



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) 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

www.bcbstx.com/bb/ind/bb_gh2a01bftitxp_tx_2026.pdf or by calling 1-888-697-0683. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-855-756-4448 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible? | \$0 | See the Common Medical Events chart below for your costs for services this <u>plan</u> covers. |
| Are there services covered before you meet your deductible? | Yes. | 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 <u>deductibles</u> for specific services? | No. | You don't have to meet <u>deductibles</u> for specific services. |
| What is the <u>out-of-pocket</u> limit for this <u>plan</u> ? | Not Applicable. | This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses. |
| What is not included in the <u>out-of-pocket</u> limit? | Not Applicable. | This <u>plan</u> does not have an <u>out-of-pocket limit</u> on your expenses. |
| Will you pay less if you use a <u>network provider</u> ? | Yes. See www.bcbstx.com/go/mhb or call 1-888-697-0683 for a list of Participating providers. | This <u>plan</u> 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 <u>plan</u> 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> ? | Yes. | This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> . |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|--|--|--|--|
| | | Indian Health Care Provider (IHCP) (You will pay the least) | Non-IHCP Provider (You will pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | No Charge | Not Covered | Virtual Visits are available. See your benefit booklet* (Your PCP) for details. |
| | <u>Specialist</u> visit | No Charge | Not Covered | <u>Referral</u> required. |
| | Preventive care/screening/immunization | No Charge | Not Covered | You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. |
| If you have a test | <u>Diagnostic test</u> (x-ray, blood work) | No Charge | Not Covered | <u>Referral</u> may be required. <u>Preauthorization</u> may also be required; see your benefit booklet* (Outpatient Lab and X-Ray services) for details. |
| | Imaging (CT/PET scans, MRIs) | No Charge | Not Covered | <u>Referral</u> may be required. <u>Preauthorization</u> may also be required; See your benefit booklet* (Outpatient Lab and X-Ray services) for details. |
| If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.bcbstx.com/rx26/6T | Generic drugs (Preferred) | No Charge | Not Covered | Limited to a 30-day supply at retail (or a 90-day supply at a <u>network</u> of select retail pharmacies). Up to a 90-day supply at mail order. <u>Specialty drugs</u> limited to a 30-day supply except for certain FDA-designated dosing regimens. Certain drugs require approval before they will be covered. <u>Cost sharing</u> for insulin included in the drug list will not exceed \$25 per prescription for a 30-day supply, regardless of the amount or type of insulin needed to fill the prescription. |
| | Generic drugs (Non-Preferred) | No Charge | Not Covered | |
| | Brand drugs (Preferred) | No Charge | Not Covered | |
| | Brand drugs (Non-Preferred) | No Charge | Not Covered | |
| | Specialty drugs (Preferred) | No Charge | Not Covered | |
| | <u>Specialty drugs</u> (Non-Preferred) | No Charge | Not Covered | |
| | | | | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No Charge | Not Covered | <u>Referral</u> required. <u>Preauthorization</u> may also be required. For Outpatient Infusion Therapy, see your benefit booklet* (Outpatient Facility Services) for details. |
| | Physician/surgeon fees | No Charge | Not Covered | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|--|--|--|
| | | Indian Health Care Provider (IHCP) (You will pay the least) | Non-IHCP Provider (You will pay the most) | |
| If you need immediate medical attention | <u>Emergency room care</u> | No Charge | No Charge | None |
| | <u>Emergency medical transportation</u> | No Charge | No Charge | <u>Preauthorization</u> may be required for non-emergency transportation; see your benefit booklet* (Ambulance Services) for details. |
| | <u>Urgent care</u> | No Charge | Not Covered | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No Charge | Not Covered | <u>Referral</u> required. <u>Preauthorization</u> may also be required; see your benefit booklet* (Inpatient Hospital Services) for details. |
| | Physician/surgeon fees | No Charge | Not Covered | <u>Referral</u> required. <u>Preauthorization</u> may also be required; see your benefit booklet* (Inpatient Professional Services) for details. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | No Charge | Not Covered | <u>Preauthorization</u> may be required; See your benefit booklet* (Behavioral Health Services) for details. |
| | Inpatient services | No Charge | Not Covered | <u>Referral</u> required. <u>Preauthorization</u> may also be required; see your benefit booklet* (Behavioral Health Services) for details. |
| If you are pregnant | Office visits | No Charge | Not Covered | Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). |
| | Childbirth/delivery professional services | No Charge | Not Covered | |
| | Childbirth/delivery facility services | No Charge | Not Covered | |

*For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com/bb/ind/bb_gh2a01bftitxp_tx_2026.pdf

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|----------------------------------|--|--|--|
| | | Indian Health Care Provider (IHCP) (You will pay the least) | Non-IHCP Provider (You will pay the most) | |
| If you need help recovering or have other special health needs | <u>Home health care</u> | No Charge | Not Covered | 60 visits/year. <u>Referral</u> required. <u>Preadmission</u> may also be required; see your benefit booklet* (Extended Care Services) for details. |
| | <u>Rehabilitation services</u> | No Charge | Not Covered | Separate 35-visit maximum per benefit period for <u>Habilitation services</u> and <u>Rehabilitation services</u> , including chiropractic care. <u>Referral</u> required. <u>Preadmission</u> may also be required; see your benefit booklet* (<u>Rehabilitation Services</u> and <u>Habilitation Services</u>) for details. |
| | <u>Habilitation services</u> | No Charge | Not Covered | |
| | <u>Skilled nursing care</u> | No Charge | Not Covered | 25 days/year. <u>Referral</u> required. <u>Preadmission</u> may also be required; see your benefit booklet* (Extended Care Services) for details. |
| | <u>Durable medical equipment</u> | No Charge | Not Covered | <u>Referral</u> required. <u>Preadmission</u> may also be required; see your benefit booklet* (<u>Durable Medical Equipment</u>) for details. |
| | <u>Hospice services</u> | No Charge | Not Covered | <u>Referral</u> required. <u>Preadmission</u> may also be required; see your benefit booklet* (Extended Care Services) for details. |
| If your child needs dental or eye care | Children's eye exam | No Charge | Up to a \$30 reimbursement is available | One visit per year. Out-of-Network reimbursement will not exceed the retail cost. See your benefit booklet* (Pediatric Vision Care Benefits) for details. |
| | Children's glasses | No Charge | Up to a \$75 reimbursement is available | One pair of glasses per year. Reimbursement for frames, lenses, and lens options purchased Out-of-Network is available (not to exceed the retail cost). See your benefit booklet* (Pediatric Vision Care Benefits) for details. |
| | Children's dental check-up | Not Covered | Not Covered | None |

*For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com/bb/ind/bb_gh2a01bfttxp_tx_2026.pdf

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Abortion (Except for a pregnancy that, as certified by a physician, places the woman in danger of death)
- Acupuncture
- Bariatric surgery
- Cosmetic surgery (Except when medically necessary)
- Dental care (Adult and child)
- Infertility treatment (Diagnosis and treatment covered; in vitro not covered)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (Unless medically necessary)
- Routine eye care (Adult)
- Routine foot care (Except when medically necessary)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care (35 visits/year combined with habilitation and rehabilitation services)
- Hearing aids (Limited to 1 hearing aid per ear every 36 months)

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 Blue Cross and Blue Shield of Texas at 1-888-697-0683 or visit www.bcbstx.com. You may also contact your state insurance department at 1-800-252-3439 or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 OR state Health Insurance Marketplace or SHOP.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Texas Department of Insurance at 1-800-578-4677 or visit <https://tdi.texas.gov>.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Not Applicable.

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 1-888-697-0683.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-697-0683.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-697-0683.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-888-697-0683.

To see examples of how this 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 plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. 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 plan's overall deductible
- Specialist copayment
- Hospital (facility) copayment
- Other copayment

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*)

Total Example Cost **\$12,700**

In this example, Peg would pay:

| Cost Sharing | |
|--------------------|-----|
| <u>Deductibles</u> | \$0 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$0 |

What isn't covered

| | |
|-----------------------------------|-------------|
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$60 |

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible
- Specialist copayment
- Hospital (facility) copayment
- Other copayment

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost **\$5,600**

In this example, Joe would pay:

| Cost Sharing | |
|--------------------|-----|
| <u>Deductibles</u> | \$0 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$0 |

What isn't covered

| | |
|-----------------------------------|-------------|
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$20 |

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The plan's overall deductible
- Specialist copayment
- Hospital (facility) copayment
- Other copayment

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost **\$2,800**

In this example, Mia would pay:

| Cost Sharing | |
|--------------------|-----|
| <u>Deductibles</u> | \$0 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$0 |

What isn't covered

| | |
|-----------------------------------|------------|
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$0 |

The plan would be responsible for the other costs of these EXAMPLE covered services.



Non-Discrimination Notice

Health Care Coverage Is Important For Everyone

We do not discriminate on the basis of race, color, national origin (including limited English knowledge and first language), age, disability, or sex (as understood in the applicable regulation). We provide people with disabilities with reasonable modifications and free communication aids to allow for effective communication with us. We also provide free language assistance services to people whose first language is not English.

To receive reasonable modifications, communication aids or language assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, you can file a grievance with:

| | | |
|--|----------|-----------------------------------|
| Office of Civil Rights Coordinator | Phone: | 855-664-7270 (voicemail) |
| Attn: Office of Civil Rights Coordinator | TTY/TDD: | 855-661-6965 |
| 300 E. Randolph St., 35th Floor | Fax: | 855-661-6960 |
| Chicago, IL 60601 | Email: | civilrightscoordinator@bcbsil.com |

You can file a grievance by mail, fax or email. If you need help filing a grievance, please call the toll-free phone number listed on the back of your ID card (TTY: 711).

You may file a civil rights complaint with the US Department of Health and Human Services, Office for Civil Rights, at:

| | | |
|------------------------------------|-------------------|--|
| US Dept of Health & Human Services | Phone: | 800-368-1019 |
| 200 Independence Avenue SW | TTY/TDD: | 800-537-7697 |
| Room 509F, HHH Building | Complaint Portal: | ocrportal.hhs.gov/ocr/smartscreen/main.jsf |
| Washington, DC 20201 | Complaint Forms: | hhs.gov/civil-rights/filing-a-complaint/index.html |

This notice is available on our website at bcbstx.com/legal-and-privacy/non-discrimination-notice

bcbstx.com

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ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 855-710-6984 (TTY: 711) or speak to your provider.

| | |
|---------------------|--|
| Español Spanish | ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 855-710-6984 (TTY: 711) o hable con su proveedor. |
| العربية Arabic | تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات ملائمة لتقديم المعلومات بتنسيقات يمكن الوصول إليها مجلًا. اتصل على الرقم 855-710-6984 (TTY: 711) أو تحدث إلى مقدم الخدمة. |
| 中文 Chinese | 注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 855-710-6984（文本电话：711）或咨询您的服务提供商。 |
| Français French | ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 855-710-6984 (TTY : 711) ou parlez à votre fournisseur. |
| Deutsch German | ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 855-710-6984 (TTY: 711) an oder sprechen Sie mit Ihrem Provider. |
| ગુજરાતી Gujarati | ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાચીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. થોય ઓફિશિલ સહાય અને એક્સેસિબલ ફોર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મુખ્ય ઉપલબ્ધ છે. 855-710-6984 (TTY: 711) પર કોણ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો. |
| हिन्दी Hindi | ध્યાન દें: યदि આપ હિન્દી બोલતો હોય, તો આપકે લિએ નિઃશુલ્ક ભાષા સહાયતા સેવાએ ઉપલબ્ધ હોતી હોયાં। સુલમ પ્રારૂપો મેં જાનકારી પ્રદાન કરને કે લિએ ઉપયુક્ત સહાયક સાધન ઔર સેવાએ મિનિઃશુલ્ક ઉપલબ્ધ હોયાં। 855-710-6984 (TTY: 711) પર કોણ કરો અથવા અપને પ્રદાતા સાથે વાત કરો। |
| Italiano Italian | ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'855-710-6984 (tty: 711) o parla con il tuo fornitore. |
| 한국어 Korean | 주의: 한국어 를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 855-710-6984(TTY: 711)으로 전화하거나 서비스 제공업체에 문의하십시오. |
| Diné Navajo | SHOOH: Diné bee yáñilti'gogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jiik'eh ná hólq. Bee ahil hane'go bee nida'anishí t'áá ákodaata'éhígíi dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadílyaa bich'í[ahoot'í'gíí éí t'áá jiik'eh hólq. Kohjí' 855-710-6984 (TTY: 711) hodiilnih doodago nika'análwo'í bich'í[hanidzih. |
| فارسی Farsi | توجه: اگر فارسی صحبت می کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمکها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، بهطور رایگان موجود می باشند. با شماره 855-710-6984 (تلنامبر: 711) تماس بگیرید یا با ازایده‌های خود صحبت کنید. |
| Polski Polish | UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwój pod numer 855-710-6984 (TTY: 711) lub porozmawiaj ze swoim dostawcą. |
| РУССКИЙ Russian | ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 855-710-6984 (TTY: 711) или обратитесь к своему поставщику услуг. |
| Tagalog Tagalog | PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyon tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 855-710-6984 (TTY: 711) o makipag-usap sa iyong provider. |
| اردو Urdu | توجه: اگر آپ اردو بولجئ پئیں، تو آپ کے لئے زبان کی مفت مدد کی خدمات دستیاب پئیں۔ قابل رسائی فارمیشنس میں معلومات فراہم کرنے کے لئے مناسب معاون امداد اور خدمات بھی مفت دستیاب پئیں۔ 855-710-6984 (TTY: 711) پر کال کریں۔ |
| Việt Vietnamese | LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 855-710-6984 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn. |