



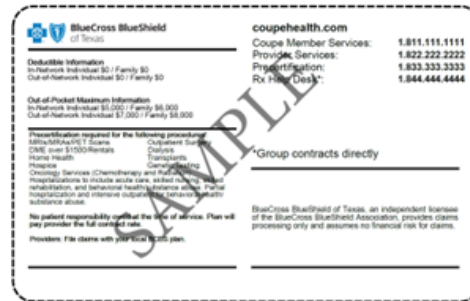
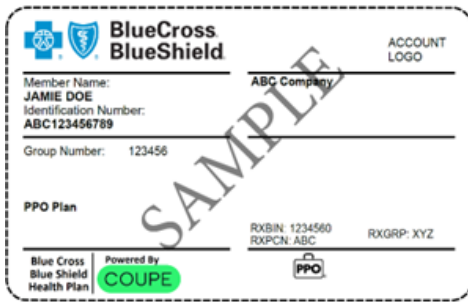
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Check ID Cards for New Coupe Health Plan Members

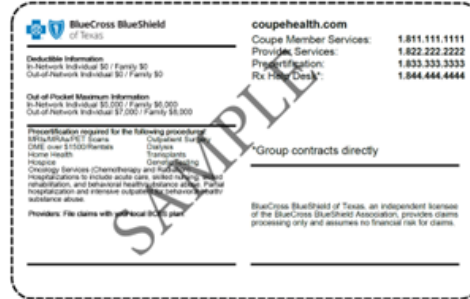
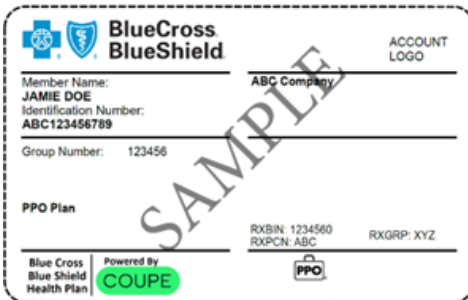
As a reminder, providers in our commercial PPO network and Blue High Performance Network® may see members with our [new Coupe Health benefit plan](#) in coming months. This plan streamlines the payment process for your office and our Coupe Health members.

Coupe Health is generally a copay-only plan. Members pay no coinsurance, and in some plan types, no deductibles. Members have options for a Coupe Health plan with or without financing, which affects how providers collect payments. **To identify these members, look for Coupe on the member ID card.**

For our members with a financing plan: You won't collect any copay for your services. Instead, Blue Cross and Blue Shield of Texas will reimburse you directly for the full allowed amount, including the member share. The ID card will indicate: No patient responsibility owed at the time of service. Plan will pay provider the full contract rate.



For members with a non-financing plan: You will collect copays from members according to members' plan benefits. Here is their ID card sample:



As with all our members, it's important to ask to see the member ID card before all appointments, and to check eligibility and benefits. Update your records if member ID numbers have changed. Use [Availity® Essentials](#) or your preferred vendor to check membership, coverage and prior authorization requirement; to inquire about benefits; and to confirm that you are in-network for the member's policy. Emergency services are covered at the in-network benefit level.

If you have questions, call the provider services number on the member ID card.

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Coupe Health is an independent company that has contracted with BCBSTX to provide an alternative health plan for members with coverage through BCBSTX.

Please note that checking of eligibility and benefits information, and/or the fact that any pre-service review has been conducted, is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member's eligibility and the terms of the member's certificate of coverage applicable on the date services were rendered.