Coverage Period: 01/01/2023-12/31/2023
Coverage for: Individual/Family | Plan Type: PPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) 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 <u>www.bcbstx.com</u> or by calling 1-855-357-5228. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms see the Glossary. You can view the Glossary at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/ or call 1-800-456-5974 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: \$2,000 Individual / \$4,000 Family Out-of-Network: \$6,000 Individual / \$12,000 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> .
Are there services covered before you meet your deductible?	Yes. Services that charge a copay, prescription drugs, and In-Network diagnostic tests, home health, skilled nursing, and hospice are covered before you meet your deductible.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply.
Are there other deductibles for specific services?	Yes per occurence: \$250 Individual / \$500 Family perscription drug deductible. 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 <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	In-Network: \$5,000 Individual / \$10,000 Family Out-of-Network: \$14,000 Individual / \$28,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the <u>out-of-pocket limit?</u>	<u>Deductibles, premiums, preauthorization</u> penalties, <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> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.bcbstx/com or call 1-855-357-5228 for a list of In-Network providers.	This plan 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 plan pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.

Do you need a <u>referral</u> to	No.	You can see the specialist you choose without a referral.
see a specialist?	INO.	rou can see the <u>specialist</u> you choose without a <u>referral</u> .

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Common	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important
Medical Event		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Information
	Primary care visit to treat an injury or illness	\$35 <u>copay</u> /visit;	30% coinsurance	Virtual visits available through MDLive \$10 copay. In-Network.
If you visit a health	<u>Specialist</u> visit	\$45 <u>copay</u> /visit;	30% coinsurance	None
care <u>provider's</u> office or clinic	Preventive care/screening/ immunization	No Charge;	30% coinsurance	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 Out-of-Network through the 6th birthday.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No Charge;	30% coinsurance	Office visit copay may apply.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	None

Common	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important
Medical Event		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Information
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at: www.mybenefits.org	Tier 1	Retail: \$10 copay / prescription Mail: \$20 copay / prescription;	Total Cost of prescription	Members must meet a separate <u>prescription</u> <u>drug deductible</u> before <u>copay</u> costs apply: \$250 Individual / \$500 Family
	Tier 2	Retail: \$30 copay / prescription Mail: \$60 copay / prescription;	Total Cost of prescription	Retail: one copay per 30-day supply Retail -90: two copays up to 90 day supply Mail: two copays up to 90-day supply. Members electing to purchase brand name drugs when a generic is available will be required to pay the difference between the cost
	Tier 3	Retail: \$50 copay / prescription Mail: \$100 copay / prescription;	Total Cost of prescription	of the Generic drug and Brand Name drug, plus the Brand Name Copayment. Specialty drug prescriptions must be filled through Lumicera Specialty Pharmacy. One copay per 30-day supply.
	Specialty drugs	\$30 / \$50 copay / prescription;	Total Cost of prescription	
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
surgery	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	20% <u>coinsurance</u> after \$500 <u>copay</u> /visit	20% <u>coinsurance</u> after \$500 <u>copay</u> /visit	Copay waived if admitted.
meulcai allention	Emergency medical transportation	20% coinsurance	20% coinsurance	None

Common	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important
Medical Event		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Information
	<u>Urgent care</u>	\$35 / \$45 <u>copay/</u> visit;	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	All services must be preauthorized; \$250 penalty applies. <u>Out-of-Network</u> for failure to preauthorize.
July	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral	Outpatient services	\$35 / \$45 copay / office visit; 20% coinsurance for other outpatient services	30% coinsurance office visit 40% coinsurance for other outpatient services	Limited to 30 visits per plan year. Substance abuse treatment limited to 3 series per lifetime. Certain services must be preauthorized; refer to benefit booklet for details.
health, or substance abuse services	Inpatient services	20% coinsurance	40% coinsurance	Limited to 30 days per plan year. Substance abuse treatment limited to 3 series per lifetime. All services must be preauthorized; \$250 penalty applies Out-of-Network for failure to preauthorize.
If you are pregnant	Office visits	\$35 / \$45 <u>copay</u> / initial visit;	30% coinsurance	20% <u>coinsurance</u> applies after initial visit In- Network. <u>Cost sharing</u> does not apply for preventive services. Depending on the type of services, a <u>copayment</u> , coinsurance, or <u>deductible</u> may apply.
	Childbirth/delivery professional services	20% coinsurance	30% coinsurance	Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	All services must be preauthorized;



Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Information
				\$250 penalty applies <u>Out-of-Network</u> for failure to preauthorize.
	Home health care	No Charge;	30% coinsurance	Limited to 60 visits per <u>plan</u> year. All services must be preauthorized.
	Rehabilitation services	\$35 / \$45 <u>copay</u> / visit;	30% coinsurance	None
If you need help recovering or have other special health needs	Habilitation services	\$35 / \$45 <u>copay</u> / visit;	30% coinsurance	None
	Skilled nursing care	No Charge;	30% coinsurance	Limited to 25 days per plan year. All services must be preauthorized.
	Durable medical equipment	20% coinsurance	40% coinsurance	None
	Hospice services	No Charge;	30% coinsurance	All services must be preauthorized.
	Children's eye exam	No Charge;	30% coinsurance	None
If your child needs dental or eye care	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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)

- Hearing Aids
- Infertility treatment
- Long-term care

- Private-duty nursing
- Routine foot care
- Weight loss programs

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

Chiropractic care

- Non-emergency care when traveling Outside the U.S.
- Routine eye care (Adult)

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 1-855-357-5228, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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. 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 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: Blue Cross Blue Shield of Texas at 1-855-357-5228 or visit www.bcbstx.com, or contact the U.S. Department of Labor's Employee Benefits Security Administrations at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Contact the Texas Department of Insurance at 1-800-252-3439 or visit www.texashealthoptions.com.

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 <u>plan</u> doesn't meet the <u>Minimum Value Standards</u>, you may be eligible for a <u>premium tax credit</u> to help you pay for a <u>plan</u> through the <u>Marketplace</u>.

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-855-357-5228.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-357-5228.]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-357-5228.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-357-5228.]

To see examples of how the 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 <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. 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>	\$1,000
■ Specialist copayment	\$40
■ 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)

in this example, Peg would pay:			
Cost Sharing			
Deductibles	\$1,000		
Copayments	\$30		
Coinsurance	\$1,000		
What isn't covered			
Limits or exclusions	\$60		
The total Peg would pay is	\$2,090		

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>	\$1,000
Specialist copayment	\$40
■ 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 \$7,400

In this example, Joe would pay:

Cost Sharing		
Deductibles	\$1,250	
Copayments	\$700	
Coinsurance	\$20	
What isn't covered		
Limits or exclusions	\$60	
The total Joe would pay is	\$2,030	

Mia's Simple Fracture

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

■ The plan's overall deductible	\$1,000
Specialist copayment	\$40
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	\$1,900
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$900
Copayments	\$800
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,700

Note: These numbers assume the patient does not participate in the <u>plan's</u> wellness program. If you participate in the <u>plan's</u> wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact:1-855-357-5228.

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

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.

ةيبرحلا Arabic	إ ناك كثيدا وأ ندل صخش هدعاسة قانساً، كثيدلف ق حلا في لوصحاا على قدعاسما تامولعمالو قميرورضاا كتغلب ن منود قيا تكلفة. ثدحتال يهلإ مجرته يروف، لصنا على مقر قمدخ علامعاا روكذماا على ريهظ قفاطبه كتيوضع. نإفر مل نكذ عضاؤ، وأ تنذك لا كنامة قفاطبه لصناف على 6984-710-855.
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 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 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.
�જુ ૨ાતી Gujarati	જો તમને અથવા તમે મદદ કર¢ રહ્યા હોય એવી કોઈ બી� વ્ય¢ક્તને એસ.બી.એમ. ૄુ ભાિષયા સાથે વાત કરવા માંઢ, તમારા સભ્યપદના કાડર્ની પાછળ આપેલ ગ્રાહક સેવા નબ્ર ૨ પર કૉલ કરો. જો આપ સભ્યપદ ના ધરાવતા હોવ, અથવા આપની પાસે કાડર્ નથી તો 855-710-6984 નબ્ર ૨ પર કૉલ કરો.
♦ह ंद ♦ Hindi	य�द आपके, या आप िजसक� सहायता कर रहे 🕫 उसके, प्रश्न 🐌, तो आपको अपनी भाषा म� �नःशुल्क सहायता और जानकार� प्राप्त करने का अ�धकार हैं। �कसी अनुवादक से बात करने के �लए, अपने सदस्य काडर् के पीछे �दए गए ग्राहक सेवा नंबर पर कॉल कर�। य�द आप सदस्य नह�ं ॎ३, या आपके पास काडर् नह�ं हैं, तो 855-710-6984 पर कॉल कर�।
日本語 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 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 회원 카드 뒷면에 있는고객 서비스 번호로 전화하십시오. 회원이 아니시거나 카드가 없으시면 855-710-6984 으로 전화주십시오.
ພາສາລາວ Laotian	ຖ້ າທ່ານ ືຫຼ ຄຸ່ນວິທທ່ານກຳລັງໃຫ້ ການຊ່ວຍເຫຼອວີມໍຄາຖາມ, ທ່ານວີມວິສດໍຂເວືອາການຊ່ວຍເຫຼອ ແລະ ໍຂມູນເປັນນພາສາຂອງທ່ານໄດ້ ໂດຍໍບວີມຄ່າໃຊ້ຈ່າຍ. ເພື່ອສົມກັບນາຍແປພາສາ, ໃຫ້ ໂທຫາເວີບຜ່າຍໍບວິລ ການລຸກຄ້າວິທວີ່ນຢູ່ ດ້ານຫຼັງທັດສະມາວິຊກຂອງທ່ານ. ຖ້າທ່ານໍບແມ່ນສະມາວິຊກ, ວືຫຼຸ່ບວີມທັດ, ໃຫ້ ໂທຫາເວີບ 855-710-6984.
Diné Navajo	T'11 ni, 47 doodago [a'da b7k1 an1n7lwo'7g77, na'7d7[kidgo, ts'7d1 bee n1 ah00ti'i' t'11 n77k'e n7k1 a'doolwo[. Ata' halne'7 bich'8' hadeesdzih n7n7zingo 47 kwe'4 da'7n7ishgi 1k1 an7daalwo'7g77 bich'8' hod77lnih, bee n44h0zinii bine'd66' bik11'. Koj7 atah naaltsoos n1 had7t'44g00 47 doodago bee n44h0zin7g77 1dingo koj8' hod77lnih 855-710-6984.
ىسرىاف Persian	رگا امش، به شما که کسی یا وا می کمک دینک، ملاؤسه فتشاد دیشاب، ق حنیا از دیراد به که نابز دوخ، به روطناگیار کمک و تاعلاطا تخایر د دییامذ. تهج و گتفگیک با مجرتمی هافش، با تنامدخیر تشم به هر امش یا که رد تشپرتراک تیوضدع دیرادن، هراشم با 898-710-855 سامة لیصاح دییامذ.
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 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 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 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 tagasalinwika, 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.
ودرا Urdu	ں پرکارگا پا وک کسی یا سےسیا درفوک سجکی پا ددم ہے ہررکا رہیں، کیئوکا لاوس شریپرد ہے وت، پا وکا کینپا نابنر رہیم تعدددہ روا تنامولعہ لصاح نےنرکاکا قح ہے مجرتہ سے تنابر نےنرکاکے بے یا، رمٹسکہ سورسار بمذرپال ایک رہیر کا بیا ہے تو کہ کی تشہر رپا جرد ہے بارگا پا ربمہ رہید یا پاکے سالیا ٹراک رہید ہے وت، 10-6984 رپالکا
Tiếng Việt 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 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 Phone: 855-664-7270 (voicemail)

300 E. Randolph St. TTY/TDD: 855-661-6965 35th Floor Fax: 855-661-6960

Chicago, Illinois 60601 Email: <u>CivilRightsCoordinator@hcsc.net</u>

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 Phone: 800-368-1019 200 Independence Avenue SW TTY/TDD: 800-537-7697

Room 509F, HHH Building 1019 Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Washington, DC 20201 Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html