

 The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.bcbstx.com or by calling 1-855-357-5228. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/> or call 1-800-456-5974 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$1,500 Individual / \$4,500 Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. Services that charge a <u>copay</u> , <u>prescription</u> drugs, and <u>In-Network diagnostic tests</u> , <u>home health</u> , <u>skilled nursing</u> , and <u>hospice</u> are covered before you meet your <u>deductible</u> .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this <u>plan</u> covers certain preventive services without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered preventive services at: https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	\$5,500 Individual / \$8,700 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the out-of-pocket limit?	<u>Deductibles</u> , <u>premiums</u> , <u>preauthorization</u> , <u>penalties</u> , <u>balance-billed charges</u> , and <u>health care this plan doesn't cover</u> .	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a network provider?	Yes. See www.bcbstx.com or call 1-855-357-5228 for a list of <u>In-Network</u> providers.	This plan uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the plan's network. This plan <u>does not cover out-of-network</u> providers or services. Check with your <u>provider</u> before you get services.

Do you need a referral to see a specialist?

Yes.

Your Primary Care Physician (PCP) coordinates your medical care, as appropriate, either by providing treatment or by issuing Referrals to direct you to Participating Providers.



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$10 <u>copay</u> /visit; <u>deductible</u> does not apply	Not Covered	Virtual visits available through MDLive <u>\$0 copay</u> . In-Network.
	<u>Specialist</u> visit	\$40 <u>copay</u> /visit; <u>deductible</u> does not apply	Not Covered	None
	<u>Preventive care/screening/immunization</u>	No Charge; <u>deductible</u> does not apply	Not Covered	You may have to pay for services that aren't <u>preventive</u> . Ask your PCP if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No Charge; <u>deductible</u> does not apply	Not Covered	Office visit <u>copay</u> may apply. Certain Diagnostic Procedures are subject to deductible.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	Not Covered	None



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at: www.mybenefits.org	Tier 1	Retail: \$10 <u>copay</u> / prescription Mail: \$20 <u>copay</u> / prescription; <u>deductible</u> does not apply	Total Cost of prescription	Retail: one copay per 30-day supply Retail-90: two copays up to 90 day supply Mail: two <u>copays</u> up to 90-day supply. Members electing to purchase brand name drugs when a generic is available will be required to pay the difference between the cost of the Generic drug and Brand Name drug, plus the Brand Name <u>Copayment</u> . <u>Specialty drug</u> prescriptions must be filled through Lumicera Specialty Pharmacy. One <u>copay</u> per 30-day supply.
	Tier 2	Retail: \$30 <u>copay</u> / prescription Mail: \$60 <u>copay</u> / prescription; <u>deductible</u> does not apply	Total Cost of prescription	
	Tier 3	Retail: \$50 <u>copay</u> / prescription Mail: \$100 <u>copay</u> / prescription; <u>deductible</u> does not apply	Total Cost of prescription	
	<u>Specialty drugs</u>	\$30 / \$50 copay / prescription; <u>deductible</u> does not apply	Total Cost of prescription	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	Not Covered	None
	Physician/surgeon fees	20% <u>coinsurance</u>	Not Covered	
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u> after \$600 <u>copay</u> /visit	Not Covered*	<u>Copay</u> waived if admitted.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	Not Covered*	None

*Out-of-network emergency claims will process with in-network level of benefits if the ER diagnosis verifies visit as a true emergency. However, if it is determined to be a non-emergency, the claim will process as out-of-network and benefits will deny due to your plan not having coverage out-of-network.



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<u>Urgent care</u>	\$60 <u>copay</u> /visit; <u>deductible</u> does not apply	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	Not Covered	All services must be preauthorized.
	Physician/surgeon fees	20% <u>coinsurance</u>	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$10 /\$40 <u>copay</u> / office visit; <u>deductible</u> does not apply 20% <u>coinsurance</u> for other outpatient services	Not Covered Not Covered	Certain services must be preauthorized; refer to benefit booklet for details.
	Inpatient services	20% <u>coinsurance</u>	Not Covered	All services must be preauthorized.
If you are pregnant	Office visits	\$10 / \$40 <u>copay</u> / initial visit; <u>deductible</u> does not apply	Not Covered	20% <u>coinsurance</u> applies after initial visit In-Network. <u>Cost sharing</u> does not apply for preventive services. Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	Not Covered	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	20% <u>coinsurance</u>	Not Covered	All services must be preauthorized;



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	<u>Home health care</u>	No Charge; <u>deductible</u> does not apply	Not Covered	Limited to 60 visits per <u>plan</u> year. All services must be preauthorized.
	<u>Rehabilitation services</u>	\$10 / \$40 <u>copay</u> / visit; <u>deductible</u> does not apply	Not Covered	None
	<u>Habilitation services</u>	\$10 / \$40 <u>copay</u> / visit; <u>deductible</u> does not apply	Not Covered	None
	<u>Skilled nursing care</u>	No Charge; <u>deductible</u> does not apply <u>deductible</u> does not apply	Not Covered	Limited to 25 days per plan year. All services must be preauthorized.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	Not Covered	None
	<u>Hospice services</u>	No Charge; <u>deductible</u> does not apply	Not Covered	All services must be preauthorized.
If your child needs dental or eye care	Children's eye exam	No Charge; <u>deductible</u> does not apply	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing Aids
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care
- Non-emergency care when traveling Outside the U.S.
- Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the plan at 1-855-357-5228, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Blue Cross Blue Shield of Texas at 1-855-357-5228 or visit www.bcbstx.com, or contact the U.S. Department of Labor's Employee Benefits Security Administrations at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Contact the Texas Department of Insurance at 1-800-252-3439 or visit www.texashealthoptions.com.

Does this plan provide Minimum Essential Coverage? Yes.

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet the Minimum Value Standards? Yes.

If your plan doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a plan through the [Marketplace](#).

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-855-357-5228.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-357-5228.]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-357-5228.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-855-357-5228.]

To see examples of how the plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible \$5,000
- Specialist copayment \$0
- Hospital (facility) coinsurance \$0
- Other coinsurance \$0

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
---------------------------	-----------------

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$5,000
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$5,060

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$5,000
- Specialist copayment \$0
- Hospital (facility) coinsurance \$0
- Other coinsurance \$0

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
---------------------------	----------------

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$5,000
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Joe would pay is	\$5,060

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The plan's overall deductible \$5,000
- Specialist copayment \$0
- Hospital (facility) coinsurance \$0
- Other coinsurance \$0

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,900
---------------------------	----------------

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,900
Copayments	\$0
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,900

The plan would be responsible for the other costs of these EXAMPLE covered services.

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance.
We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.

To receive language or communication assistance free of charge, please call at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St.
35th Floor
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960
Email: CivilRightsCoordinator@hcsc.net

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services Phone: 800-368-1019
200 Independence Avenue SW TTY/TDD: 800-537-7697
Room 509F, HHH Building 1019 Complaint Portal: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>
Washington, DC 20201 Complaint Forms: <http://www.hhs.gov/ocr/office/file/index.html>