



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at <http://www.bcbstx.com/coverage/index.html> or by calling 1-877-299-2377.

| Important Questions | Answers | Why this Matters: |
|---|--|---|
| What is the overall deductible? | \$0 | See the chart starting on page 2 for your other costs for services this plan covers. |
| Are there other deductibles for specific services? | Yes. Per Occurrence: \$150 In-Network Inpatient Admission. There are no other specific deductibles . | You must pay all the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| Is there an out-of-pocket limit on my expenses? | Yes. For In-Network \$1,250 Individual/ \$3,750 Family Includes deductible. | The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| What is not included in the out-of-pocket limit? | Premiums, balance-billed charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the out-of-pocket limit . |
| Does this plan use a network of providers? | Yes. See www.bcbstx.com for a list of participating providers. | If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers . |
| Do I need a referral to see a specialist? | Yes. All specialist visits require a written PCP referral unless it's for an OB/GYN or for emergency care. | This plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan's permission before you see the specialist . |
| Are there services this plan doesn't cover? | Yes. | Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about excluded services . |

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If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-855-756-4448 to request a copy.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the health plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- The plan may encourage you to use In-Network **providers** by charging you lower **deductibles**, **copayments**, and **coinsurance** amounts.

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|--|--|---|---|--|
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | \$25 copay/visit | Not Covered | ---none--- |
| | Specialist visit | \$45 copay/visit | Not Covered | |
| | Other practitioner office visit | \$25 copay/visit | Not Covered | Acupuncture not covered. |
| | Preventive care/screening/immunization | No Charge | Not Covered | ---none--- |
| If you have a test | Diagnostic test (x-ray, blood work) | No Charge | Not Covered | ---none--- |
| | Imaging (CT / PET scans, MRIs) | \$250 copay/visit | Not Covered | Deductible and coinsurance do not apply; other focus procedures take the office visit copay. CT for heart disease screening maximum benefit of 1 test for EDT every 5 years. |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.bcbstx.com/member/rx_drugs.html | Preferred Generic Drugs | No Charge | Not Covered | One Copay per 30-Day Supply, up to a 90-Day Supply. Generics Plus Formulary applies. Certain women's preventative services will be covered with no cost to the member. |
| | Non-Preferred Generic Drugs | \$10 retail/\$20 mail copay/prescription | Not Covered | |
| | Preferred Brand Drugs | \$35 retail/\$70 mail copay/prescription | Not Covered | |
| | Non-Preferred Brand Drugs | \$75 retail/\$150 mail copay/prescription | Not Covered | |
| | Specialty Drugs | \$150 copay/prescription | Not Covered | |

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| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|--|---|---|--|
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | \$100 copay/visit | Not Covered | ---none--- |
| | Physician/surgeon fees | No Charge | Not Covered | |
| If you need immediate medical attention | Emergency room services | \$300 copay/visit | \$300 copay/visit | Copay amount waived if admitted. If admitted, Inpatient Hospital services deductible will apply. |
| | Emergency medical transportation | No Charge | No Charge | ---none--- |
| | Urgent care | No Charge | Not covered | Copay may apply. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No Charge | Not covered | \$150 In-Network Inpatient Per Occurrence Deductible. |
| | Physician/surgeon fee | No Charge | Not Covered | ---none--- |
| If you have mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | \$25 copay/visit | Not Covered | \$100 In-Network Outpatient Surgery copay, facility only. |
| | Mental/Behavioral health inpatient services | No Charge | Not Covered | \$150 In-Network Inpatient Per Occurrence Deductible. |
| | Substance use disorder outpatient services | \$25 copay/visit | Not Covered | \$100 In-Network Outpatient Surgery copay, facility only. |
| | Substance use disorder inpatient services | No Charge | Not Covered | \$150 In-Network Inpatient Per Occurrence Deductible. |
| If you are pregnant | Prenatal and postnatal care | \$25 copay/initial visit | Not Covered | Copay applies to first prenatal visit (per pregnancy) |
| | Delivery and all inpatient services | No Charge | Not Covered | \$150 In-Network Inpatient Per Occurrence Deductible. |
| If you need help recovering or have other special health needs | Home health care | No Charge | Not Covered | Limited to 60 visits per year. |
| | Rehabilitation services | No Charge | Not Covered | Limited to combined 35 visits per year, including Chiropractic. |
| | Habilitation services | No Charge | Not Covered | |
| | Skilled nursing care | No Charge | Not Covered | Limited to 25 days per year. |
| | Durable medical equipment | No Charge | Not Covered | ---none--- |
| Hospice service | No Charge | Not Covered | | |

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| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|--|-----------------------|---|---|---|
| If your child needs dental or eye care | Eye exam | No Charge | Not Covered | Limited to one visit per calendar year. |
| | Glasses | No Charge | Not Covered | Frames limited to one pair per calendar year. |
| | Dental check-up | Not Covered | Not Covered | ---none--- |

Excluded Services & Other Covered Services:

| Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other <u>excluded services</u> .) | | |
|---|---|--|
| <ul style="list-style-type: none"> Acupuncture Bariatric surgery | <ul style="list-style-type: none"> Dental Care (Adult) Long-term care | <ul style="list-style-type: none"> Private-duty nursing (Only covered for extended care expenses) Weight loss programs |

| Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.) | | |
|---|---|---|
| <ul style="list-style-type: none"> Chiropractic care Cosmetic surgery (Only covered for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors or diseases. When Medically Necessary.) Hearing aids (Limited to 2 per 3 years) | <ul style="list-style-type: none"> Infertility treatment (Diagnosis covered but treatment and Invitro not covered) Most coverage provided outside the United States. See www.bcbstx.com Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none"> Routine eye care (Adult) Routine foot care (Only covered in connection with diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency) |

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-877-299-2377. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact Blue Cross and Blue Shield of Texas at 1-877-299-2377 or visit www.bcbstx.com, or contact U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-299-2377.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-299-2377.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-877-299-2377.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-299-2377.

————— *To see examples of how this plan might cover costs for a sample medical situation, see the next page.* —————

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About These Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under the plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$7,220
- Patient pays \$320

Sample care costs:

| | |
|----------------------------|----------------|
| Hospital charges (mother) | \$2,700 |
| Routine obstetric care | \$2,100 |
| Hospital charges (baby) | \$900 |
| Anesthesia | \$900 |
| Laboratory tests | \$500 |
| Prescriptions | \$200 |
| Radiology | \$200 |
| Vaccines, other preventive | \$40 |
| Total | \$7,540 |

Patient pays:

| | |
|----------------------|--------------|
| Deductibles | \$150 |
| Copays | \$20 |
| Coinsurance | \$0 |
| Limits or exclusions | \$150 |
| Total | \$320 |

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$4,670
- Patient pays \$730

Sample care costs:

| | |
|--------------------------------|----------------|
| Prescriptions | \$2,900 |
| Medical Equipment and Supplies | \$1,300 |
| Office Visits and Procedures | \$700 |
| Education | \$300 |
| Laboratory tests | \$100 |
| Vaccines, other preventive | \$100 |
| Total | \$5,400 |

Patient pays:

| | |
|----------------------|--------------|
| Deductibles | \$0 |
| Copays | \$650 |
| Coinsurance | \$0 |
| Limits or exclusions | \$80 |
| Total | \$730 |

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Questions and answers about Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No**. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No**. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes**. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes**. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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