-Network**
General Information						
Calendar-Year Deductible						
Individual	$2,500	N/A	$2,000	$3,000	$3,500[2]	$7,000
Family	$6,500	N/A	$5,000	$9,000	$10,400	$20,800
Coinsurance Maximum						
Individual	$5,000/calendar year	N/A	$3,000/calendar year	$5,000/calendar year	$3,500/calendar year[2]	$7,000/calendar year
Family	$9,500/calendar year	N/A	$7,250/calendar year	$13,500/calendar year	$10,400/calendar year	$20,800/calendar year
Out-of-Pocket Limit[1]						
Individual	$7,500/calendar year	N/A	$5,000/calendar year	$8,000/calendar year	$3,500/calendar year[2]	$7,000/calendar year
Family	$16,000/calendar year	N/A	$12,250/calendar year	$22,500/calendar year	$10,400/calendar year	$20,800/calendar year
Lifetime Maximum (per person)	unlimited	N/A	unlimited	unlimited	unlimited	unlimited
Other						
Hospital Deductible (per admission)	$100	N/A	$100	$250	N/A	N/A
Penalty for Failure to Preauthorize	N/A	N/A	N/A	$500	N/A	$500
PCP Referral Required	Yes	N/A	No	No	No	No
Pre-Existing Conditions Limitation	No	N/A	No	No	No	No

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Physician Services						
Office Visit	100% after $25 copay	N/A	100% after $25 copay	70% after deductible	100% after deductible	60% after deductible
Office Procedure	80% after deductible	N/A	90% after deductible	70% after deductible	100% after deductible	60% after deductible
Urgent Care Office Visit	100% after $45 copay	N/A	100% after $45 copay	70% after deductible	100% after deductible	60% after deductible
Office Procedure	80% after deductible	N/A	90% after deductible	70% after deductible	100% after deductible	60% after deductible
Specialist Office Visit/Airrosti	100% after $35 copay	N/A	100% after $35 copay	70% after deductible	100% after deductible	60% after deductible
Office Procedure	80% after deductible	N/A	90% after deductible	70% after deductible	100% after deductible	60% after deductible
Retail Health Clinic	100% after $25 copay	N/A	100% after $25 copay	70% after deductible	100% after deductible	60% after deductible
Office Procedure	80% after deductible	N/A	90% after deductible	70% after deductible	100% after deductible	60% after deductible
MDLIVE Virtual Visit	100% after $15 copay	N/A	100% after $15 copay	N/A	100% after deductible	N/A
Office Procedure Routine Exams	80% after deductible	N/A	90% after deductible	70% after deductible	100% after deductible	60% after deductible
Gynecological Exam	100%	N/A	100%	70% after deductible	100%	60% after deductible
Cancer Screening	100%	N/A	100%	70% after deductible	100%	60% after deductible
Eye Exam (1 every 12 months)	100% after $25/$35[3] copay	N/A	100% after $25/$35[3] copay	70% after deductible	100% after deductible	60% after deductible
Hearing Exam	100% after $25/$35[3] copay	N/A	100% after $25/$35[3] copay	70% after deductible	100% after deductible	60% after deductible
Well-Child Care	100%	N/A	100%	70% after deductible	100%	60% after deductible
Immunizations • Influenza • Pneumoccocal • Zoster, minimum age of 50 • Rabies • Hep B • T-Dap • Tetanus Vaccines	100%	N/A	100%	70% after deductible	100%	60% after deductible

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Allergy Testing/Treatment						
Testing	80% after deductible	N/A	90% after deductible	70% after deductible	100% after deductible	60% after deductible
Injections	80% after deductible	N/A	90% after deductible	70% after deductible	100% after deductible	60% after deductible
Office Visit	100% after $25/$35 copay[3]	N/A	100% after $25/$35 copay[3]	70% after deductible	100% after deductible	60% after deductible
Diagnostic X-ray and Lab	80% after deductible	N/A	90% after deductible	70% after deductible	100% after deductible	60% after deductible
Pre-Existing Conditions Limitation	No	No	No	No	No	No
Hospital Services						
Inpatient Hospital Expenses	80% after deductible	N/A	90% after deductible	70% after deductible	100% after deductible	60% after deductible
Outpatient Surgery	80% after deductible	N/A	90% after deductible	70% after deductible	100% after deductible	60% after deductible
Emergency Medical Services	80% after $200 copay (copay waived if admitted)	N/A	90% after $200 copay (copay waived if admitted)	90% after $200 copay	100% after deductible	100% after deductible
(Facility Only)	deductible waived	N/A	deductible waived	deductible waived	100% after deductible	100% after deductible
Non-Emergency Use of ER	50% after deductible	N/A	50% after deductible	50% after deductible	100% after deductible	60% after deductible
Pre-Existing Conditions Limitation	No	N/A	No	No	No	No
Other Services						
Chiropractic Services						
Office Visit	100% after $25/$35 copay[3]	N/A	100% after $25/$35 copay[3]	70% after deductible	100% after deductible	60% after deductible
Other Services	80% after deductible	N/A	90% after deductible	70% after deductible	100% after deductible	60% after deductible
Maximum	35 visits/calendar year	N/A	35 visits/calendar year	35 visits/calendar year	35 visits/calendar year	35 visits/calendar year
Durable Medical Equipment	80% after deductible	N/A	90% after deductible	70% after deductible	100% after deductible	60% after deductible
Skilled Nursing or Convalescent Facility	80% after deductible	N/A	90% after deductible	70% after deductible	100% after deductible	60% after deductible
Max. Days/Calendar Year	120 Days	N/A	120 Days	120 Days	120 Days	120 Days

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Hospice Care	80% after deductible	N/A	90% after deductible	70% after deductible	100% after deductible	60% after deductible
Lifetime Maximum	Unlimited	N/A	Unlimited	Unlimited	Unlimited	Unlimited
Home Health Care	80% after deductible	N/A	90% after deductible	70% after deductible	100% after deductible	60% after deductible
Calendar Year Maximum	120 visits	N/A	120 visits	120 visits	120 visits	120 visits
Prescriptions						
Retail Pharmacy Card (copay for a 30-day supply)	100% after copay	Refer to Summary Plan Description	100% after copay	Refer to Summary Plan Description	100% after deductible	Refer to Summary Plan Description
Generic	$10		$10			
Non-Preferred Generic	50% ($25 min - $35 max)		50% ($25 min - $35 max)			
Preferred Brand Name	$40		$40			
Non-Preferred Brand Name	50% ($70 min - $100 max)		50% ($70 min - $100 max)			
Preferred Specialty	$100		$100			
Non-Preferred Specialty	50% ($150 min - $250 max)		50% ($150 min - $250 max)			
Immunizations Covered • Influenza • Pneumoccocal • Zoster, minimum age of 50 • Rabies • Hep B • T-Dap • Tetanus Vaccines	100%	Refer to Summary Plan Description	100%	Refer to Summary Plan Description	100% after deductible	Refer to Summary Plan Description
Mail Order Prescriptions (copay for a 90-day supply) • Generic • Preferred Brand Name • Non-Preferred Brand Name	2 times retail copay	N/A	2 times retail copay	N/A	100% after deductible	N/A

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Mental Health Services						
Inpatient	80% after deductible	N/A	90% after deductible	70% after deductible	100% after deductible	60% after deductible
Partial Hospitalization	80% after deductible	N/A	90% after deductible	70% after deductible	100% after deductible	60% after deductible
Outpatient Counseling	80% after deductible	N/A	90% after deductible	70% after deductible	100% after deductible	60% after deductible

1. Out-of-pocket limit: deductible, coinsurance percentage, prescription drug copay and medical copay.
2. $100 increase due to IRS regulation.
3. If service is delivered by a primary care physician, the copayment is $25. If service is delivered by a specialist, the copayment is $35.

Benefits for the plans are paid at a percentage of the allowable amount as determined by Blue Cross and Blue Shield of Texas.

The comparison is not the summary plan description. Please refer to your summary plan description benefit booklet for a detailed description of your health plan, including limitations and exclusions. Benefits will be paid according to the summary plan description only.