



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](http://www.bcbstx.com) or by calling 1-800-521-2227. 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 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	In-Network: \$500 Individual / \$1,500 Family Out-of-Network: \$750 Individual / \$2,250 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> .
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. Services that charge a <u>copay</u> , <u>prescription</u> drugs, and <u>In-Network</u> <u>diagnostic tests</u> , <u>home</u> <u>health</u> , <u>skilled nursing</u> , and <u>hospice</u> are 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.
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet deductibles for specific services.
<b>What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u>?</b>	In-Network: \$2,000 Individual / \$6,000 Family Out-of-Network: \$4,000 Individual / \$12,000 Family	The <u>out-of-pocket</u> <u>limit</u> is the most you could pay in a year for covered services.
<b>What is not included in the <u>out-of-pocket</u> <u>limit</u>?</b>	<u>Deductible</u> , <u>premiums</u> , <u>preauthorization</u> penalties, <u>balance-billed</u> charges, 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</u> <u>limit</u> .
<b>Will you pay less if you use a <u>network</u> <u>provider</u>?</b>	Yes. See <a href="http://www.bcbstx.com">www.bcbstx.com</a> or call 1-800-521-2227 for a list of <u>In-Network</u> providers.	This plan uses a <u>provider</u> <u>network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's</u> <u>network</u> . You will pay the most if you use an <u>out-of-network</u> <u>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 plan pays ( <u>balance</u> <u>billing</u> ). Be aware your <u>network</u> <u>provider</u> might use an <u>out-of-network</u> <u>provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$25 <u>copay</u> /visit; <u>deductible</u> does not apply	30% <u>coinsurance</u>	Virtual visits available through MDLive \$10 <u>copay</u> . In-Network.
	<u>Specialist</u> visit	\$25 <u>copay</u> /visit; <u>deductible</u> does not apply	30% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	\$25 <u>copay</u> /visit; <u>deductible</u> does not apply.	30% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your <u>plan</u> will pay for. No Charge for child immunizations <u>Out-of-Network</u> through the 6 <sup>th</sup> birthday.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	No Charge; <u>deductible</u> does not apply	30% <u>coinsurance</u>	Office visit <u>copay</u> may apply.
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
<b>If you need drugs to treat your illness or condition</b> More information about <b><u>prescription drug coverage</u></b> is available at <a href="http://www.mybenefits.org">www.mybenefits.org</a>	Tier 1	Retail: \$5 <u>copay</u> / prescription Mail: \$10 <u>copay</u> / prescription; <u>deductible</u> does not apply	Total Cost of prescription	Retail: one <u>copay</u> 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> .
	Tier 2	Retail: \$20 <u>copay</u> / prescription Mail: \$40 <u>copay</u> / prescription; <u>deductible</u> does not apply	Total Cost of prescription	
	Tier 3	Retail: \$35 <u>copay</u> / prescription Mail: \$70 <u>copay</u> / prescription; <u>deductible</u> does not apply	Total Cost of prescription	



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>Specialty drugs</u>	\$20 / \$35 <u>copay</u> / prescription; <u>deductible</u> does not apply	Total Cost of prescription	<u>Specialty drug</u> prescriptions must be filled through Lumicera Specialty Pharmacy. One <u>copay</u> per 30-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	10% <u>coinsurance</u> after \$90 <u>copay</u> /visit	10% <u>coinsurance</u> after \$90 <u>copay</u> /visit	Copay waived if admitted.
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	Subject to mileage pricing.
	<u>Urgent care</u>	\$25 <u>copay</u> /visit; <u>deductible</u> does not apply	30% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	All services must be preauthorized; \$250 penalty applies. <u>Out-of-Network</u> for failure to preauthorize.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <u>copay</u> / office visit; <u>deductible</u> does not apply 10% <u>coinsurance</u> for other outpatient services	30% <u>coinsurance</u> office visit 30% <u>coinsurance</u> for other outpatient services	Limited to 30 visits per plan year. Substance abuse treatment limited to 3 series per lifetime. Certain services must be preauthorized; refer to benefit booklet for details.
	Inpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Limited to 30 days per plan year. Substance abuse treatment limited to 3 series per lifetime. All services must be preauthorized; \$250 penalty applies <u>Out-of-Network</u> for failure to preauthorize.
If you are pregnant	Office visits	\$25 <u>copay</u> / initial visit; <u>deductible</u> does not apply	30% <u>coinsurance</u>	10% <u>coinsurance</u> applies after initial visit In-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)	
	Childbirth/delivery professional services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Cost sharing 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. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	All services must be preauthorized; \$250 penalty applies <u>Out-of-Network</u> for failure to preauthorize.
If you need help recovering or have other special health needs	<u>Home health care</u>	No Charge; <u>deductible</u> does not apply	30% <u>coinsurance</u>	Limited to 60 visits per <u>plan</u> year. All services must be preauthorized.
	<u>Rehabilitation services</u>	\$25 <u>copay</u> / visit; <u>deductible</u> does not apply	30% <u>coinsurance</u>	None
	<u>Habilitation services</u>	\$25 <u>copay</u> / visit; <u>deductible</u> does not apply	30% <u>coinsurance</u>	None
	<u>Skilled nursing care</u>	No Charge; <u>deductible</u> does not apply	30% <u>coinsurance</u>	Limited to 25 days per plan year. All services must be preauthorized.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	<u>Hospice services</u>	No Charge; <u>deductible</u> does not apply	30% <u>coinsurance</u>	All services must be preauthorized.
If your child needs dental or eye care	Children's eye exam	\$25 <u>copay</u> / visit; <u>deductible</u> does not apply	30% <u>coinsurance</u>	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.)		
<ul style="list-style-type: none"><li>• Acupuncture</li><li>• Bariatric surgery</li><li>• Cosmetic surgery</li><li>• Dental care (Adult)</li></ul>	<ul style="list-style-type: none"><li>• Hearing Aids</li><li>• Infertility treatment</li><li>• Long-term care</li></ul>	<ul style="list-style-type: none"><li>• Private-duty nursing</li><li>• Routine foot care</li><li>• Weight loss programs</li></ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"><li>• Chiropractic care</li></ul>	<ul style="list-style-type: none"><li>• Non-emergency care when traveling outside the U.S.</li></ul>	<ul style="list-style-type: none"><li>• Routine eye care (Adult)</li></ul>

**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 1-800-521-2227, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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](http://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](http://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: Blue Cross and Blue Shield of Texas at 1-800-521-2227 or visit [www.bcbstx.com](http://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](http://www.dol.gov/ebsa/healthreform). Contact the Texas Department of Insurance at 1-800-252-3439 or visit [www.texashealthoptions.com](http://www.texashealthoptions.com).

## Does this plan provide Minimum Essential Coverage? [Yes]

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

## 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 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	\$250
■ Specialist copayment	\$20
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

#### 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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
---------------------------	-----------------

#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$250
Copayments	\$40
Coinsurance	\$1,100
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,450</b>

### Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$250
■ Specialist copayment	\$20
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

#### 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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
---------------------------	----------------

#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$250
Copayments	\$600
Coinsurance	\$100
What isn't covered	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$1,010</b>

### Mia's Simple Fracture

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

■ The plan's overall deductible	\$250
■ Specialist copayment	\$20
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

#### This EXAMPLE event includes services like:

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

<b>Total Example Cost</b>	<b>\$1,900</b>
---------------------------	----------------

#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$250
Copayments	\$200
Coinsurance	\$90
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$540</b>

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

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To speak to an interpreter, call the customer service number on the back of your member card. If you are not a member, or don't have a card, call 855-710-6984.

[illegible]



**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](mailto: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>