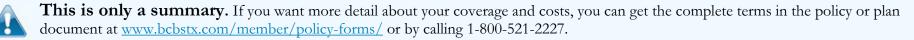
Summary of Benefits and Coverage: What this Plan Covers & What it Costs



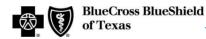
Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	Network \$250 Individual/ \$750 Family. Out-of-Network \$500 Individual/ \$1,500 Family. Doesn't apply to certain services that charge a copay, preventive care, and prescription drugs. Copays don't count toward the deductible.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket</u> <u>limit</u> on my expenses?	Yes. For Network \$1,250 Individual/ \$3,750 Family. For Out-of-Network \$2,500 Individual/ \$7,500 Family.	The <u>out-of-pocket</u> 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 <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Does this plan use a <u>network</u> of <u>providers</u> ?	Yes. See <u>www.bcbstx.com</u> or call 1-800-810-2583 for a list of Network 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 <u>specialist</u> ?	No. You don't need a referral to see a specialist.	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 5. See your policy or plan document for additional information about <u>excluded services</u> .

Questions: Call 1-800-521-2227 or visit us at <u>www.bcbstx.com/coverage</u> If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <u>www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf</u> or call 1-855-756-4448 to request a copy. Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association Summary of Benefits and Coverage: What this Plan Covers & What it Costs

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

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$25 copay/visit	40% coinsurance	none
provider s office of children	Specialist visit	\$45 copay/visit	40% coinsurance	
	Other practitioner office visit	\$25 copay/visit	40% coinsurance	Acupuncture not covered.
	Preventive care/screening/immunization	No Charge	40% coinsurance	none
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	none
If you have a test	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	

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Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2015 - 12/31/2015

Coverage for: Individual/Family | Plan Type: PPO

Common Medical Event	Services You May Need	Your cost if you use a Network Provider	Your cost if you use an Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat	Preferred generic drugs	No Charge	No Charge	
your illness or condition	Non-preferred generic drugs	\$10 retail/\$20 mail copay/prescription	50% coinsurance plus retail copay	One Copay per 30-Day Supply, up to a
More information about prescription drug coverage is available at	Preferred brand drugs	\$35 retail/\$70 mail copay/prescription	50% coinsurance plus retail copay	90-Day Supply. Standard Formulary applies. Certain women's preventative services will be covered with no cost to the member.
www.bcbstx.com/memb er/rx_drugs.html	Non-preferred brand drugs	\$75 retail/\$150 mail copay/prescription	50% coinsurance plus retail copay	
	Specialty drugs	\$150 copay/prescription	50% coinsurance plus copay	Standard Formulary applies. Certain women's preventative services will be covered with no cost to the member.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance plus \$100 copay/visit	40% coinsurance plus \$200 copay/visit	Elective abortion is not covered.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room services	20% coinsurance after \$300 copay/visit	20% coinsurance after \$300 copay/visit	Copay amount waived if admitted. If admitted, Inpatient Hospital services deductible will apply.
	Emergency medical transportation	20% coinsurance	20% coinsurance	none
	Urgent care	\$75 copay/visit	40% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$150 copay plus 20% coinsurance	\$250 copay plus 40% coinsurance	Deductible/coinsurance applies after copay is met. \$250 penalty for failure to preauthorize Out-of-Network.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	none

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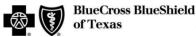
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	Mental/behavioral health outpatient services	\$25 copay/visit or 20% coinsurance for other outpatient services	40% coinsurance	Outpatient: Network \$100/Out-of-Network \$200 Outpatient Surgery copay, facility only. Certain services must be preauthorized. Pre-authorization is required for Psychological testing; Neuropsychological testing;
If you have mental health, behavioral health,	Mental/behavioral health inpatient services	\$150 copay plus 20% coinsurance	\$250 copay plus 40% coinsurance	
or substance abuse needs	Substance use disorder outpatient services\$25 copay/visit or 20% coinsurance for other outpatient services40% coinsurance	Electroconvulsive therapy; Repetitive Transcranial magnetic Stimulation; and Intensive Outpatient Treatment. Inpatient:		
	Substance use disorder inpatient services	\$150 copay plus 20% coinsurance	\$250 copay plus 40% coinsurance	Deductible/coinsurance applies after copay is met. \$250 penalty for failure to preauthorize Out-of-Network.
If you are pregnant	Prenatal and postnatal care	\$25 copay/initial visit	40% coinsurance	Copay applies to first prenatal visit (per pregnancy)
	Delivery and all inpatient services	\$150 copay plus 20% coinsurance	\$250 copay plus 40% coinsurance	Deductible/coinsurance applies after copay is met.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Limited to 60 visits per year. Preauthorization required.
	Rehabilitation services	20% coinsurance	40% coinsurance	Limited to combined 35 visits per year,
	Habilitation services	20% coinsurance	40% coinsurance	including Chiropractic.
	Skilled nursing care	20% coinsurance	40% coinsurance	Limited to 25 days per year. Preauthorization required.
	Durable medical equipment	20% coinsurance	40% coinsurance	none
	Hospice service	20% coinsurance	40% coinsurance	Preauthorization required.

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Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2015 - 12/31/2015

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Common Medical Event	Services You May Need	Your cost if you use a 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	Reimbursed up to \$30	One visit per calendar year. Up to age 19.
	Glasses	No Charge	Reimbursed up to \$30 frames/\$25 single vision lenses	One pair per calendar year. Up to age 19.
	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.)			
AcupunctureBariatric surgeryDental care (Adult and Child)	 Long term care Private duty nursing (Only covered for extended care expenses) 	 Termination of pregnancy (Except in limited circumstances) 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.)			
 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 1 for each ear every 3 years) 	 Infertility treatment (Diagnosis covered but treatment and invitro not covered) Non-emergency care when traveling outside the U.S. 	 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 1-800-521-2227. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or <u>www.dol.gov/ebsa</u>, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or <u>www.cciio.cms.gov</u>.

Questions: Call 1-800-521-2227 or visit us at www.bcbstx.com/coverage

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 1-800-521-2227 or visit <u>www.bcbstx.com</u>, or contact U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit <u>www.dol.gov/ebsa/healthreform</u>.

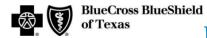
Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy** <u>does provide</u> 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 <u>does meet</u> the minimum value standard for the benefits it provides.

Language Access Services:



Coverage Examples:

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.

(normal delivery))
Amount owed to providers: \$7,	540
Plan pays \$5,940	
Patient pays \$1,600	
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	\$300
Copays	\$200
Coinsurance	\$900
Limits or exclusions	\$200
Total	\$1,600

Having a baby

Coverage Period: 01/01/2015 - 12/31/2015 Coverage for: Individual/Family | Plan Type: PPO

Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

Amount owed to providers: \$5,400

■Plan pays \$4,120

■ Patient pays \$1,280

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:

Total	\$1,280
Limits or exclusions	\$80
Coinsurance	\$200
Copays	\$700
Deductibles	\$300

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BlueCross BlueShield of Texas

P600CHC Blue Choice Platinum PPOSM 010

Coverage Examples:

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 <u>deductibles</u>, <u>copayments</u>, and <u>coinsurance</u> 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 <u>copayments</u>, <u>deductibles</u>, and <u>coinsurance</u>. 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.