This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bcbstx.com or by calling 1-800-521-2227.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For In-Network providers **$500** Individual/**$1,000** Family For Out-of-Network providers **$2,500** Individual/**$5,000** Family Services that charge a copay, home health, skilled nursing, hospice, In-Network preventive care and prescription drugs do not apply to the overall deductible. 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** Out-of-Network inpatient admission. 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 **$2,000** Individual/**$4,000** Family For Out-of-Network providers **$6,000** Individual/**$10,000** Family Prescription drug limit: **$4,600** Individual/**$9,200** Family	The **out-of-pocket limit** amount 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?	Out-of-Network deductibles, Out-of-Network copays, premiums, balance-billed charges, preauthorization penalties, and health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Does this plan use a network of providers?	Yes. See www.bcbstx.com or call **1-800-810-2583** for a list of 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**.

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

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

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	50% coinsurance	---none---
	Specialist visit	$35 copay/visit	50% coinsurance	---none---
	Other practitioner office visit	$35 copay/visit	50% coinsurance	Chiropractic services are limited to 10 visits per plan year In- and Out-of-Network.
	Preventive care/screening/immunization	No Charge	50% coinsurance	Deductible waived In-Network. No charge for child immunizations Out-of-Network through the 6th birthday.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	50% coinsurance	Deductible waived In-Network. No charge with office visit copay.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	---none---

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbstx.com	Generic drugs	$10 retail / $20 mail order copay/ prescription	$10 copay/ prescription plus 20% coinsurance	Retail covers a 30 day supply and mail order covers a 90 day supply. With appropriate prescription, up to a 90 day supply is available. A separate prescription drug out-of-pocket limit applies: $4,600 Individual/$9,200 Family Members electing to purchase preferred/non-preferred brand name drugs when a generic equivalent is available, will be required to pay the difference between the cost of the generic and preferred/non-preferred brand name drug plus the preferred brand name drug. Non-Participating mail order is not covered. For Non-Participating pharmacy, member must file claim.
	Preferred brand drugs	$25 retail / $50 mail order copay/ prescription	$25 copay/ prescription plus 20% coinsurance	
	Non-preferred brand drugs	$40 retail / $80 mail order copay/ prescription	$40 copay/ prescription plus 20% coinsurance	
	Specialty drugs	$75 retail copay/ prescription	$75 retail copay/ prescription plus 20% coinsurance	Must be obtained through Prime Specialty Pharmacy. Mail order is not covered. For Non-Participating pharmacy, member must file claim. Specialty medications can be purchased up to a 90 day supply at retail pharmacy
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	---none---
	Physician/surgeon fees	20% coinsurance	50% coinsurance	---none---

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	$125 copay/visit plus 20% coinsurance	$125 copay/visit plus 20% coinsurance	Emergency room copay waived if admitted. If admitted, inpatient hospital expenses will apply.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Ground and air transportation covered.
	Urgent care	$45 copay/visit	50% coinsurance	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	Preauthorization is required; $250 penalty if services are not preauthorized Out-of-Network providers. $500 deductible per admission for Out-of-Network providers.
	Physician/surgeon fee	20% coinsurance	50% coinsurance	---none---
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$20 copay/visit	50% coinsurance	Certain services must be preauthorized, refer to benefits booklet for details.
	Mental/Behavioral health inpatient services	20% coinsurance	50% coinsurance	All services must be preauthorized. $250 penalty if services are not preauthorized Out-of-Network providers. $500 deductible per admission for Out-of-Network providers.
	Substance use disorder outpatient services	$20 copay/visit	50% coinsurance	Certain services must be preauthorized, refer to benefits booklet for details.
	Substance use disorder inpatient services	20% coinsurance	50% coinsurance	All services must be preauthorized. $250 penalty if services are not preauthorized Out-of-Network providers. $500 deductible per admission for Out-of-Network providers.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	$20 copay/visit	50% coinsurance	Copay applies to first prenatal visit (per pregnancy).
	Delivery and all inpatient services	20% coinsurance	50% coinsurance	Preauthorization is required; $250 penalty if services are not preauthorized Out-of-Network providers. $500 deductible per admission for Out-of-Network providers.
If you need help recovering or have other special health needs	Home health care	No Charge	50% coinsurance	Deductible waived In-Network. Preauthorization is required. Limited to 60 visits per plan year.
	Rehabilitation services	$35 copay/visit	50% coinsurance	Limited to 12 visits per plan year. Includes, but not limited to physical, occupational and manipulative therapy.
	Habilitation services	$35 copay/visit	50% coinsurance	
	Skilled nursing care	No Charge	50% coinsurance	Deductible waived In-Network. Preauthorization is required. Limited to 25 days per plan year.
	Durable medical equipment	20% coinsurance	50% coinsurance	---none---
	Hospice service	No Charge	50% coinsurance	Deductible waived In-Network. Preauthorization is required.
If your child needs dental or eye care	Eye exam	$20 copay PCP/ $35 copay SPC	50% coinsurance	---none---
	Glasses	Not Covered	Not Covered	---none---
	Dental check-up	Not Covered	Not Covered	---none---

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- 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)
- Weight loss programs

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

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)	
• Chiropractic care	• Routine eye care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.
For more information on your rights to continue coverage, contact the plan at 1-800-521-2227. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact BlueCross BlueShield of Texas at 1-800-521-2227 or visit www.bcbstx.com, or contact U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your **appeal**. Contact the Texas Department of Insurance's Consumer Health Assistance Program at (855) 839-2427 or visit www.texashealthoptions.com.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-521-2227.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-521-2227.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码**1-800-521-2227.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-521-2227.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,620
- **Patient pays** $1,920

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	$500
Copays	$20
Coinsurance	$1,250
Limits or exclusions	$150
Total	**$1,920**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,070
- **Patient pays** $1,330

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	$500
Copays	$540
Coinsurance	$210
Limits or exclusions	$80
Total	**$1,330**

Note: These examples are based on individual coverage only.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from Out-of-Network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.