**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 www.bcbstx.com or by calling 1-800-521-2227.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | For In-Network providers **$2,000** Individual/**$6,000** Family<br>For Out-of-Network providers **$4,000** Individual/**$8,000** Family | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. |
| **Are there other deductibles for specific services?** | No. There are no other specific deductibles. | You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| **Is there an out-of-pocket limit on my expenses?** | Yes. For In-Network providers **$5,000** Individual/**$10,000** Family<br>For Out-of-Network providers **$10,000** Individual/**$20,000** Family | 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, preauthorization penalties, 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 or call 1-800-810-2583 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?** | No. | You can see the **specialist** you choose without permission from this plan. |
| **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**. |

- **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 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**.)
- This 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 | 40% coinsurance | ---none--- |
| | Specialist visit | $75 copay/visit | 40% coinsurance | ---none--- |
| | Other practitioner office visit | 20% coinsurance | 40% coinsurance | Chiropractic services are limited to 35 visits per calendar year In- and Out-of-Network. |
| | Preventive care/screening/immunization | No Charge | 40% coinsurance | No charge for child immunizations Out-of-Network through the 6th birthday. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No Charge | 40% coinsurance | ---none--- |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 40% coinsurance | ---none--- |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is | Generic drugs | 30% coinsurance | 30% coinsurance | You will pay the full cost of the drug if you choose a brand-name drug when a generic is available; unless your physician directs "Brand Necessary" on your prescription. You will also pay the full cost of the drug at CVS & Walgreens. |
| | Preferred brand drugs | 30% coinsurance | 30% coinsurance | |
| | Non-preferred brand drugs | 50% coinsurance | 50% coinsurance | |

| 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 |
|---|---|---|---|---|
| available at www.medco.com or 1-800-922-8279.com | Specialty drugs | 30% coinsurance up to $225 per prescription | 30% coinsurance up to $225 per prescription | To fill your prescription through the specialty pharmacy, Accredo, please contact 1-800-922-8279. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 40% coinsurance | ---none--- |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | ---none--- |
| **If you need immediate medical attention** | Emergency room services | 20% coinsurance and $300 copay | 20% coinsurance and $300 copay | Emergency room copayment waived if admitted. |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | Ground and air transportation covered. |
| | Urgent care | $30 copay/visit | 40% coinsurance | ---none--- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 40% coinsurance | Preauthorization required for In-Network and Out-of-Network. Penalty for not preauthorizing $300 for Out-of-Network only. $25/$75 copay/visit for physician hospital visit. |
| | Physician/surgeon fee | 20% coinsurance | 40% coinsurance | |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | $25 copay PCP/ $75 copay SPC | 40% coinsurance | Copay applies for Outpatient services, copay waived if admitted. All services must be preauthorized for In-Network and Out-of-Network. Penalty for not preauthorizing $300 for Out-of-Network only. Inpatient/Outpatient Physician charges $25/$75 copay/visit. |
| | Mental/Behavioral health inpatient services | 20% coinsurance | 40% coinsurance | |
| | Substance use disorder outpatient services | $25 copay PCP/ $75 copay SPC | 40% coinsurance | |
| | Substance use disorder inpatient services | 20% coinsurance | 40% coinsurance | |
| **If you are pregnant** | Prenatal and postnatal care | $25 copay/visit | 40% coinsurance | Penalty for not preauthorizing $300 for Out-of-Network only. Newborn is covered 100% for the first 4 days, deductible waived. |
| | Delivery and all inpatient services | 20% coinsurance | 40% coinsurance | |

| 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 need help recovering or have other special health needs** | Home health care | 20% coinsurance | 40% coinsurance | Preauthorization is required. Limited to 60 visits max per calendar year. |
| | Rehabilitation services | 20% coinsurance | 40% coinsurance | ---none--- |
| | Habilitation services | 20% coinsurance | 40% coinsurance | |
| | Skilled nursing care | 20% coinsurance | 40% coinsurance | Preauthorization is required. Limited to 60 days max per calendar year, must follow a hospital confinement of at least 3 consecutive days for same or related cause. |
| | Durable medical equipment | 20% coinsurance | 40% coinsurance | ---none--- |
| | Hospice service | 20% coinsurance | 40% coinsurance | Preauthorization is required. Limited to 180 days lifetime max. |
| **If your child needs dental or eye care** | Eye exam | Not Covered | Not Covered | ---none--- |
| | Glasses | Not Covered | Not Covered | ---none--- |
| | 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 excluded services.)**

- Cosmetic surgery
- Hearing aids
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine foot care (only covered with diagnosis of Diabetes)

**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.)**

- Acupuncture (Limited to $1,000 or 30 visits per calendar year)
- Bariatric surgery (only covered per BCBS Medical policy)
- Chiropractic care (35 maximum visits per calendar year)
- Dental care (only for accidents)
- Most coverage provided outside the United States. See www.bcbstx.com.
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Weight loss programs (only covered per BCBS Medical policy)

## 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 1-800-521-2227. 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.

## 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 BlueCross BlueShield of Texas at 1-800-521-2227 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. Additionally, a consumer assistance program can help you file your **appeal**. Contact the Texas Department of Insurance's Consumer Health Assistance Program at (855) 839-2427 or visit www.texashealthoptions.com.

## 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 1-800-521-2227..

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 this plan might cover costs for a sample medical situation, see the next page.*

## 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 this plan. The actual care you receive will be different from these examples, and the cost of that care will also 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** $4,420
- **Patient pays** $3,120

**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 | $2,000 |
| Copays | $40 |
| Coinsurance | $930 |
| Limits or exclusions | $150 |
| **Total** | **$3,120** |

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

- **Amount owed to providers:** $5,400
- **Plan pays** $2,760
- **Patient pays** $2,640

**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 | $2,000 |
| Copays | $380 |
| Coinsurance | $180 |
| Limits or exclusions | $80 |
| **Total** | **$2,640** |

Note: These examples are based on individual coverage only.

# Questions and answers about the 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.

**Questions:** Call 1-800-521-2227or visit us at www.bcbstx.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-855-756-4448 to request a copy.