




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, call 1-800-521-2227 or at www.bcbstx.com. 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 www.healthcare.gov/sbc-glossary/ or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	<u>In-Network</u> : \$2,700 Individual / \$5,400 Family <u>Out-of-Network</u> : \$5,200 Individual / \$10,400 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 policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your deductible?	Yes. Certain <u>preventive care</u> is covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without cost sharing and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	<u>In-Network</u> : \$6,600 Individual / \$13,200 Family <u>Out-of-Network</u> : \$19,800 Individual / \$39,600 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>Premiums</u> , <u>balance-billing</u> charges, <u>preauthorization</u> penalties, and health care this <u>plan</u> doesn't cover.	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 1-800-810-2583 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a referral to see a specialist?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	Virtual visits are available, please refer to your <u>plan</u> policy for more details.
	<u>Specialist</u> visit	30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	None
	<u>Preventive care/screening/immunization</u>	No Charge; <u>deductible</u> does not apply	50% <u>coinsurance</u> after <u>deductible</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. No Charge for child immunizations <u>Out-of-Network</u> through the 6th birthday.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	None
	Imaging (CT/PET scans, MRIs)	30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at caremark.com	Generic drugs	30% coinsurance after deductible	Not Covered	Retail covers a 30-day supply Maintenance Medications are only available through CVS Retail Pharmacies or CVS Mail Order.
	Preferred brand drugs	30% coinsurance after deductible	Not Covered	
	Non-preferred brand drugs	30% coinsurance after deductible	Not Covered	Payment of the difference between the cost of a brand name drug and a generic may be required if a generic drug is available.
	<u>Specialty drugs</u>	30% coinsurance, \$300 min/prescription, \$500 max/prescription after deductible	Not Covered	Specialty Drugs are only available through CVS Specialty Pharmacy
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	None
	Physician/surgeon fees	30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>In-Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	Facility Charges; 30% <u>coinsurance</u> after deductible ER Physician Charges: 30% <u>coinsurance</u> after deductible	Facility Charges; 30% <u>coinsurance</u> after deductible ER Physician Charges: 30% <u>coinsurance</u> after deductible	None
	<u>Emergency medical transportation</u>	30% <u>coinsurance</u> after deductible	30% <u>coinsurance</u> after deductible	Ground and air transportation covered.
	<u>Urgent care</u>	30% <u>coinsurance</u> after deductible	50% <u>coinsurance</u> after deductible	You may have to pay for services that are not covered by the visit fee. For an example, see “If you have a test” on page 2.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <u>coinsurance</u> after deductible	50% <u>coinsurance</u> after deductible	<u>Preauthorization</u> is required; \$250 penalty if not preauthorized <u>Out-of-Network</u> .
	Physician/surgeon fees	30% <u>coinsurance</u> after deductible	50% <u>coinsurance</u> after deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	30% <u>coinsurance</u> after deductible	50% <u>coinsurance</u> after deductible	Certain services must be preauthorized; refer to your benefit booklet* for details. Virtual visits are available, please refer to your <u>plan</u> policy for more details.
	Inpatient services	30% <u>coinsurance</u> after deductible	50% <u>coinsurance</u> after deductible	<u>Preauthorization</u> is required; \$250 penalty if not preauthorized <u>Out-of-Network</u> .
If you are pregnant	Office visits	30% <u>coinsurance</u> after deductible	50% <u>coinsurance</u> after deductible	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	30% <u>coinsurance</u> after deductible	50% <u>coinsurance</u> after deductible	
	Childbirth/delivery facility services	30% <u>coinsurance</u> after deductible	50% <u>coinsurance</u> after deductible	<u>Preauthorization</u> is required; \$250 penalty if not preauthorized <u>Out-of-Network</u> .

* For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-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>	30% <u>coinsurance</u> after deductible	50% <u>coinsurance</u> after deductible	Limited to 90 visits per calendar year. <u>Preauthorization</u> is required.
	<u>Rehabilitation services</u>	30% <u>coinsurance</u> after deductible	50% <u>coinsurance</u> after deductible	Limited to 60 visits combined for all therapies per calendar year. Includes occupational, physical, and speech therapy.
	<u>Habilitation services</u>	30% <u>coinsurance</u> after deductible	50% <u>coinsurance</u> after deductible	
	<u>Skilled nursing care</u>	30% <u>coinsurance</u> after deductible	50% <u>coinsurance</u> after deductible	Limited to 90 days per calendar year. <u>Preauthorization</u> is required.
	<u>Durable medical equipment</u>	30% <u>coinsurance</u> after deductible	50% <u>coinsurance</u> after deductible	None
	<u>Hospice services</u>	30% <u>coinsurance</u> after deductible	50% <u>coinsurance</u> after deductible	<u>Preauthorization</u> is required.
If your child needs dental or eye care	Children's eye exam	30% <u>coinsurance</u> after deductible	50% <u>coinsurance</u> after deductible	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 <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .)		
<ul style="list-style-type: none"> Acupuncture Cosmetic surgery Dental care (Adult) 	<ul style="list-style-type: none"> Infertility treatment (diagnosis of infertility covered) Long-term care Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> Routine eye care (Adult) Routine foot care (with the exception of person with diagnosis of diabetes) Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"> Bariatric surgery Chiropractic care (35 visits per year) 	<ul style="list-style-type: none"> Hearing aids (limited to 1 per ear per 36-month period and \$1,500 max ever 36 months) 	<ul style="list-style-type: none"> Private-duty nursing

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: For group health coverage contact the plan, Blue Cross and Blue Shield of Texas at 1-800-521-2227 or visit www.bcbstx.com. For group health coverage subject to ERISA, contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For non-federal governmental group health plans, contact Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law. 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 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: For group health coverage subject to ERISA: Blue Cross and Blue Shield of Texas at 1-800-521-2227 or visit www.bcbstx.com, the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, and the Texas Department of Insurance, Consumer Protection at 1-800-252-3439 or www.tdi.texas.gov. For non-federal governmental group health plans and church plans that are group health plans, Blue Cross and Blue Shield of Texas at 1-800-521-2227 or www.bcbstx.com or contact the Texas Department of Insurance, Consumer Protection at 1-800-252-3439 or www.tdi.texas.gov. Additionally, a consumer assistance program can help you file your appeal. Contact the Texas Department of Insurance's Consumer Health Assistance Program at 1-800-252-3439 or visit www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/tx.html.

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 1-800-521-2227.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-521-2227.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-521-2227.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-521-2227.

To see examples of how this 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 <u>plan's</u> overall <u>deductible</u>	\$2,700
■ <u>Specialist</u> <u>coinsurance</u>	30%
■ Hospital (facility) <u>coinsurance</u>	30%
■ Other <u>coinsurance</u>	30%

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	\$12,700
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,700
<u>Copayments</u>	\$10
<u>Coinsurance</u>	\$3,000
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$5,770

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$2,700
■ <u>Specialist</u> <u>coinsurance</u>	30%
■ Hospital (facility) <u>coinsurance</u>	30%
■ Other <u>coinsurance</u>	30%

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	\$5,600
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,700
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$3,220

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$2,700
■ <u>Specialist</u> <u>coinsurance</u>	30%
■ Hospital (facility) <u>coinsurance</u>	30%
■ Other <u>coinsurance</u>	30%

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	\$2,800
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,700
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$30
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,730

Non-Discrimination Notice

Health Care Coverage Is Important For Everyone

We do not discriminate on the basis of race, color, national origin (including limited English knowledge and first language), age, disability, or sex (as understood in the applicable regulation). We provide people with disabilities with reasonable modifications and free communication aids to allow for effective communication with us. We also provide free language assistance services to people whose first language is not English.

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

If you believe we have failed to provide a service, or think we have discriminated in another way, you can file a grievance with:

Office of Civil Rights Coordinator	Phone:	855-664-7270 (voicemail)
Attn: Office of Civil Rights Coordinator	TTY/TDD:	855-661-6965
300 E. Randolph St., 35th Floor	Fax:	855-661-6960
Chicago, IL 60601	Email:	civilrightscoordinator@bcbsil.com

You can file a grievance by mail, fax or email. If you need help filing a grievance, please call the toll-free phone number listed on the back of your ID card (TTY: 711).

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

US Dept of Health & Human Services	Phone:	800-368-1019
200 Independence Avenue SW	TTY/TDD:	800-537-7697
Room 509F, HHH Building	Complaint Portal:	
Washington, DC 20201	ocrportal.hhs.gov/ocr/smartscreen/main.jsf	Complaint Forms:
	hhs.gov/civil-rights/filing-a-complaint/index.html	

This notice is available on our website at bcbstx.com/legal-and-privacy/non-discrimination-notice

ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 855-710-6984 (TTY: 711) or speak to your provider.

Español Spanish	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 855-710-6984 (TTY: 711) o hable con su proveedor.
العربية Arabic	تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 855-710-6984 (TTY: 711) أو تحدث إلى مقدم الخدمة.



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