

Plan Year 2023-2024

Bronze – HD Medical Plan (Consumer HSA-3K-6900 E)



This plan uses a preferred provider network. While you can use any doctor, clinic, hospital, or healthcare facility you want; you save money when you use providers in the Blue Cross and Blue Shield of Texas Blue Choice PPO network. It's important to have a relationship with a Primary Care Physician (PCP) who can be your partner in managing your care. They can help you avoid duplicating tests and services and connect you to a specialist, but you are not required to see a PCP before you see a specialist.

These Plan Highlights address only particular aspects of the benefits available under the Plan. Various other expenses, limits, exclusions, and other rules also apply. For more details about your benefits, please refer to the individual summary plan descriptions (SPDs), plan document, certificate of coverage, or (where applicable) insurance contracts for each plan. If there is any discrepancy, these more complete descriptions will govern. TX Health Benefits Pool reserves the right to amend or terminate the plan at any time, which may affect the information provided in these Plan Highlights.

BENEFIT COVERAGE	NETWORK YOU PAY	OUT-OF-NETWORK YOU PAY																								
Deductible																										
Individual	\$3,000	\$6,900																								
Family ¹	\$6,000	\$12,000																								
Out of Pocket Maximum <i>(includes deductible, copays, and coinsurance)</i>																										
Individual	\$6,900	Unlimited																								
Family	\$13,800	Unlimited																								
Coinsurance	20% after deductible	50% after deductible																								
Office Visits	20% after deductible	50% after deductible																								
Preventive Care	No Charge	50% after deductible																								
Telehealth <i>(General)</i>	\$44 per visit until deductible is met	Not Covered																								
Diagnostic Lab / X-Ray	20% after deductible	50% after deductible																								
Major Imaging <i>(CT scan, PET scan, MRI, nuclear medicine)</i>	20% after deductible	50% after deductible																								
Inpatient Hospital <i>(Prior Authorization required)</i>	20% after deductible	50% after deductible																								
Emergency Room Facility Charges – <i>(\$500 Emergency Room Fee waived if admitted)</i>	\$500 Emergency Room Fee plus 20% after deductible	\$500 Emergency Room Fee plus 20% after deductible																								
Physician Charges	20% after deductible	20% after deductible																								
Urgent Care	20% after deductible	50% after deductible																								
Outpatient Surgery	20% after deductible	50% after deductible																								
Prescription Drug Plan After Deductible <i>(Per 30-day/60-day/90day supply Retail or Mail Order)</i>																										
Disease Management Maintenance <i>(generic)</i>																										
Tier 1 <i>(lower-cost generics and some brand name drugs)</i>																										
Tier 2* <i>(includes most brands and some higher cost generics)</i>																										
Tier 2 <i>(insulins)</i>																										
Tier 3* <i>(non-preferred drugs)</i>																										
Tier 4 <i>(specialty drugs)</i>																										
Tier 5 <i>(cost share drugs)</i>																										
	<table border="1"> <thead> <tr> <th>30-day supply</th> <th>60-day supply</th> <th>90-day supply</th> </tr> </thead> <tbody> <tr> <td>\$0 copay</td> <td>\$0 copay</td> <td>\$0 copay</td> </tr> <tr> <td>\$10 copay</td> <td>\$20 copay</td> <td>\$30 copay</td> </tr> <tr> <td>\$45 copay</td> <td>\$90 copay</td> <td>\$135 copay</td> </tr> <tr> <td>\$25 copay</td> <td>\$50 copay</td> <td>\$75 copay</td> </tr> <tr> <td>\$90 copay</td> <td>\$180 copay</td> <td>\$270 copay</td> </tr> <tr> <td>\$150 copay</td> <td>N/A</td> <td>N/A</td> </tr> <tr> <td>\$175 copay</td> <td>\$350 copay</td> <td>\$525 copay</td> </tr> </tbody> </table>	30-day supply	60-day supply	90-day supply	\$0 copay	\$0 copay	\$0 copay	\$10 copay	\$20 copay	\$30 copay	\$45 copay	\$90 copay	\$135 copay	\$25 copay	\$50 copay	\$75 copay	\$90 copay	\$180 copay	\$270 copay	\$150 copay	N/A	N/A	\$175 copay	\$350 copay	\$525 copay	Not Covered
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* If a participant obtains a brand-name drug when a preferred generic equivalent is available, they are responsible for the brand copay plus the cost difference between the brand-name drug and the preferred generic drug.

¹ When a member of a family unit satisfies the Individual Deductible amount for the plan year, no further deductible will be required for him or her for that plan year.

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