The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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 <u>www.bcbstx.com</u> or by calling 1-800-521-2227. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> 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:
What is the overall deductible?	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> .
Are there services covered before you meet your <u>deductible?</u>	Yes. Services that charge a <u>copay</u> , <u>prescription</u> drugs, and <u>In-Network 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.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	In-Network: \$2,000 Individual / \$6,000 Family Out-of-Network: \$4,000 Individual / \$12,000 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services.
What is not included in the <u>out-of-pocket limit?</u>	<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 limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.bcbstx/com or call 1-800-521-2227 for a list of In-Network providers.	This plan 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 plan 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 <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the specialist you choose without a referral.



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

Common		What You Will Pay		Limitations, Exceptions, & Other Important	
Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Information	
	Primary care visit to treat an injury or illness	\$25 <u>copay</u> /visit; <u>deductible</u> does not apply	30% coinsurance	Virtual visits available through MDLive \$10 copay. In-Network.	
	Specialist visit	\$25 <u>copay</u> /visit; <u>deductible</u> does not apply	30% coinsurance	None	
If you visit a health care <u>provider's</u> office or clinic	Preventive care/screening/ immunization	\$25 <u>copay</u> /visit; <u>deductible</u> does not apply.	30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. No Charge for child immunizations Out-of-Network through the 6th birthday.	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No Charge; deductible does not apply	30% coinsurance	Office visit copay may apply.	
	Imaging (CT/PET scans, MRIs)	10% coinsurance	30% coinsurance	None	
If you need drugs to	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	
treat your illness or condition More information about prescription drug coverage is available	Tier 2	Retail: \$20 copay / prescription Mail: \$40 copay / prescription; deductible does not apply	Total Cost of prescription	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 Copayment.	
at www.mybenefits.org	Tier 3	Retail: \$35 copay / prescription Mail: \$70 copay / prescription; deductible 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		What You Will Pay		Limitations Evacutions & Other Important	
Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information	
	Specialty drugs	\$20 / \$35 copay / prescription; deductible does not apply	Total Cost of prescription	Specialty drug prescriptions must be filled through Lumicera Specialty Pharmacy. One copay per 30-day supply.	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	None	
	Physician/surgeon fees Emergency room care	10% <u>coinsurance</u> 10% <u>coinsurance</u> after \$90 <u>copay</u> /visit	30% coinsurance 10% coinsurance after \$90 copay/visit	Copay waived if admitted.	
If you need immediate medical attention	Emergency medical transportation	10% coinsurance	10% coinsurance	Subject to mileage pricing.	
attention	Urgent care	\$25 <u>copay</u> /visit; <u>deductible</u> does not apply	30% coinsurance	None	
If you have a hospital	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	All services must be preauthorized; \$250 penalty applies. <u>Out-of-Network</u> for failure to preauthorize.	
stay	Physician/surgeon fees	10% coinsurance	30% coinsurance	None	
If you need mental	Outpatient services	\$25 <u>copay</u> / office visit; <u>deductible</u> does not apply 10% <u>coinsurance</u> for other outpatient services	30% coinsurance office visit 30% coinsurance 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.	
health, behavioral health, or substance abuse services	Inpatient services	10% <u>coinsurance</u>	30% coinsurance	Limited to 30 days per plan year. Substance abuse treatment limited to 3 series per lifetime. All services must be preauthorized; \$250 penalty applies Out-of-Network for failure to preauthorize.	
If you are pregnant	Office visits	\$25 <u>copay</u> / initial visit; <u>deductible</u> does not apply	30% coinsurance	10% coinsurance 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		What You Will Pay		Limitations, Exceptions, & Other Important	
Medical Event	Services You May Need	Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Information	
	Childbirth/delivery professional services	10% coinsurance	30% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	All services must be preauthorized; \$250 penalty applies <u>Out-of-Network</u> for failure to preauthorize.	
	Home health care	No Charge; deductible does not apply	30% coinsurance	Limited to 60 visits per <u>plan</u> year. All services must be preauthorized.	
	Rehabilitation services	\$25 <u>copay</u> / visit; <u>deductible</u> does not apply	30% coinsurance	None	
If you need help recovering or have other special health	Habilitation services	\$25 <u>copay</u> / visit; <u>deductible</u> does not apply	30% coinsurance	None	
needs	Skilled nursing care	No Charge; <u>deductible</u> does not apply	30% coinsurance	Limited to 25 days per plan year. All services must be preauthorized.	
	Durable medical equipment	10% coinsurance	30% coinsurance	None	
	Hospice services	No Charge; <u>deductible</u> does not apply	30% coinsurance	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% coinsurance	None	
dental of eye care	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 N	IOT Cover (Check your policy or <u>plan</u> document for more informa	ation and a list of any other <u>excluded services</u> .)
AcupunctureBariatric surgeryCosmetic surgeryDental care (Adult)	Hearing AidsInfertility treatmentLong-term care	Private-duty nursingRoutine foot careWeight loss programs
Other Covered Services (Limitations	may apply to these services. This isn't a complete list. Please se	e your <u>plan</u> document.)
Chiropractic care	 Non-emergency care when traveling outside the 	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 1-800-521-2227, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, 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 <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. 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 <u>www.bcbstx.com</u>, or contact the U.S. Department of Labor's Employee Benefits Security Administrations at 1-866-444-EBSA (3272) or visit <u>www.dol.gov/ebsa/healthreform</u>. Contact the Texas Department of Insurance at 1-800-252-3439 or visit <u>www.texashealthoptions.com</u>.

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, kwiijigo 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 <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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>	\$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)

Primary care physician office visits (including disease education)

This EXAMPLE event includes services like:

Diagnostic tests (blood work)

Total Example Cost

Prescription drugs

Durable medical equipment (glucose meter)

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>	\$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)

Mia's Simple Fracture

(in-network emergency room visit and follow

up care)

Durable medical equipment (crutches) Rehabilitation services (physical therapy)

■ The plan's overall deductible

■ Hospital (facility) coinsurance

Specialist copayment

Total Example Cost

\$7,400

Other coinsurance

Total Example Cost \$12,800

In this example, Peg would pay:

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

In this example, Joe would pay:

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

In this example. Mia would pay:

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

\$250

\$20

10%

10%

\$1,900

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.

ةبيرحلا Arabic	نا ناكا كثيدًا وأ ندل صخش هدعاسة بمانساً، كثيرلف ق حلا في لوصحًا على قدعاسمًا تامولعمالو تميرورضاًا كتغلب نء نود تميا تكلفة. ثدحتًا لى لم هجرته يروف، لصنًا على مقر تمدخ علامعًا روكذمًا على ربهظ تقاطب كتيوضع. ن إفر مل نكة عضد اؤ، وأ تخك لا كنامة تقاطب، لصنًاف على 1894-710-858.
繁體中文 Chinese	如果您, 或您正在協助的對象, 對此有疑問, 您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員, 請致電印在您的會員卡背面的客戶服務電話號碼。如果您不是會員, 或沒有會員卡, 請致電 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, composez le numéro du service client indiqué au verso de votre carte de membre. Si vous n'êtes pas membre ou si vous n'avez pas de carte, veuillez composer le 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Kundenservicenummer auf der Rückseite Ihrer Mitgliedskarte an. Falls Sie kein Mitglied sind oder keine Mitgliedskarte besitzen, rufen Sie bitte 855-710-6984 an.
�ુજુ રાતી Gujarati	જો તમને અથવા તમે મદદ કર¢ રહ્યા હોય એવી કોઈ બી� ળ્ય¢્તને એસ.બી.એમ. ♦ુ ભાિષયા સાથે વાત કરવા માં¢, તમારા સભ્યપદના કાડર્ની પાછળ આપેલ ય્રાહક સેવા નંબ ૨ પર કૉલ કરો. જો આપ સભ્યપદ ના ધરાવતા હોવ, અથવા આપની પાસે કાડર્ નથી તો 855-710-6984 નંબ ૨ પર કૉલ કરો.
♦ हंद ♦ Hindi	य�द आपके, या आप िजसक� सहायता कर रहे 🛊 उसके, प्रश्न 🛊, तो आपको अपनी भाषा 🕸 �नःशुल्क सहायता और जानकार� प्राप्त करने का अ�धकार है। �कसी अनुवादक से बात करने के �लए, अपने सदस्य काडर् के पीछे �दए गए ग्राहक सेवा नंबर पर कॉल कर�। य�द आप सदस्य नह�ं 🐞, या आपके पास काडर् नह�ं है, तो 855-710-6984 पर कॉल कर�।
日本語 Japanese	ご本人様、またはお客様の身の回りの方でも、ご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、メンバーカードの裏のカスタマーサービス番号までお電話ください。メンバーでない場合またはカードをお持ちでない場合は 855-710-6984 までお電話ください。
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 회원 카드 뒷면에 있는고객 서비스 번호로 전화하십시오. 회원이 아니시거나 카드가 없으시면 855-710-6984 으로 전화주십시오.
ພາສາລາວ Laotian	ຖ້ າທ່ານ ໊ຫຼ ຄຸ້ນວິທທ່ານກຳລັງໃຫ້ການຊ່ວຍເຫຼອວີມໍຄາຖາມ,ທ່ານວິມວິສດໍຂເວືອາການຊ່ວຍເຫຼອ ແລະໍຂມູນເປັນນພາສາຂອງທ່ານໄດ້ ໂດຍໍບວີມຄຳໃຊ້ຈ່າຍ. ເພື່ອລື ມາຮັບນາຍແປພາສາ, ໃຫ້ ໂທຫາເວີບຝ່າຍໍບວິລ ການລຸກຄ້າວິທີມຢູ່ ດັ ^{່ງ} ນຫຼັງ ປັດສະມາວິຊກຂອງທ່ານ. ຖ້າທ່ານໍບແມ່ນສະມາວິຊກ, ວີຫຼ່ບວີມພັດ, ໃຫ້ ໂທຫາເວີບ 855-710-6984.
Diné Navajo	T'11 ni, 47 doodago [a'da b7k1 an1n7lwo'7g77, na'7d7[kidgo, ts'7d1 bee n1 ah00ti'i't'11 n77k'e n7k1 a'doolwo[. Ata' halne'7 bich'8' hadeesdzih n7n7zingo 47 kwe'4 da'7n7ishgi 1k1 an7daalwo'7g77 bich'8' hod77lnih, bee n44h0zinii bine'd66' bik11'. Koj7 atah naaltsoos n1 had7t'44g00 47 doodago bee n44h0zin7g77 1dingo koj8' hod77lnih 855-710-6984.
یسراف Persian	ل صاح دیبیامذ.رگا امش، به شما که کسی یا و ا می کمک دینک، یالوسه متشاد دیشاب، قحنیا ار دیراد به که نابز دوخ، به روط ناگیار کمک و تناعلاطا تخایر د دیبامذ. تنهج و گنفگ یک با مجرتمی هانش، با تنامدخ برتشم به هر امش یا که رد تشپ تراک تنهوضت دیرادن، با هر امشه 480-710-855 سامة جرد هدشت سا سامة دیریگیر. رگا وضت دیتسین، یا تراک تنهوضت دیرادن، با هر امشه 6984-710-855 سامة
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы поговорить с переводчиком, позвоните в отдел обслуживания клиентов по телефону, указанному на обратной стороне вашей карточки участника. Если вы не являетесь участником или у вас нет карточки, позвоните по телефону 855-710-6984.
Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete comuníquese con el número del Servicio al Cliente que figura en el reverso de su tarjeta de miembro. Si usted no es miembro o no posee una tarjeta, llame al 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa numero ng serbisyo para sa kustomer sa likod ng iyong kard ng miyembro. Kung ikaw ay hindi isang miyembro, o kaya ay walang kard, tumawag sa 855-710-6984.
ودرا Urdu	رگا پاً وکہ کسی یا ہےسیا درفوک سج کی پاً ددم ہے ہررک ریب، یئوکا لاوس شیپرد ہے وت، پاً وکا ہیپا نابنر ریم تخد ددہ روا تنامولعہ لرصاح ہزرکا کا قحہ ہے جبرتہ سے تنابہ ہنرکا کے ہیل، رمٹسکا سورسا ربمذر پال ای ریزکا وج پا کے ٹراک کی تشد رپ جرد ہے۔ رگا پاً ربمدریہد ریب، یا پا کے سال ٹراک ریپہ ہے وت، 8948-710-855 رپ لاک ریپرکا
Tiếng Việt Vietnamese	Nếu quý vị hoặc người mà quý vị giúp đỡ có bất kỳ câu hỏi nào, quý vị có quyền được hỗ trợ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với thông dịch viên, gọi số dịch vụ khách hàng nằm ở phía sau thẻ hội viên của quý vị. Nếu quý vị không phải là hội viên hoặc không có thẻ, gọi số 855-710-6984.

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 Phone: 855-664-7270 (voicemail)

300 E. Randolph St. TTY/TDD: 855-661-6965 35th Floor Fax: 855-661-6960

Chicago, Illinois 60601 Email: <u>CivilRightsCoordinator@hcsc.net</u>

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