


**⚠️ The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit [www.bcbstx.com/member/policy-forms/2023](http://www.bcbstx.com/member/policy-forms/2023) or by calling 1-800-521-2227. 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 <https://www.healthcare.gov/sbc-glossary/> or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	Network: \$3,000 Individual/\$6,000 Family. Out-of-Network: \$5,200 Individual/\$10,400 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>	Doesn't apply to In-Network Preventive Care.	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>	Yes. Network: \$3,000 Individual/\$6,000 Family. Out-of-Network: \$10,400 Individual/\$20,800 Family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services.
<b>What is not included in the out-of-pocket limit?</b>	<u>Preauthorization</u> penalties, <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">www.bcbstx.com</a> or call 1-800-810-2583 for a list of Network Providers.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a referral to see a specialist?</b>	No. You don't need a <u>Referral</u> to see a <u>Specialist</u> .	You can see the <u>specialist</u> you choose without a <u>referral</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
		Network Provider (You will pay the least)	Out-of-Network Provider (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	No charge after <u>Deductible</u>	30% <u>coinsurance</u>	None
	<u>Specialist</u> visit	No charge after <u>Deductible</u>	30% <u>coinsurance</u>	
	Preventive care/screening/immunization	No Charge	30% <u>coinsurance</u>	There is No Charge for Out-of-Network immunizations from birth through the day of the 6th birthday. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your <u>plan</u> will pay for.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	No charge after <u>Deductible</u>	30% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	No charge after <u>Deductible</u>	30% <u>coinsurance</u>	
<b>If you need drugs to treat your illness or condition</b>  More information about <b>prescription drug coverage</b> is available at 1-800-521-2227	Preferred generic drugs	No charge after <u>Deductible</u>	No charge after <u>Deductible</u>	Up to a 90-day supply for generic and brand drugs. Up to a 30-day supply for <u>Specialty Drugs</u> . Certain women's preventive services will be covered with no cost to the member. <u>Cost Sharing</u> for insulin included in the drug list will not exceed \$25 per prescription for a 30-day supply, regardless of the amount or type of insulin needed to fill the prescription.
	Non-preferred generic drugs	No charge after <u>Deductible</u>	No charge after <u>Deductible</u>	
	Preferred brand drugs	No charge after <u>Deductible</u>	No charge after <u>Deductible</u>	
	Non-preferred brand drugs	No charge after <u>Deductible</u>	No charge after <u>Deductible</u>	
	<u>Specialty drugs</u>	No charge after <u>Deductible</u>	No charge after <u>Deductible</u>	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	No charge after <u>Deductible</u>	30% <u>coinsurance</u>	None
	Physician/surgeon fees	No charge after <u>Deductible</u>	30% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	No charge after <u>Deductible</u>	No charge after <u>Deductible</u>	None
	<u>Emergency medical transportation</u>	No charge after <u>Deductible</u>	No charge after <u>Deductible</u>	
	<u>Urgent care</u>	No charge after <u>Deductible</u>	30% <u>coinsurance</u>	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	No charge after <u>Deductible</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> required Out-of-Network; failure to preauthorize at least two business days prior to admission will result in \$250 reduction in benefits.
	Physician/surgeon fees	No charge after <u>Deductible</u>	30% <u>coinsurance</u>	None
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	No charge after <u>Deductible</u>	30% <u>coinsurance</u>	Outpatient: <u>Preauthorization</u> required for psychological testing, neuropsychological testing, electroconvulsive therapy, repetitive transcranial magnetic stimulation, and intensive outpatient treatment; failure to preauthorize at least two business days prior to service will result in 50% reduction in benefits (not to exceed \$500). Inpatient: <u>Preauthorization</u> required Out-of-Network; failure to preauthorize at least two business days prior to admission will result in \$250 reduction in benefits.
	Inpatient services	No charge after <u>Deductible</u>	30% <u>coinsurance</u>	
<b>If you are pregnant</b>	Office visits	No charge after <u>Deductible</u>	30% <u>coinsurance</u>	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge after <u>Deductible</u>	30% <u>coinsurance</u>	
	Childbirth/delivery facility services	No charge after <u>Deductible</u>	30% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		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>	No charge after <u>Deductible</u>	30% <u>coinsurance</u>	60 visit maximum per benefit period. <u>Preauthorization</u> required for Out-of-Network.
	<u>Rehabilitation services</u>	No charge after <u>Deductible</u>	30% <u>coinsurance</u>	For Outpatient, limited to combined 35 visits per year, including Chiropractic.
	<u>Habilitation services</u>	No charge after <u>Deductible</u>	30% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	No charge after <u>Deductible</u>	30% <u>coinsurance</u>	25 day maximum per benefit period. <u>Preauthorization</u> required for Out-of-Network.
	<u>Durable medical equipment</u>	No charge after <u>Deductible</u>	30% <u>coinsurance</u>	None
	<u>Hospice services</u>	No charge after <u>Deductible</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> required for Out-of-Network.
<b>If your child needs dental or eye care</b>	Children's eye exam	Covered	Not Covered	Eye <u>Screenings</u> only. Does not include refractions. One visit per year for members ages 17 and younger.
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	

#### Excluded Services & Other Covered Services:

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

- Abortion
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Private-duty nursing
- Weight loss programs

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

- Chiropractic care
- Hearing aids
- Infertility treatment (Invitro and artificial insemination are not covered unless shown in your plan document)
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult - One visit every two years for members ages 18 and older)
- Routine foot care (Only covered in connection with diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency)

**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 1-800-521-2227 or visit [www.bcbstx.com](http://www.bcbstx.com). You may also contact your state insurance department at 1-800-252-3439 or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/about-ebsa/ask-a-question/ask-ebsa](http://www.dol.gov/ebsa/about-ebsa/ask-a-question/ask-ebsa). 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 OR state health insurance marketplace or SHOP.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: the Claim review section at Blue Cross and Blue Shield of Texas or visit [www.bcbstx.com](http://www.bcbstx.com) or the Texas Department of Insurance, or [www.tdi.texas.gov](http://www.tdi.texas.gov).

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

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

**Does this plan meet the Minimum Value Standards? 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 1-800-521-2227.

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, kwiiijigo holne' 1-800-521-2227.

*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)

■ <b>The plan's overall deductible</b>	\$2,800
■ <b>Specialist</b>	\$0
■ <b>Hospital (facility)</b>	\$0
■ <b>Other</b>	\$0

**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>\$12,700</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
Deductibles	\$2,800
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,860</b>

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

■ <b>The plan's overall deductible</b>	\$2,800
■ <b>Specialist</b>	\$0
■ <b>Hospital (facility)</b>	\$0
■ <b>Other</b>	\$0

**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>\$5,600</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
Deductibles	\$2,800
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,820</b>

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

■ <b>The plan's overall deductible</b>	\$2,800
■ <b>Specialist</b>	\$0
■ <b>Hospital (facility)</b>	\$0
■ <b>Other</b>	\$0

**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>\$2,800</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
Deductibles	\$2,800
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,800</b>

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



**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, sexual orientation, health status 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.  
35<sup>th</sup> Floor  
Chicago, Illinois 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/portal/lobby.jsf>  
Complaint Forms: <http://www.hhs.gov/ocr/office/file/index.html>



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.

Español 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, llame al 855-710-6984.
العربية Arabic	إن كان لديك أو لدى شخص تساعدك أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم فوري، اتصل بلع الرقم 855-710-6984.
繁體中文 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，請撥電話號碼 855-710-6984。
Français 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, appelez 855-710-6984.
Deutsch 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 Nummer 855-710-6984 an.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ.બી.એમ. કાયદેમુબાબતે પ્રશ્ન હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કોલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपके अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनवादक से बात करने के लिए 855-710-6984 पर कॉल करें।
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
Diné Navajo	T'áá ni, éi doodago la'da biká anánilwo'ígíí, na'ídiilkidgo, ts'ídá bee ná ahóótí'í t'áá níik'e níká a'doolwoł dóó bina'ídiilkidígíí bee níł h odoonih. Ata'dahalne'ígíí bich'í' hodiilnih kwe'é 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سوالی 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 شماره 855-710-6984 تماس حاصل نمایید.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiegokolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984.
Русский 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 связаться с переводчиком, позвоните по телефону 855-710-6984.
Tagalog 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 855-710-6984.
اردو 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 اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984.