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 1-877-278-5214 or at www.bcbstx.com. 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?	In-Network: $400 Individual / $800 Family Non-Network: $500 Individual / $1,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Services that charge a copayment, diagnostic test, and preventive care are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. Per occurrence: $200 In-Network / $400 Non-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.
What is the out-of-pocket limit for this plan?	In-Network: $3,000 Individual / $6,000 Family Non-Network: $15,000 Individual / $30,000 Family For prescription drug coverage, $2,500/individual and $5,000/family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bcbstx.com or call 1-877-278-5214 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use a non-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use a non-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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 (You will pay the least)	Non-Network 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	$25 copayment/visit; deductible does not apply	40% coinsurance after deductible	Virtual visits is a covered benefit only when provided through BCBSTX designated telemedicine provider.**
	Specialist visit	$45 copayment/visit; deductible does not apply	40% coinsurance after deductible	None**
	Preventive care/screening/immunization	No Charge; deductible does not apply	No Charge; deductible does not apply	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. No Charge for child immunizations Non-Network through the 6th birthday.**
If you have a test	Diagnostic test (x-ray, blood work)	No Charge; deductible does not apply	40% coinsurance after deductible	Certain services must be preauthorized; refer to your benefit booklet* for details.**
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	40% coinsurance after deductible	Certain services must be preauthorized; refer to your benefit booklet* for details.**

* For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com.
** The Plan pays based on a percentage of Medicare for Non-Network and Out-of-Network area providers.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Non-specialty drugs	Generic 30% coinsurance (short-term prescription) 25% coinsurance (long-term prescription) Preferred Brand 30% coinsurance (short-term prescription) 25% coinsurance (long-term prescription) Non-preferred Brand 50% coinsurance (short-term and long-term prescriptions)	If using a non-network pharmacy, you pay 100% of the difference between the actual cost and the discounted network cost plus the short-term coinsurance. Claims must be submitted for non-network pharmacies.	**Generic**: Max/prescription: $50 (short-term), $100 (long-term). Short-term covers prescriptions up to 34 days/fill; long-term covers ongoing prescriptions for up to 90 days/fill. Long-term prescriptions are available only at Smart90 pharmacies (CVS, Walgreens, and Express Scripts). After the third time you fill a short-term supply of a long-term medication, you must switch to a long-term prescription with a participating Smart90 pharmacy, or you will pay 100% of the cost. Coverage is based on Express Scripts formulary. **Preferred Brand**: Max/prescription: $125 (short-term), $250 (long-term). Limitations are identical to **generic** drugs (see above). **Non-preferred Brand**: Max/prescription: $200 (short-term), $400 (long-term) Limitations are identical to **generic** drugs (see above).
	Specialty drugs	Generic 30% coinsurance (short-term prescription) 25% coinsurance (long-term prescription) Preferred Brand 30% consurance (short-term prescription) 25% coinsurance (long-term prescription) Non-preferred Brand 50% coinsurance (short-term and long-term prescriptions)		**Generic**: Max/prescription: $100 (short-term), $200 (long-term). Limitations are identical to **generic** drugs (see above). **Preferred Brand**: Max/prescription: $250 (short-term), $500 (long-term). Limitations are identical to **generic** drugs (see above). **Non-preferred Brand**: Max/prescription: $400 (short-term), $800 (long-term). Limitations are identical to **generic** drugs (see above). Certain specialty drugs must be pre-certified and filled by Accredo, Express Scripts specialty pharmacy. Registration may be required to participate in copay assistance programs.

* For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com.
** The Plan pays based on a percentage of Medicare for Non-Network and Out-of-Network area providers.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	40% coinsurance after deductible	None**
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	None**
If you need immediate medical attention	Emergency room care	Facility Charges: $150 copayment/visit plus 20% coinsurance after deductible ER Physician Charges: 20% coinsurance after deductible	Facility Charges: $150 copayment/visit plus 20% coinsurance after deductible ER Physician Charges: 20% coinsurance after deductible	Emergency room copayment waived if admitted. Services provided at Non-Network facilities after stabilization will be covered at the Non-Network level.**
	Emergency medical transportation	20% coinsurance after deductible	20% coinsurance after deductible	Ground and air transportation covered.**
	Urgent care	$45 copayment/visit; deductible does not apply	40% coinsurance after deductible	None**
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	40% coinsurance after deductible	$200 inpatient admission deductible for In-Network providers. $400 inpatient admission deductible for Non-Network providers. Preauthorization is required; $500 penalty if not preauthorized Non-Network.**
	Physician/surgeon fees	20% coinsurance after deductible	40% coinsurance after deductible	None**
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copayment/office visit; deductible does not apply 20% coinsurance for other outpatient services after deductible	40% coinsurance after deductible	Certain services must be preauthorized; refer to your benefit booklet* for details. Virtual visits are available, please refer to your plan policy for more details.**
	Inpatient services	20% coinsurance after deductible	40% coinsurance after deductible	$200 inpatient admission deductible for In-Network providers. $400 inpatient admission deductible for Non-Network providers. Preauthorization is required; $500 penalty if not preauthorized Non-Network.**

* For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com.
** The Plan pays based on a percentage of Medicare for Non-Network and Out-of-Network area providers.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you are pregnant	Office visits	$25 copayment/visit; deductible does not apply	40% coinsurance	Copayment applies to first prenatal visit (per pregnancy). Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).**
	Childbirth/delivery professional services	20% coinsurance after deductible	40% coinsurance after deductible	
	Childbirth/delivery facility services	20% coinsurance after deductible	40% coinsurance after deductible	$200 inpatient admission deductible for In-Network providers. $400 inpatient admission deductible for Non-Network providers. Preauthorization is required; $500 penalty if not preauthorized Non-Network.**
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	40% coinsurance after deductible	Preauthorization is required.**
	Rehabilitation services	$25 Primary Care Provider /$45 Specialist copayment/office visit; deductible does not apply 20% coinsurance after deductible for other outpatient services	40% coinsurance after deductible	Occupational and physical therapy visits are combined at 60 maximum per calendar year. Speech therapy is limited to 30 visits per calendar year. Additional visits may be authorized, if medically necessary.**
	Habilitation services	$25 Primary Care Provider /$45 Specialist copayment/office visit; deductible does not apply 20% coinsurance after deductible for other outpatient services	40% coinsurance after deductible	
	Skilled nursing care	20% coinsurance after deductible	40% coinsurance after deductible	Preauthorization is required.**
	Durable medical equipment	20% coinsurance after deductible	40% coinsurance after deductible	None**
	Hospice services	20% coinsurance after deductible	40% coinsurance after deductible	Preauthorization is required.**

* For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com.
** The Plan pays based on a percentage of Medicare for Non-Network and Out-of-Network area providers.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

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.)

- Cosmetic surgery
- Dental care
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine eye care
- Routine foot care (with the exception of person with diagnosis of diabetes)

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

- Acupuncture
- Bariatric surgery
- Chiropractic care (20 visits per year)
- Hearing aids (1 per ear per 36-month period)
- Infertility treatment (Fertility treatment only when provided through Progyny)
- Private-duty nursing (except for inpatient private duty nursing)
- Weight loss programs (Only through Omada programs, available through the Pharmacy benefit)

* For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com.
** The Plan pays based on a percentage of Medicare for Non-Network and Out-of-Network area providers.

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: For group health coverage contact the plan, Blue Cross and Blue Shield of Texas at 1-877-278-5214 or visit www.bcbstx.com. For group health coverage subject to ERISA, contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. For non-federal governmental group health plans, contact Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law. 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.

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: For group health coverage subject to ERISA: Blue Cross and Blue Shield of Texas at 1-877-278-5214 or visit www.bcbstx.com, the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, and the Texas Department of Insurance, Consumer Protection at 1-800-252-3439 or www.tdi.texas.gov. For non-federal governmental group health plans and church plans that are group health plans, Blue Cross and Blue Shield of Texas at 1-877-278-5214 or www.bcbstx.com or contact the Texas Department of Insurance, Consumer Protection at 1-800-252-3439 or www.tdi.texas.gov. 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.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/tx.html.

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? 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 1-877-278-5214.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-278-5214.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-877-278-5214.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-278-5214.

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	$400
Specialist copayment	$45
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	
Deductibles*	$600
Copayments	$30
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,890**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$400
Specialist copayment	$45
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	
Deductibles	$400
Copayments	$300
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,820**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$400
Specialist copayment	$45
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	
Deductibles	$400
Copayments	$400
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,100**

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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

BlueCross BlueShield of Texas

Health care coverage is important for everyone.

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 talk to an interpreter, call 855-710-6984. 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, sexual orientation, health status or disability. 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, IL 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960

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/smartscreen/main.jsf
Complaint Forms: https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html

	To receive language or communication assistance free of charge, please call us at 855-710-6984.
Español	Llámenos al 855-710-6984 para recibir asistencia lingüística o comunicación en otros formatos sin costo.
العربية	لتلقي المساعدة اللغوية أو التواصل مجانًا، يرجى الاتصال بنا على الرقم 855-710-6984.
繁體中文	如欲獲得免費語言或溝通協助，請撥打855-710-6984與我們聯絡。
Français	Pour bénéficier gratuitement d'une assistance linguistique ou d'une aide à la communication, veuillez nous appeler au 855-710-6984.
Deutsch	Um kostenlose Sprach- oder Kommunikationshilfe zu erhalten, rufen Sie uns bitte unter 855-710-6984 an.
ગુજરાતી	ભાષા અથવા સંચાર સહાય મફતમાં મેળવવા માટે, કૃપા કરીને અમને 855-710-6984 પર કૉલ કરો.
हिंदी	निःशुल्क भाषा या संचार सहायता प्राप्त करने के लिए, कृपया हमें 855-710-6984 पर कॉल करें।
Italiano	Per assistenza gratuita alla lingua o alla comunicazione, chiami il numero 855-710-6984.
한국어	언어 또는 의사소통 지원을 무료로 받으려면 855-710-6984번으로 전화해 주세요.
Navajo	Niná: Doo bilagáana bizaad dinits'á'góó, shá ata' hodooni nínízingo, t'áájíík'eh bee náhaz'á. 1-866-560-4042 jj' hodíilni.
فارسی	برای دریافت کمک زبانی یا ارتباطی رایگان، لطفاً با شماره 855-710-6984 تماس بگیرید.
Polski	Aby uzyskać bezpłatną pomoc językową lub komunikacyjną, prosimy o kontakt pod numerem 855-710-6984.
Русский	Чтобы бесплатно воспользоваться услугами перевода или получить помощь при общении, звоните нам по телефону 855-710-6984.
Tagalog	Para makatanggap ng tulong sa wika o komunikasyon nang walang bayad, pakitawagan kami sa 855-710-6984.
اردو	مفت میں زبان یا مواصلت کی مدد موصول کرنے کے لیے، براہ کرم ہمیں 855-710-6984 پر کال کریں۔
Tiếng Việt	Để được hỗ trợ ngôn ngữ hoặc giao tiếp miễn phí, vui lòng gọi cho chúng tôi theo số 855-710-6984.