




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, call 1-866-355-5999 or at [www.bcbstx.com/trsactivecare](http://www.bcbstx.com/trsactivecare). 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.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf](http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf) or call 1-855-756-4448 to request a copy.

| Important Questions                                                | Answers                                                                                                                                                                                          | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|--------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall deductible?</b>                             | \$2,500 Individual / \$5,000 Family                                                                                                                                                              | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .                                                                                                                                                        |
| <b>Are there services covered before you meet your deductible?</b> | Yes. Services that charge a <u>copayment</u> , <u>prescription drugs</u> , and <u>In-Network preventive care</u> and <u>diagnostic test</u> are covered before you meet your <u>deductible</u> . | 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. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                              |
| <b>Are there other deductibles for specific services?</b>          | No                                                                                                                                                                                               | You don't have to meet <u>deductibles</u> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>What is the out-of-pocket limit for this plan?</b>              | \$8,150 Individual / \$16,300 Family                                                                                                                                                             | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.                                                                                                                                                                                                                                                                              |
| <b>What is not included in the out-of-pocket limit?</b>            | <u>Premiums</u> , <u>balance-billed</u> charges, and health care this <u>plan</u> doesn't cover.                                                                                                 | Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u>                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Will you pay less if you use a network provider?</b>            | Yes. See <a href="http://www.bcbstx.com/trsactivecare">www.bcbstx.com/trsactivecare</a> or call 1-866-355-5999 for a list of <u>network providers</u> .                                          | 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 provider's 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. |
| <b>Do you need a referral to see a specialist?</b>                 | 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> .                                                                                                                                                                                                                                                                                                                                                                       |

 All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| Common Medical Event                                          | Services You May Need                            | What You Will Pay                                                                                                      |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                    |
|---------------------------------------------------------------|--------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                               |                                                  | In-Network Provider<br>(You will pay the least)                                                                        | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>If you visit a health care provider's office or clinic</b> | Primary care visit to treat an injury or illness | \$30 <u>copayment</u> /visit; <u>deductible</u> does not apply; except 30% <u>coinsurance</u> for office surgery       | Not Covered                                        | Includes Internist, General Physician, Family Practitioner, Pediatrician, Behavioral Health Physicians, or Gynecologist. Virtual visits may be available, please refer to your <u>plan</u> policy for more details; TRS Virtual Health Medical Consult Fee: \$0.                                                                                                                                                                          |
|                                                               | <u>Specialist</u> visit                          | \$70 <u>copayment</u> /visit; <u>deductible</u> does not apply; except 30% <u>coinsurance</u> for office surgery       | Not Covered                                        | None                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|                                                               | <u>Preventive care/screening/immunization</u>    | No Charge; <u>deductible</u> does not apply; except \$30 PCP/ \$70 SPC <u>copayment</u> /visit for hearing or eye exam | Not Covered                                        | TRS <u>Preventive Care</u> – <a href="https://www.trs.texas.gov/Pages/healthcare_covered_preventive_care.aspx">https://www.trs.texas.gov/Pages/healthcare_covered_preventive_care.aspx</a> . You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. 1 per plan year limitation for Hearing and Eye exam. |
| <b>If you have a test</b>                                     | <u>Diagnostic test</u> (x-ray, blood work)       | No Charge; <u>deductible</u> does not apply                                                                            | Not Covered                                        | Outpatient Lab/X-ray services performed at a hospital apply 30% <u>coinsurance</u> after <u>deductible</u> .                                                                                                                                                                                                                                                                                                                              |
|                                                               | Imaging (CT/PET scans, MRIs)                     | 30% <u>coinsurance</u>                                                                                                 | Not Covered                                        | <u>Preauthorization</u> may be required.                                                                                                                                                                                                                                                                                                                                                                                                  |

\* For more information about limitations and exceptions, see the plan or policy document at [www.bcbstx.com/trsactivecare](http://www.bcbstx.com/trsactivecare).

| Common Medical Event                                                                                                                                                                                      | Services You May Need                          | What You Will Pay                                                                                                                                                                            |                                                                                     | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                           |                                                | In-Network Provider (You will pay the least)                                                                                                                                                 | Out-of-Network Provider (You will pay the most)                                     |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <p><b>If you need drugs to treat your illness or condition</b></p> <p>More information about <b>prescription drug coverage</b> is available at <a href="http://www.caremark.com">www.caremark.com</a></p> | Generic drugs                                  | <u>Copayment/prescription, deductible</u> doesn't apply to non-specialty generics: \$15 (Retail first fill), \$30 (Retail second fill - maintenance drugs), \$45 (Mail Order or Retail-Plus) | See Limitations, Exceptions, & Other Important Information column for more details. | <p>Covers 31-day supply (Retail), 60-90 day supply (Mail Order or Retail-Plus). Includes contraceptive drugs &amp; devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives.</p> <p><u>In-network:</u> Precertification &amp; step therapy required. Your cost will be higher for choosing Brand over Generics unless prescribed Dispense as Written.</p> <p><u>Out-of-Network:</u> You pay 100% of the full cost at the time of purchase. After the <u>deductible's</u> met, you will be reimbursed the allowable amount as determined by CVS Caremark. Must submit <u>claim</u> to CVS Caremark within 12 months of service date to be reimbursed.</p> <p>All <u>Specialty drugs</u> must be filled at CVS Specialty Pharmacy. Retail not covered. 31-day supply limit.</p> |
|                                                                                                                                                                                                           | Preferred brand drugs                          | 30% <u>coinsurance</u> , after <u>deductible</u>                                                                                                                                             | See Limitations, Exceptions, & Other Important Information column for more details. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                                                                                                                                                           | Non-preferred brand drugs                      | 50% <u>coinsurance</u> , after <u>deductible</u>                                                                                                                                             | See Limitations, Exceptions, & Other Important Information column for more details. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                                                                                                                                                           | <u>Specialty drugs</u>                         | 30% <u>coinsurance</u> , after <u>deductible</u>                                                                                                                                             | See Limitations, Exceptions, & Other Important Information column for more details. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <p><b>If you have outpatient surgery</b></p>                                                                                                                                                              | Facility fee (e.g., ambulatory surgery center) | 30% <u>coinsurance</u>                                                                                                                                                                       | Not Covered                                                                         | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|                                                                                                                                                                                                           | Physician/surgeon fees                         | 30% <u>coinsurance</u>                                                                                                                                                                       | Not Covered                                                                         | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |

\* For more information about limitations and exceptions, see the plan or policy document at [www.bcbstx.com/trsactivecare](http://www.bcbstx.com/trsactivecare).

| Common Medical Event                                                      | Services You May Need                     | What You Will Pay                                                     |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                             |
|---------------------------------------------------------------------------|-------------------------------------------|-----------------------------------------------------------------------|----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                           | In-Network Provider<br>(You will pay the least)                       | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                    |
| If you need immediate medical attention                                   | <u>Emergency room care</u>                | 30% <u>coinsurance</u>                                                | 30% <u>coinsurance</u>                             | Free Standing Emergency Rooms apply a \$500 <u>copayment</u> per visit prior to the <u>deductible</u> . Once the <u>deductible</u> and <u>copayment</u> are applied, there is a 30% <u>coinsurance</u> .                                                                                                                                           |
|                                                                           | <u>Emergency medical transportation</u>   | 30% <u>coinsurance</u>                                                | 30% <u>coinsurance</u>                             | Ground and air transportation covered. Non-emergency transport: not covered, except if <u>preauthorized</u> .                                                                                                                                                                                                                                      |
|                                                                           | <u>Urgent care</u>                        | \$50 <u>copayment</u> /visit; <u>deductible</u> does not apply        | Not Covered                                        | None                                                                                                                                                                                                                                                                                                                                               |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)        | 30% <u>coinsurance</u>                                                | Not Covered                                        | None                                                                                                                                                                                                                                                                                                                                               |
|                                                                           | Physician/surgeon fees                    | 30% <u>coinsurance</u>                                                | Not Covered                                        | None                                                                                                                                                                                                                                                                                                                                               |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | \$30 <u>copayment</u> /office visit; <u>deductible</u> does not apply | Not Covered                                        | Certain services must be preauthorized; refer to benefits booklet for details. Virtual visits are available through TRS-Virtual Health; Behavioral Health Consult Fees: Psychiatrist (Initial Visit) \$70.00, Psychiatrist (Ongoing Visit) \$70.00, Psychologist, Licensed Clinical Social Worker \$70.00.                                         |
|                                                                           | Inpatient services                        | 30% <u>coinsurance</u>                                                | Not Covered                                        | None                                                                                                                                                                                                                                                                                                                                               |
| If you are pregnant                                                       | Office visits                             | \$30 <u>copayment</u> /office visit; <u>deductible</u> does not apply | Not Covered                                        | <u>Copayment</u> applies to first prenatal visit (per pregnancy). <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
|                                                                           | Childbirth/delivery professional services | 30% <u>coinsurance</u>                                                | Not Covered                                        |                                                                                                                                                                                                                                                                                                                                                    |
|                                                                           | Childbirth/delivery facility services     | 30% <u>coinsurance</u>                                                | Not Covered                                        | None                                                                                                                                                                                                                                                                                                                                               |

\* For more information about limitations and exceptions, see the plan or policy document at [www.bcbstx.com/trsactivecare](http://www.bcbstx.com/trsactivecare).

| Common Medical Event                                                  | Services You May Need            | What You Will Pay                                              |                                                 | Limitations, Exceptions, & Other Important Information                                              |
|-----------------------------------------------------------------------|----------------------------------|----------------------------------------------------------------|-------------------------------------------------|-----------------------------------------------------------------------------------------------------|
|                                                                       |                                  | In-Network Provider (You will pay the least)                   | Out-of-Network Provider (You will pay the most) |                                                                                                     |
| <b>If you need help recovering or have other special health needs</b> | <u>Home health care</u>          | 30% <u>coinsurance</u>                                         | Not Covered                                     | Limited to 60 visits per plan year.                                                                 |
|                                                                       | <u>Rehabilitation services</u>   | \$30 <u>copayment</u> /visit; <u>deductible</u> does not apply | Not Covered                                     | This includes physical therapy, occupational therapy, and speech therapy.                           |
|                                                                       | <u>Habilitation services</u>     | \$30 <u>copayment</u> /visit; <u>deductible</u> does not apply | Not Covered                                     |                                                                                                     |
|                                                                       | <u>Skilled nursing care</u>      | 30% <u>coinsurance</u>                                         | Not Covered                                     | Limited to 25 days per plan year.                                                                   |
|                                                                       | <u>Durable medical equipment</u> | 30% <u>coinsurance</u>                                         | Not Covered                                     | Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse. |
|                                                                       | <u>Hospice services</u>          | 30% <u>coinsurance</u>                                         | Not Covered                                     | None                                                                                                |
| <b>If your child needs dental or eye care</b>                         | Children's eye exam              | \$70 <u>copayment</u> /visit; <u>deductible</u> does not apply | Not Covered                                     | 1 routine eye exam/plan year if performed by an ophthalmologist or optometrist.                     |
|                                                                       | Children's glasses               | Not Covered                                                    | Not Covered                                     | None                                                                                                |
|                                                                       | Children's dental check-up       | Not Covered                                                    | Not Covered                                     | None                                                                                                |

### Excluded Services & Other Covered Services:

| <b>Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u>.)</b> |                                                                                                                                  |                                                                                                                                                                                                           |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Cosmetic surgery</li> <li>• Dental care (Adult and Children)</li> </ul>                                                             | <ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>• Routine foot care (with the exception of person with diagnosis of diabetes)</li> <li>• Weight loss programs (except for required preventive services)</li> </ul> |

| <b>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)</b>                                                                                                                                                                                                       |                                                                                                                                                                                                                                                 |                                                                                                                                                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>• Acupuncture (in lieu of anesthesia and nausea during pregnancy)</li> <li>• Bariatric surgery (Limited to Blue Distinction Center Plus. 30% after <u>deductible</u>. \$5,000 per procedure <u>copayment</u> for professional charges.)</li> <li>• Chiropractic care (35 visits per plan year)</li> </ul> | <ul style="list-style-type: none"> <li>• In Hearing aids (limited to \$1,000 per 36 months for members age 19 and older)</li> <li>• Infertility treatment (Limited to the diagnosis &amp; treatment of underlying medical condition)</li> </ul> | <ul style="list-style-type: none"> <li>• Private-duty nursing</li> <li>• Routine eye care (Adult, 1 routine eye exam per plan year)</li> </ul> |

\* For more information about limitations and exceptions, see the plan or policy document at [www.bcbstx.com/trsactivecare](http://www.bcbstx.com/trsactivecare).

**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 1-866-355-5999, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). 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](http://www.HealthCare.gov) or call 1-800-318-2596.

**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 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: Blue Cross and Blue Shield of Texas at 1-866-355-5999 or visit [www.bcbstx.com/trsactivecare](http://www.bcbstx.com/trsactivecare), or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit [www.dol.gov/ebsa/healthreform](http://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 1-800-252-3439 or visit [www.texashealthoptions.com](http://www.texashealthoptions.com).

**Does this plan provide Minimum Essential Coverage? Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet the Minimum Value Standards? Yes**

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 1-866-355-5999.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-355-5999.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-866-355-5999.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-355-5999.

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

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## 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 <u>plan's</u> overall <u>deductible</u> | \$2,500 |
| ■ <u>Specialist copayment</u>                 | \$70    |
| ■ Hospital (facility) <u>coinsurance</u>      | 30%     |
| ■ Other <u>coinsurance</u>                    | 30%     |

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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,800</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$2,500        |
| Copayments                        | \$70           |
| Coinsurance                       | \$3,000        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$5,630</b> |

### Managing Joe's type 2 Diabetes

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

|                                               |         |
|-----------------------------------------------|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$2,500 |
| ■ <u>Specialist copayment</u>                 | \$70    |
| ■ Hospital (facility) <u>coinsurance</u>      | 30%     |
| ■ Other <u>coinsurance</u>                    | 30%     |

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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$7,400</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$2,500        |
| Copayments                        | \$800          |
| Coinsurance                       | \$900          |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Joe would pay is</b> | <b>\$4,260</b> |

### Mia's Simple Fracture

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

|                                               |         |
|-----------------------------------------------|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$2,500 |
| ■ <u>Specialist copayment</u>                 | \$70    |
| ■ Hospital (facility) <u>coinsurance</u>      | 30%     |
| ■ Other <u>coinsurance</u>                    | 30%     |

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$1,900</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i>               |                |
|-----------------------------------|----------------|
| Deductibles                       | \$1,400        |
| Copayments                        | \$300          |
| Coinsurance                       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,700</b> |



# BlueCross BlueShield of Texas

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To speak to an interpreter, call the customer service number on the back of your member card. If you are not a member, or don't have a card, call 855-710-6984.

|                          |                                                                                                                                                                                                                                                                                                                                                                                                  |
|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| العربية<br>Arabic        | إن كان لديك أو لدى شخص تساعدك أسئلة، ف لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث إلى مترجم فوري، اتصل على رقم خدمة العملاء المذكور على ظهر بطاقة عضويتك. فإن لم تكن عضوًا، أو كنت لا تملك بطاقة، فاتصل على 855-710-6984.                                                                                                                               |
| 繁體中文<br>Chinese          | 如果您，或您正在協助的對象，對此有疑問，您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員，請致電印在您的會員卡背面的客戶服務電話號碼。如果您不是會員，或沒有會員卡，請致電 855-710-6984。                                                                                                                                                                                                                                                                                            |
| Français<br>French       | Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, composez le numéro du service client indiqué au verso de votre carte de membre. Si vous n'êtes pas membre ou si vous n'avez pas de carte, veuillez composer le 855-710-6984.                      |
| Deutsch<br>German        | Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Kundenservicenummer auf der Rückseite Ihrer Mitgliedskarte an. Falls Sie kein Mitglied sind oder keine Mitgliedskarte besitzen, rufen Sie bitte 855-710-6984 an.                            |
| ગુજરાતી<br>Gujarati      | જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ.બી.એમ. દુભાષિયા સાથે વાત કરવા માટે, તમારા સભ્યપદના કાર્ડની પાછળ આપેલ ગ્રાહક સેવા નંબર પર કોલ કરો. જો આપ સભ્યપદ ના ધરાવતા હોવ, અથવા આપની પાસે કાર્ડ નથી તો 855-710-6984 નંબર પર કોલ કરો.                                                                                                                                             |
| हिंदी<br>Hindi           | यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए, अपने सदस्य कार्ड के पीछे दिए गए ग्राहक सेवा नंबर पर कॉल करें। यदि आप सदस्य नहीं हैं, या आपके पास कार्ड नहीं है, तो 855-710-6984 पर कॉल करें।                                                                              |
| 日本語<br>Japanese          | ご本人様、またはお客様の身の回りの方でも、ご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、メンバーカードの裏のカスタマーサービス番号までお電話ください。メンバーでない場合またはカードをお持ちでない場合は 855-710-6984 までお電話ください。                                                                                                                                                                                                                        |
| 한국어<br>Korean            | 만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 회원 카드 뒷면에 있는 고객 서비스 번호로 전화하십시오. 회원이 아니시거나 카드가 없으시면 855-710-6984 으로 전화하십시오.                                                                                                                                                                                                                                             |
| ລາວ<br>Laotian           | ຖ້າທ່ານ ຫຼື ຄົນທີ່ທ່ານກຳລັງໃຫ້ການຊ່ວຍເຫຼືອມີຄຳຖາມ, ທ່ານມີສິດຂໍເອົາການຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໄດ້ໃດໆບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອຕົວກັບພາຍແພດພາສາ, ໃຫ້ໃບຫາດັບຢ່າງບໍ່ມີຄ່າການຊາກຄຳທີ່ມີຄຳຕອບຊ່ວຍເຫຼືອຂອງທ່ານ. ຖ້າທ່ານບໍ່ແມ່ນສະມາຊິກ, ຫຼື ບໍ່ມີບັດ, ໃຫ້ໃບຫາດັບ 855-710-6984.                                                                                                                    |
| Diné<br>Navajo           | T'áá ni, éí doodago la'da biká anánílwo'ígíí, na'idílkidgo, ts'idá bee ná ahóótí'i' t'áá nílk'e níká a'doolwol. Ata' halne'í bich'i' hadeesdzih nínízingo éí kwe'é da'iníishgi áká anídaalwo'ígíí bich'i' hodíílnih, bee nééhózinii bine'déé' bikáá'. Kojí atah naaltsoos ná hadít'écégóó éí doodago bee nééhózinígíí ádingo kojí' hodíílnih 855-710-6984.                                       |
| فارسی<br>Persian         | اگر شما، یا کسی که شما به او کمک می کنید، سوالاتی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با خدمات مشتری به شماره ای که در پشت کارت عضویت شما درج شده است تماس بگیرید. اگر عضو نیستید، یا کارت عضویت ندارید، با شماره 855-710-6984 تماس حاصل نمایید.                                                                |
| Русский<br>Russian       | Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы поговорить с переводчиком, позвоните в отдел обслуживания клиентов по телефону, указанному на обратной стороне вашей карточки участника. Если вы не являетесь участником или у вас нет карточки, позвоните по телефону 855-710-6984. |
| Español<br>Spanish       | Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete comuníquese con el número del Servicio al Cliente que figura en el reverso de su tarjeta de miembro. Si usted no es miembro o no posee una tarjeta, llame al 855-710-6984.                                              |
| Tagalog<br>Tagalog       | Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa numero ng serbisyo para sa kustomer sa likod ng iyong kard ng miyembro. Kung ikaw ay hindi isang miyembro, o kaya ay walang kard, tumawag sa 855-710-6984.                       |
| اردو<br>Urdu             | اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کر رہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، کسٹمر سروس نمبر پر کال کریں جو آپ کے کارڈ کی پشت پر درج ہے۔ اگر آپ ممبر نہیں ہیں، یا آپ کے پاس کارڈ نہیں ہے تو، 855-710-6984 پر کال کریں۔                                                                                    |
| Tiếng Việt<br>Vietnamese | Nếu quý vị hoặc người mà quý vị giúp đỡ có bất kỳ câu hỏi nào, quý vị có quyền được hỗ trợ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với thông dịch viên, gọi số dịch vụ khách hàng nằm ở phía sau thẻ hội viên của quý vị. Nếu quý vị không phải là hội viên hoặc không có thẻ, gọi số 855-710-6984.                                                                     |



**Health care coverage is important for everyone.**

We provide free communication aids and services for anyone with a disability or who needs language assistance.  
We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.

To receive language or communication 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, contact us to file a grievance.

Office of Civil Rights Coordinator  
300 E. Randolph St.  
35th Floor  
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)  
TTY/TDD: 855-661-6965  
Fax: 855-661-6960  
Email: [CivilRightsCoordinator@hcsc.net](mailto:CivilRightsCoordinator@hcsc.net)

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

U.S. Dept. of Health & Human Services  
200 Independence Avenue SW  
Room 509F, HHH Building 1019  
Washington, DC 20201

Phone: 800-368-1019  
TTY/TDD: 800-537-7697  
Complaint Portal: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>  
Complaint Forms: <http://www.hhs.gov/ocr/office/file/index.html>