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 by calling 1-800-521-2227 or at https://policy-srv.box.com/s/qmhgkacl13d5rfpo5odehkfjxm8btbzw

### Important Questions | Answers | Why this Matters:
--- | --- | ---
**What is the overall deductible?** | For In-Network providers: $1,000 Individual/$3,000 Family For Out-of-Network providers: $2,000 Individual/$4,000 Family Doesn’t apply to prescription drugs, services that charge a copay, inpatient hospital expenses, and In-Network preventive care, home health, skilled nursing, hospice and diagnostic tests. Copays and per occurrence deductibles do not count toward the deductible. | 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?** | Yes. Per occurrence: $500 In- and Out-of-Network inpatient admission. Prescription drugs: $75 Individual. There are no other specific deductibles. | You must pay all of 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 providers: $3,500 Individual/$6,500 Family For Out-of-Network providers: $6,000 Individual/$12,000 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](http://www.bcbstx.com) or call 1-800-810-2583 for a list of In-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 specialist?** | 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 **excluded services**.

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**Questions:** Call 1-800-521-2227 or visit us at [www.bcbstx.com](http://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 [www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf](http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf) or call 1-855-756-4448 to request a copy.

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association
- **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.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use an In-Network Provider</th>
<th>Your Cost If You Use an Out-of-Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider's office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$30 copay/visit</td>
<td>30% coinsurance</td>
<td>---none---</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$30 copay/visit</td>
<td>30% coinsurance</td>
<td>---none---</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>$30 copay/visit</td>
<td>30% coinsurance</td>
<td>Chiropractic services are limited to 35 visits combined for all physical therapies per benefit year combined, In- and Out-of-Network. Acupuncture is covered at 20% coinsurance In-network, 50% Out-of-network, limited to 20 visits per calendar year.</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No Charge</td>
<td>30% coinsurance</td>
<td>No Charge for child immunizations Out-of-Network through the 6th birthday.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No Charge</td>
<td>30% coinsurance</td>
<td>---none---</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>---none---</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>Your Cost If You Use an In-Network Provider</td>
<td>Your Cost If You Use an Out-of-Network Provider</td>
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<td>----------------------</td>
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<td>--------------------------------------------</td>
<td>-------------------------------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Generic drugs</td>
<td>$10 retail / $25 mail order copay/prescription</td>
<td>$10 copay/prescription plus 20% coinsurance</td>
<td>A separate deductible applies to prescription drug: $75 Individual. Retail benefit costs are based on a 30 day supply; with appropriate prescription up to a 90-day supply is available. Mail order covers a 90 day supply. Out-of-Network mail order is not covered. For Out-of-Network pharmacy, member must file claim.</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>$40 retail / $100 mail order copay/prescription</td>
<td>$40 copay/prescription plus 20% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>$60 retail / $150 mail order copay/prescription</td>
<td>$60 copay/prescription plus 20% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>20% of cost, $100 max/prescription</td>
<td>20% of cost, $100 max/prescription</td>
<td>Benefits apply after annual deductible has been met. Available at any retail pharmacy Mail order is not covered. For Out-of-Network pharmacy, member must file claim.</td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>---none---</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>---none---</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Emergency room services</td>
<td>25% coinsurance after $350 copay/visit</td>
<td>25% coinsurance after $350 copay/visit</td>
<td>Emergency room copay waived if admitted.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>Ground and air transportation covered.</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$75 copay/visit</td>
<td>30% coinsurance</td>
<td>---none---</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Preauthorization is required; $250 penalty if services are not preauthorized Out-of-Network.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>---none---</td>
</tr>
</tbody>
</table>

More information about prescription drug coverage is available at [www.bcbstx.com](http://www.bcbstx.com)
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</tr>
</thead>
<tbody>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health outpatient services</td>
<td>$30 copay/visit</td>
<td>30% coinsurance</td>
<td>Certain services must be preauthorized; refer to benefits booklet for details.</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>All services must be preauthorized; $250 penalty if services are not preauthorized Out-of-Network.</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>$30 copay/visit</td>
<td>30% coinsurance</td>
<td>Certain services must be preauthorized; refer to benefits booklet for details.</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>All services must be preauthorized; $250 penalty if services are not preauthorized Out-of-Network.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
<td>$30 copay/visit</td>
<td>30% coinsurance</td>
<td>Copay applies to first prenatal visit (per pregnancy), then 20% coinsurance.</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Preauthorization is required; $250 penalty if services are not preauthorized Out-of-Network.</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Limited to 60 visits per calendar year. Preauthorization is required.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Limited to 35 visits combined for all physical therapies per calendar year combined.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Limited to 25 days per calendar year. Preauthorization is required.</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>---none---</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Preauthorization is required.</td>
</tr>
<tr>
<td></td>
<td>Hospice service</td>
<td>20% coinsurance</td>
<td>50% coinsurance</td>
<td>Preauthorization is required.</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
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<td>--------------------------</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Eye exam</td>
<td>$30 copay/visit</td>
<td>30% coinsurance</td>
<td>---none---</td>
</tr>
<tr>
<td></td>
<td>Glasses</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>---none---</td>
</tr>
<tr>
<td></td>
<td>Dental check-up</td>
<td>Not Covered</td>
<td>Not Covered</td>
<td>---none---</td>
</tr>
</tbody>
</table>

**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 (limited covered services)
- Dental care (Adult and children)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care (with the exception of person 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
- Bariatric surgery (morbid obesity only)
- Chiropractic care
- Hearing aids (limited to 1 new aid per ear per 36-month period)
- Routine eye care (Adult and children)
- Weight loss programs
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 Blue Cross and Blue Shield 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): Dinekehgo shika at'ohwol ninisingo, kwijjigo 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.

**Having a baby**
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $4,840
- **Patient pays:** $2,700

**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 $1,500
- Copays $0
- Coinsurance $1,000
- Limits or exclusions $200
- **Total** $2,700

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

- **Amount owed to providers:** $5,400
- **Plan pays:** $3,520
- **Patient pays:** $1,880

**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 $1,000
- Copays $600
- Coinsurance $200
- Limits or exclusions $80
- **Total** $1,880

---

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.
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 1-800-521-2227 or visit us at www.bcbstx.com.
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