BlueCross BlueShield of Texas

Central Texas (PPO)

2026

		Blue Cross Medicare Advantage Choice Plus (PPO)SM H1666-006		Blue Cross Medicare Advantage Choice Premier (PPO)SM H1666-003		Blue Cross Medicare Advantage Dental Premier (PPO)SM H8634-024	
Plan Premium		**$0**		**$96**		**$0**	
		In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Part B Premium Reduction		$0		$0		$0	
Primary Care Provider Visits		$0 Copay	50% Coinsurance	$0 Copay	50% Coinsurance	$0 Copay	50% Coinsurance
Specialist Visits		$55 Copay	50% Coinsurance	$50 Copay	50% Coinsurance	$42 Copay	50% Coinsurance
Maximum Out-of-Pocket		$9,250	$13,900	$6,750	$10,100	$6,750	$10,100
Inpatient Hospital Copay		$380/day for days 1–6	50% Coinsurance	$350/day for days 1–6	50% Coinsurance	$380/day for days 1–6	50% Coinsurance
Outpatient Hospital Copay		$425 maximum	50% Coinsurance	$375 maximum	50% Coinsurance	$395	50% Coinsurance
Labs		$0–$55	50% Coinsurance	$0–$50	50% Coinsurance	$0–$50	50% Coinsurance
X-ray/CT Scan/MRI		$0–$325	50% Coinsurance	$0–$300	50% Coinsurance	$0–$300	50% Coinsurance
Ambulance/Air Ambulance		$275/20%		$275/20%		$275/20%	
Dental	Routine Preventive	$0 Copay; 2 exams, 2 cleanings, 1 X-ray		$0 Copay; 2 exams, 2 cleanings, 1 X-ray		$0 Copay; 2 exams, 2 cleanings, 1 X-ray	
	Basic Restorative	Not Covered		Not Covered		$3,000 annually	
Vision	Routine Eye Exam	$0 Copay; 1 exam/year	Not Covered	$0 Copay; 1 exam/year	Not Covered	$0 Copay; 1 exam/year	Not Covered
	Glasses/Contacts Allowance	$100 annual allowance		$100 annual allowance		$100 annual allowance	
Hearing	Hearing Exam	$0 Copay; 1 exam/year	Not Covered	$0 Copay; 1 exam/year	Not Covered	$0 Copay; 1 exam/year	Not Covered
	Hearing Aids	$699 or $999 Copay		$699 or $999 Copay		$699 or $999 Copay	
Pharmacy	Preferred Retail Pharmacy Copays	$0/$1/17%/35%/25%		$0/$1/17%/35%/27%		$0/$1/17%/36%/25%	
	Prescription Drug Deductible	$615		$450		$615	
	Diabetic Supplies	0%–20% Coinsurance	50% Coinsurance	0%–20% Coinsurance	50% Coinsurance	0%–20% Coinsurance	50% Coinsurance
Over-the-Counter Items[1]		Not Covered		Not Covered		$30 every 3 months	
Flexible Spend Card[2]		Not Included		Not Included		Not Included	
Optional Supplemental Benefits Plan[3]		Bronze		Bronze		Not Applicable	
Plan Premium		$37.80		$42.70			
Dental	Annual Allowance	$1,000		$1,000			
	Routine Preventive	Not Included		Not Included			
	Basic Restorative	20% Coinsurance	50% Coinsurance	20% Coinsurance	50% Coinsurance		
	Major Restorative	20% Coinsurance	50% Coinsurance	20% Coinsurance	50% Coinsurance		
Vision	Glasses/Contacts Allowance	Not Included		Not Included			

See reverse for additional benefit details

BlueCross BlueShield of Texas

Central Texas (PPO) cont.

2026

		Blue Cross Medicare Advantage Protect (PPO)SM H8634-026		Blue Cross Medicare Advantage Complete (PPO)SM H8634-023		Blue Cross Medicare Advantage Optimum (PPO)SM H1666-022	
Plan Premium		**$0**		**$0**		**$142**	
		In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Part B Premium Reduction		$40		$0		$0	
Primary Care Provider Visits		$0 Copay	50% Coinsurance	$10 Copay	50% Coinsurance	$0 Copay	50% Coinsurance
Specialist Visits		$55 Copay	50% Coinsurance	$51 Copay	50% Coinsurance	$40 Copay	50% Coinsurance
Maximum Out-of-Pocket		$6,950	$11,000	$6,750	$10,100	$5,750	$10,100
Inpatient Hospital Copay		$370/day for days 1–6	50% Coinsurance	$425/day for days 1–6	50% Coinsurance	$300/day for days 1–6	50% Coinsurance
Outpatient Hospital Copay		$375 maximum	50% Coinsurance	$425 maximum	50% Coinsurance	$350	50% Coinsurance
Labs		$0–$55	50% Coinsurance	$5–$51	50% Coinsurance	$5–$55	50% Coinsurance
X-ray/CT Scan/MRI		$0–$300	50% Coinsurance	$0–$300	50% Coinsurance	$0–$300	50% Coinsurance
Ambulance/Air Ambulance		$275/20%		$275/20%		$275/20%	
Dental	Routine Preventive	$0 Copay; 2 exams, 2 cleanings, 1 X-ray		$0 Copay; 2 exams, 2 cleanings, 1 X-ray		$0 Copay; 2 exams, 2 cleanings, 1 X-ray	
	Basic Restorative	$1,000 annually		Not Covered		$750 annually	
Vision	Routine Eye Exam	$0 Copay; 1 exam/year	Not Covered	$0 Copay; 1 exam/year	Not Covered	$0 Copay; 1 exam/year	Not Covered
	Glasses/Contacts Allowance	$100 annual allowance		$100 annual allowance		$100 annual allowance	
Hearing	Hearing Exam	$0 Copay; 1 exam/year	Not Covered	$0 Copay; 1 exam/year	Not Covered	$0 Copay; 1 exam/year	Not Covered
	Hearing Aids	$699 or $999 Copay		$699 or $999 Copay		$699 or $999 Copay	Not Covered
Pharmacy	Preferred Retail Pharmacy Copays	Not Covered		$0/$1/18%/40%/27%		$0/$1/19%/39%/29%	
	Prescription Drug Deductible	Not Covered		$450		$300	
	Diabetic Supplies	0%–20% Coinsurance	50% Coinsurance	0%–20% Coinsurance	50% Coinsurance	0%–20% Coinsurance	50% Coinsurance
Over-the-Counter Items[1]		Not Covered		Not Covered		$25 every 3 months	
Flexible Spend Card[2]		Not Included		Not Included		Not Included	
Optional Supplemental Benefits Plan[3]		Silver		Bronze		Not Applicable	
Plan Premium		$33.80		$29.30			
Dental	Annual Allowance	$1,000		$1,000			
	Routine Preventive	Not Included		Not Included			
	Basic Restorative	Not Included		20% Coinsurance	50% Coinsurance		
	Major Restorative	20% Coinsurance	50% Coinsurance	20% Coinsurance	50% Coinsurance		
Vision	Glasses/Contacts Allowance	Not Included		Not Included			

See reverse for additional benefit details

BlueCross BlueShield of Texas

Central Texas (PPO) cont.

2026

		Blue Cross Medicare Advantage Health Choice (PPO)SM H8634-025		Blue Cross Medicare Advantage Preferred (PPO)SM H8634-033	
Plan Premium		**$0**		**$110**	
		In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
Part B Premium Reduction		$0		$0	
Primary Care Provider Visits		$0 Copay	50% Coinsurance	$7 Copay	50% Coinsurance
Specialist Visits		$46 Copay	50% Coinsurance	$47 Copay	50% Coinsurance
Maximum Out-of-Pocket		$9,250	$13,900	$8,000	$12,500
Inpatient Hospital Copay		$405/day for days 1–6	50% Coinsurance	$375/day for days 1–6	50% Coinsurance
Outpatient Hospital Copay		$400 maximum	50% Coinsurance	$390 maximum	50% Coinsurance
Labs		$0–$50	50% Coinsurance	$0–$50	50% Coinsurance
X-ray/CT Scan/MRI		$0–$300	50% Coinsurance	$0–$300	50% Coinsurance
Ambulance/Air Ambulance		$275/20%		$275/20%	
Dental	Routine Preventive	$0 Copay; 2 exams, 2 cleanings, 1 X-ray		$0 Copay; 2 exams, 2 cleanings, 1 X-ray	
	Basic Restorative	Not Covered		Not Covered	
Vision	Routine Eye Exam	$0 Copay; 1 exam/year	$40 allowance	$0 Copay; 1 exam/year	$40 allowance
	Glasses/Contacts Allowance	$100 annual allowance		$100 annual allowance	
Hearing	Hearing Exam	$0 Copay; 1 exam/year	Not Covered	$0 Copay; 1 exam/year	Not Covered
	Hearing Aids	$699 or $999 Copay	Not Covered	$699 or $999 Copay	Not Covered
Pharmacy	Preferred Retail Pharmacy Copays	$0/$1/18%/39%/25%		$0/$1/17%/37%/27%	
	Prescription Drug Deductible	$615		$450	
	Diabetic Supplies	0%–20% Coinsurance	50% Coinsurance	0%–20% Coinsurance	50% Coinsurance
Over-the-Counter Items[1]		Not Covered		Not Covered	
Flexible Spend Card[2]		$500/annually for dental, vision, and hearing		Not Included	
Optional Supplemental Benefits Plan[3]		Bronze		Bronze	
Plan Premium		$42.60		$34.30	
Dental	Annual Allowance	$1,000		$1,000	
	Routine Preventive	Not Included		Not Included	
	Basic Restorative	20% Coinsurance	50% Coinsurance	20% Coinsurance	50% Coinsurance
	Major Restorative	20% Coinsurance	50% Coinsurance	20% Coinsurance	50% Coinsurance
Vision	Glasses/Contacts Allowance	Not Included		Not Included	

See reverse for additional benefit details

Central Texas (PPO) **2026**

Blue Cross Medicare Advantage[SM] plans	Offered in the following counties
Choice Plus (PPO) - H1666-006	Caldwell, Hays, Lee, Milam
Choice Premier (PPO) - H1666-003	Bastrop, Burnet, Caldwell, Fayette, Hays, Lampasas, Lee, Llano, Milam, Travis, Williamson
Dental Premier (PPO) - H8634-024 **Protect (PPO) - H8634-026** **Complete (PPO) - H8634-023** **Health Choice (PPO) - H8634-025**	Bell, Blanco, Brazos, Burleson, Coleman, Coryell, Mills, Runnels
Optimum (PPO) - H1666-022	Bastrop, Burnet, Caldwell, Fayette, Hays, Lampasas, Lee, Llano, Milam, Travis, Williamson
Preferred (PPO) - H8634-033	Falls, Leon, Limestone, Madison, Mason, McLennan, Robertson, San Saba, Travis, Williamson

Plans vary by county. Refer to the Summary of Benefits for plan availability and more information about what we cover and what you pay. Learn more at **www.getbluetx.com/mapd/sb**

[1] **Over-the-Counter Items.** You can purchase approved over-the-counter (OTC) items at no cost based on your plan limit. This includes OTC items like pain relievers and allergy medicine to help with your basic health and medical needs.

[2] **Flexible Spend Card.** Pre-loaded flexible spend card with an annual limit of $1,000 to help reduce out-of-pocket expenses for dental, vision and hearing services.

[3] **Optional Supplemental Benefits Plan.** For an additional monthly premium, you can add more coverage to your plan. Adding supplemental benefits to your current plan is optional and provides you with additional dental and vision coverage.

Preferred Pharmacy Network. Save money when you fill your covered prescriptions at a convenient preferred pharmacy, including Walgreens, Albertsons, Tom Thumb, United Supermarkets, Randalls, Walmart, H-E-B, Kroger, Market Street, Amigos and select independent pharmacies.

Prescription Drug Tiers:
Tier 1 – Preferred Generic
Tier 2 – Generic
Tier 3 – Preferred Brand
Tier 4 – Non-Preferred
Tier 5 – Specialty

Additional Benefits:

Rewards Program. The Rewards Program gives you a healthy and easy way to earn up to $100 in gift cards from major retailers for completing Healthy Actions throughout the year. Visiting your doctor at least once a year can help you catch small health problems before they become big ones. You can earn up to $50 in gift cards just for completing your annual wellness visit! Earn rewards with these Healthy Actions:

-Mammogram
-Fall risk assessment
-Retinal eye exam
-Annual flu vaccine
-Annual wellness visit
-Colorectal cancer screening
-Bone density screening
-Diabetic kidney and blood sugar testing

Telehealth Benefits. Conveniently access health care services remotely via phone, computer or tablet with $0 copays.

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