SAN BENITO CONSOLIDATED INDEPENDENT SCHOOL DISTRICT

Self-Funded Medical, Pharmacy, Stop Loss Plan, and Fully Insured Medical Plans
(Proposal # RFP-0426-EHBHP)

PLAN DOCUMENTS AND RATES

BlueCross BlueShield of Texas

APPLICATION AND POLICY SCHEDULE FOR STOP LOSS COVERAGE

Employer Group Name: San Benito Consolidated Independent School District
Employer Group Address: 240 North Crocket Street
City: San Benito **State of Situs:** Texas **Zip Code:** 78586
Account Number: 300195
Employer Group Number(s): 300195, 433678
Original Effective Date of Stop Loss Policy 10/01/2025
Current Policy Effective Date: 10/01/2025
Current Policy Period The specifications set forth in this Application are for the Policy Period commencing on 10/01/2025 and ending on 09/30/2026.

The specifications below shall become effective on the first date of the Policy Period specified above and shall continue in full force and effect until the earliest of the following dates: (1) The last day of the Policy Period; (2) The date the Policy terminates; or (3) The date this Application is superseded in whole or in part by a later executed Application.

A. Covered Employees:
Number of Single Coverage Units: _____
Number of Family Coverage Units: _____

B. Individual Stop Loss Coverage:

1. New Coverage ☒ Renewal of Existing Coverage ☐

2. Stop Loss coverage during the Current Policy Period

   ☒ **[Paid]**
   Coverage for Claims incurred from 10/01/2020 to 09/30/2026 and Claims paid from 10/01/2025 to 09/30/2026.

   If a run-in contract is selected, Employer Group understands that run-out coverage is not included, and Employer Group represents that it intends to purchase run-in coverage from its next carrier.

   For new coverage only, if a run-in contract as explained in the Stop Loss Policy is purchased, claims paid by the Employer Group's prior claim administrator will be settled at the time of the annual stop loss settlement and must be reported by the Employer Group to the Company (Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company) by the end of the Employer Group's Current Policy Period or stop loss coverage for these run-in claims will be forfeited.

   ☐ (Paid Renewal Only) Claim Administrators Claims: Claims incurred on or after the Original Effective Date of Policy and paid during the Policy Period.

3. Covered Expenses includes:

   ☒ Medical Claims:
   ☒ Prescription Drug Claims with: Prime (Preferred PBM) _____
   ☐ For **Hospital Employer Groups only:** Excludes _____% of Home Hospital Medical claims
   ☐ Other (for example Dental/Vision): _____.

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4. Individual Stop Loss Provisions

a. Individual Stop Loss Deductible: $195,000
Applies per Covered Person for the Employer Group's Current Policy Period.

b. Aggregating Specific Deductible (if applicable): $_____

c. Lasered Individuals with Individual Stop Loss Deductible (if applicable):
Individual identifier, alternate Individual Stop Loss Deductible: $_____

d. Lasered Individuals excluded from Stop Loss Coverage (if applicable):
Individual identifier:
_____

e. If a run-in contract is purchased, per Item 2. above, run-in claims are covered with a maximum liability of: $_____ per Covered Person.

5. Terminal Liability Option (TLO) (does not apply to Employer Groups with Run-Out contracts):
☐ Yes ☒ No

The following applies if the answer to item above is "Yes" (Terminal Liability Option):

Must be elected at Policy inception or renewal. Premium cost is calculated by taking the average enrollment for the last two months of the Current Policy Period multiplied by three times pre-termination Individual Stop Loss rate(s). Premium is due at the time of termination, payable by lump sum within 10 days of receipt of bill. Claims will accumulate and be combined under one Individual Stop Loss Deductible specified in item B.4.a above for the Current Policy Period and Terminal Period. The Settlement for the Final Accounting Period will be described in the section of the Policy entitled SETTLEMENTS.

6. Individual Stop Loss Premium
Monthly Individual Stop Loss Premium shall be equal to the amounts obtained by multiplying the number of Covered Employees for a particular Month by:

$106.53 Composite; or
$_____for each Single Coverage Unit
$_____ for each Family Coverage Unit

C. **Aggregate Stop Loss Coverage**: Yes ☒ No ☐
If yes, complete Items 1. through 5. Below:

1. New Coverage ☒ Renewal of Existing Coverage ☐

2. Stop Loss Coverage during the current Policy Period

☒ **[Paid]**
Coverage for Claims incurred from 10/01/2020 to 09/30/2026 and Claims paid from 10/01/2025 to 09/30/2026.

If a run-in contract is selected, Employer Group understands that run-out coverage is not included, and Employer Group represents that it intends to purchase run-in coverage from its next carrier.

For new coverage only, if a run-in contract as explained in the policy is purchased, claims paid by the Employer Group's prior claim administrator will be settled at the time of the annual stop loss settlement and must be reported by the Employer Group to the Company (Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company) by the end of the Employer Group's Current Policy Period or stop loss coverage for these run-in claims will be forfeited.

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☐ (Paid Renewal Only) Claim Administrators Claims: Claims incurred on or after the Original Effective Date of Policy and paid during the Policy Period.

3. Covered Expenses:

   ☒ Medical Claims
      ☒ Claim Administrator's Provider Access Fees
   ☒ Prescription Drug Claims with: Prime (Preferred PBM) _____
   ☐ For **Hospital Employer Groups only:** Excludes _____% of Home Hospital Medical claims
   ☐ Other (for example Dental/Vision): _____

4. Aggregate Claim Liability

   a. Attachment Factor 125% of the Average Claim Value
   b. Aggregate Claim Factors:

Group Number:	300195			
Composite; or	$ 919.43	$	$	$
For each Single Coverage Unit	$	$	$	$
For each Family Coverage Unit	$	$	$	$

   c. Minimum Aggregate Point of Attachment: $13,454,865

5. Terminal Liability Option (TLO) (does not apply to Employer Groups with Run-Out contracts):
   ☐ Yes ☒ No

   The following applies if the answer to item above is "Yes" (Terminal Liability Option):

   Must be elected at Policy inception or renewal. Premium cost is calculated by taking the average enrollment for the last two months multiplied by three times pre-termination Aggregate Stop Loss rate(s). Premium is due at the time of termination, payable by lump sum within 10 days of receipt of bill.

   The Final Settlement Point of Attachment shall equal the sum of the Employer's Aggregate Claim Liability amount for the Policy Period plus 15% of the Aggregate Claim Factor multiplied by 12, and then multiplied by the average enrollment for the last two (2) months of the Current Policy Period immediately preceding termination. Furthermore, for the Final Settlement Period, the Minimum Aggregate Point of Attachment shall be the Minimum Aggregate Point of Attachment in item C.4.c. above increased by 15%. The Settlement for the Final Accounting Period will be described in the section of the Policy entitled SETTLEMENTS.

6. Aggregate Stop Loss Premium:
   ☒ Monthly Premium
   Monthly Aggregate Stop Loss Premium shall be equal to the amounts obtained by multiplying the number of Covered Employees for a particular Month by:
      $1.01 Composite; or
      $_____ for each Single Coverage Unit
      $_____ for each Family Coverage Unit

   ☐ Annual Premium (Due on the first day of the Current Policy Period): $_____

D. Additional Provisions (if elected):

1. Retirees Covered (select if included):
   Pre-65: ☐ or Post-65: ☐

2. Home Hospital Employer Groups Only: Home Hospital Provider Number(s) subject to exclusion percentage per Item B.3. & C.3.: _____

3. Monthly Aggregate Accommodation: ☐ Yes ☒ No

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4. Additional information: San Benito CISD is adding ISL and ASL effective 10/01/2025, fees include commissions of 5%. Stop Loss Includes Gene Therapy protection. BCBSTX will provide a one-time transiton credit of $100,000 for the twelve-month period beginning on the Contract Effective Date, 10/01/2025 to be used to cover costs and expenses associated with transitioning medical, stop loss, presctiption, ancillary health or other coverage to BCBSTX and/or cost and expenses associated with transitioning to a new product design with BSBSTX. [For ERISA plans: Employer is accepting the transiton credit on behalf of the ERISA plan. Employer hereby certifies that it will only use it for purposes consistent with the administration of the plan.] If Employer cancels before the expiration of the policy period 09/30/2026, Employer will be responsible for refunding to BCBSTX the full amount of the transiton credit.

Fraud Notice: Any person who knowingly, with intent to injure, defraud or deceive any insurance company submits an application containing any false, incomplete, or misleading information, may be subject to prosecution and may be found guilty of a felony under state law and subject to punishment, including fines and/or imprisonment. Submission of false information in connection with this application may also constitute a crime under federal laws. All appropriate legal remedies will be pursued in the event of insurance fraud, including prosecution under Federal Mail or Wire Fraud statutes, and/ or the Federal Racketeer Influenced and Corrupt Organizations Act. Any false statements made herein may be reported to state and federal tax and regulatory authorities as is appropriate.

The undersigned person represents that he/she is authorized and responsible for purchasing Stop Loss Coverage on behalf of the Employer Group. It is understood that the actual terms and conditions of coverage are those contained in this Application and the Stop Loss Coverage Policy into which this Application shall be incorporated at the time of acceptance by Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company ("HCSC"). Upon acceptance, HCSC shall issue a Stop Loss Coverage Policy to the Employer Group. Upon acceptance of this Application and issuance of the Stop Loss Coverage Policy, the Employer Group shall be referred to as the "Policyholder".

Tita Iruegas, Lead Account Executive
Sales Representative

Signature of Authorized Purchaser

Superintendent
Title of Authorized Purchaser

10/06/2025
Date

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Benefit Program Application ("ASO BPA")

Application to Administrative Services Only (ASO) Group Accounts

administered by Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association, hereinafter referred to as the "Claim Administrator" or "BCBSTX"

Group Status: Renewing ASO Account

Employer Account Number (6-digits): 300195 Group Number(s): 300195, 433678

Section Number(s): All

Legal Employer Name: San Benito Consolidated Independent School District

(Specify the Employer or the employee trust applying for coverage. Names of subsidiary or affiliated companies to be covered must also be named below. AN EMPLOYEE BENEFIT PLAN *MAY NOT* BE NAMED)

ERISA Regulated Group Health Plan*: ☐ Yes ☒ No

Is your ERISA Plan Year* a period of 12 months beginning on the Effective Date of Coverage specified below? ☒Yes

If not, please specify your ERISA Plan Year*: Beginning Date __/__/__ End Date __/__/__ (month/day/year)

ERISA Plan Administrator*: N/A

Plan Administrator's Address: N/A

If you maintain that ERISA is not applicable to your group health plan, give legal reason for exemption:
Non-Federal - School District ; if applicable, specify other: _____

Is your Non-ERISA Plan Year* a period of 12 months beginning on the Anniversary Date specified below? ☒Yes

If not, please specify your Non-ERISA Plan Year*: Beginning Date __/__/__ End Date __/__/__ (month/day/year)

For more information regarding ERISA, contact your Legal Advisor.

*All as defined by ERISA and/or other applicable law/regulations

Effective Date of Coverage: (Month/day/Year) 10 / 01 / 2025

Anniversary Date: (Month/Day/Year) 10 / 01 / 2026

Retiree-Only Plan(s) Identification:
For more information regarding Retiree-only plans, contact your Legal Advisor.

Do you have one or more Retiree-only plan(s)? ☐ Yes ☒ No

If yes, please provide Benefit Agreement number, or group and section numbers of the Retiree-only plan(s):
_____

Account Information	☒ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS	
Standard Industry Code (SIC): _____	Employer Identification Number (EIN): _____	
Address: _____		
City: _____	State: _____	ZIP: _____
Administrative Contact: _____	Title: _____	
Email Address: _____	Phone Number: _____	Fax Number: _____
☐ Mailing address is different from primary address		
Mailing Address: _____		
City: _____	State: _____	ZIP: _____
Mailing Contact: _____	Title: _____	
Email Address: _____	Phone Number: _____	Fax Number: _____
☐ Billing address is different from primary address		
Billing Address: _____		
City: _____	State: _____	ZIP: _____

Proprietary and Confidential Information of Claim Administrator
Not for use or disclosure outside Claim Administrator, Employer, their respective affiliated companies and third-party representatives, except with written permission of Claim Administrator.

Lines of Business (Check all applicable services) ☐ NO CHANGES ☐ See *Additional Provisions*

Medical Plan Services:

☒ PPO: Plan Name: BA0001

PPO Base Plan

Plan Name: BA0003

PPO Buy Up Plan

Plan Name: _____

Plan Name: _____

Plan Name: _____

☒ HMO: Plan Name: BA0006

HMO Plan

☐ Prescription Drug Option: Select From List

☐ No Prescription Drug Option

☐ Blue High Performance Network℠ (BlueHPN℠)

☐ EPO: Plan Name: _____

☐ POS: Plan Name: _____

Additional Services:

☒ Wellbeing Management

☐ Wellness Incentives

☐ Health Advocacy Solutions

☐ Mercer Health Advantage

☐ Custom Care Management Unit

☐ Blue Directions℠ (Private Exchange) *(If selected, the Blue Directions Addendum must be attached and made a part of the parties' Administrative Services Agreement.)*

☐ In-Hospital Indemnity (IHI)

☐ Limited Fiduciary Services for Claims and Appeals

☐ Other Select Product

☐ Other Select Product

☐ Other

☐ Other

Consumer Driven Health Plan

☐ BlueEdge℠ HCA, (*if selected, complete separate HCA Benefit Program Application*)

☐ BlueEdge℠ HSA, (Preferred Vendor: Select Vendor)* If HealthEquity, Inc. is selected, BCBSTX to send HSA enrollment to HealthEquity, Inc☐ Yes ☐ No Non-Preferred Vendor:

☐ FSA (Preferred Vendor: Select Vendor)* Non-Preferred Vendor:

☐ HRA (Preferred Vendor: Select Vendor)* Non-Preferred Vendor:

Traditional Coverage:

☐ Out-of-Area (Indemnity)

☐ Benefit Offering

Prescription Drugs:

☒ *(If selected, the PBM Fee Schedule Addendum must be attached and is part of this BPA.)*

Pharmacy Network (Select one):

- ☒ Traditional Select Network
- ☐ Advantage Network
- ☐ Preferred Network
- ☐ Elite Network
- ☐ Network on PBM Fee Schedule Addendum
- ☐ Other (please specify):

Drug List: Balanced Drug List

Other (please specify):

PPO/HSA Preventive Drug List:
Please specify: Select Option

Other Rx programs:
Please specify: Select Program

Ancillary Services:

☐ Vision Insurance *(if selected, complete a separate application)*

☒ Stop Loss Coverage (*If selected, complete separate Application and Policy Schedule for Stop Loss Coverage*)

☐ Life, Disability, Specified Disease, Accident or Hospital Indemnity Insurance (*If selected, complete a separate application for those coverages*)

☐ COBRA Administrative Services (*If selected, complete separate HCSC COBRA Administrative Services Addendum)*

☐ Dental Plan Services

Plan Name: _____ Select From List

*An HSA must be paired with a qualified high deductible health plan (HDHP) and follow strict requirements set forth by the Internal Revenue Service (IRS). Employer Groups should seek advice from their independent tax advisor, legal counsel, or other professional counselor, to ensure their proposed benefit strategy with respect to HSAs, FSAs, HRAs, or other benefit arrangements does not conflict with current IRS requirements.

Mercer Health Advantage is offered by Mercer, an independent company, and is administered by Blue Cross and Blue Shield of Texas.

Custom Care Management Unit is offered by Willis Towers Watson, an independent company, and is administered by Blue Cross and Blue Shield of Texas.

Medical and Dental benefits and services are administered by Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

Life, Disability, Specified Disease, Accident, Hospital Indemnity and Vision Insurance is underwritten by Dearborn Life Insurance Company, 701 E. 22nd St. Suite 300, Lombard, IL 60148. Blue Cross and Blue Shield of Texas is the trade name of Dearborn Life Insurance Company, an independent licensee of the Blue Cross and Blue Shield Association. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

Proprietary and Confidential Information of Claim Administrator
Not for use or disclosure outside Claim Administrator, Employer, their respective affiliated companies and third-party representatives, except with written permission of Claim Administrator.

FEE SCHEDULE

Employer shall pay amounts Claim Administrator bills Employer for benefit claims Claim Administrator processes on Employer's behalf as well as administrative fees as set forth in this Fee Schedule.

Payment Specifications

☒ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS

Employer Payment Method: ☐ **Online Bill Pay** **O Electronic** ☐ **Auto Debit** ☐ **Check**

Employer Payment Period: C| **Weekly** (cannot be selected if Check is selected as payment method above)

☐ **Semi Monthly** (cannot be selected if Check is selected as payment method above)

☐ **Monthly**

Claim Settlement Period: ☐ **Weekly** ☐ **Monthly**

Run-Off Period: Employer Payments are to be made for _____ months following the end of the Fee Schedule Period. *Standard is twelve (12) months.*

Fee Schedule Period: To begin on Effective Date of Coverage and continue for 12 months. If other than 12 months, please specify: months.

Administrative Per Employee per Month (PEPM) Charges

☐ NO CHANGES ☐ SEE ADDITIONAL PROVISIONS

	10/01/2025	10/01/2026		
Administrative Fee	$38.30	$39.83	$____	$____
Dental	$____	$____	$____	$____
Claims Fiduciary	$1.00	$tbd	$____	$____
Advanced Payment Review	25% $	tbd% $	% $	% $
*Medical Drug Rebate Credit	$(XX)	$(tbd)	$(____1	$(____1
'Rebate Credit for the Prescription Drug Program	$(XX)	$(tbd)	$(____1	$(____1
Telehealth (Virtual Visits)	$0.52	$tbd	$____	$____
Wellbeing Management	$5.85	$tbd	$____	$____
Health Advocacy Solutions	$____	$____	$____	$____
Commissions: _____	$2.50	Stbd	$____	$____
Commissions: _____	$____	$____	$____	$____
Commissions: _____	$____	$____	$____	$____
Other: Select Service Category List Service: _____	$____	Stbd	$____	$____
Other: Select Service Category List Service:	$____	$____	$____	$____
Other: Select Service Category List Service: _____	$____	$____	$____	$____
Miscellaneous: _____	$____	$____	$____	$____
Miscellaneous: _____	$____	$____	$____	$____
Total	$(____	Stbd	$____	$____

Proprietary and Confidential Information of Claim Administrator
Not for use or disclosure outside Claim Administrator, Employer, their respective affiliated companies and third-party representatives, except with written permission of Claim Administrator.

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 1-877-299-2377 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?	$5,000 Individual / $10,000 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, prescription drugs, emergency room services, diagnostic test, and certain 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. $100 Individual prescription 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 out-of-pocket limit for this plan?	$7,500 Individual / $15,000 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 1-800-810-2583 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 an out-of-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 an out-of-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?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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)	Out-of-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	$40 copayment/visit; deductible does not apply	Not Covered	Virtual visits are available, please refer to your plan policy for more details.
	Specialist visit	$100 copayment/visit; deductible does not apply	Not Covered	Referral required.
	Preventive care/screening/ immunization	No Charge; deductible does not apply	Not Covered	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.
If you have a test	Diagnostic test (x-ray, blood work)	$40 copayment/visit; deductible does not apply	Not Covered	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance	Not Covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbstx.com	Generic drugs	No Charge; deductible does not apply	Not Covered	Prescription drug deductible: $100 Individual. Retail covers a 30-day supply. With appropriate prescription, up to a 90-day supply is available. Mail order covers a 90-day supply. Payment of the difference between the cost of a brand name drug and a generic may be required if a generic drug is available.
	Preferred brand drugs	$50 retail/$125 mail order copayment/prescription	Not Covered	
	Non-preferred brand drugs	$100 retail/$250 mail order copayment/prescription	Not Covered	
	Specialty drugs	50% coinsurance	Not Covered	Specialty drugs must be obtained from In-Network specialty pharmacy provider. Specialty retail limited to a 30-day supply. Mail order is not covered.

* For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com.

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)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	Not Covered	None
	Physician/surgeon fees	30% coinsurance	Not Covered	None
If you need immediate medical attention	Emergency room care	Facility Charges: $250 copayment/visit; deductible does not apply ER Physician Charges: 30% coinsurance	Facility Charges: $250 copayment/visit; deductible does not apply ER Physician Charges: 30% coinsurance	Emergency room copayment waived if admitted.
	Emergency medical transportation	30% coinsurance	30% coinsurance	Ground and air transportation covered.
	Urgent care	$50 copayment/visit; deductible does not apply	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	Not Covered	None
	Physician/surgeon fees	30% coinsurance	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$40 copayment/visit; deductible does not apply 30% coinsurance for other outpatient services	Not Covered	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	30% coinsurance	Not Covered	None
If you are pregnant	Office visits	$40 PCP/$100 SPC copayment/visit; deductible does not apply	Not Covered	Copayment applies to first prenatal visit (per pregnancy). Cost sharing does not apply for preventive services. Depending on the type of services, 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	30% coinsurance	Not Covered	
	Childbirth/delivery facility services	30% coinsurance	Not Covered	None

* For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com.

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)	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	Not Covered	Preauthorization is required.
	Rehabilitation services	$40 PCP/$100 SPC copayment/visit; deductible does not apply 30% coinsurance for other inpatient and outpatient services	Not Covered	None
	Habilitation services	$40 PCP/$100 SPC copayment/visit; deductible does not apply 30% coinsurance for other inpatient and outpatient services	Not Covered	
	Skilled nursing care	30% coinsurance	Not Covered	Limited to 60 days per calendar year. Preauthorization is required.
	Durable medical equipment	30% coinsurance	Not Covered	None
	Hospice services	30% coinsurance	Not Covered	None
If your child needs dental or eye care	Children's eye exam	$40 PCP/$100 SPC copayment/visit; deductible does not apply	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.)

- Acupuncture
- Bariatric surgery
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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 plan document.)

- Chiropractic care (limited to 35 visits per calendar year)
- Cosmetic surgery (limited coverage)
- Dental care (Adult, limited coverage)
- Hearing aids (1 per ear per 36-month period)
- Infertility treatment (diagnosis of infertility covered; invitro not covered.)
- Routine eye care (Adult)

* For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com.

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 1-877-299-2377 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.

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Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$5,000
Specialist copayment	$100
Hospital (facility) coinsurance	30%
Other coinsurance	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)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$5,000
Copayments	$500
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$7,460**

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

The plan's overall deductible	$5,000
Specialist copayment	$100
Hospital (facility) coinsurance	30%
Other coinsurance	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)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$900
Copayments	$1,300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,220**

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

The plan's overall deductible	$5,000
Specialist copayment	$100
Hospital (facility) coinsurance	30%
Other coinsurance	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)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,700
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,400**

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

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Room 509F, HHH Building 1019
Washington, DC 20201

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TTY/TDD: 800-537-7697
Complaint Portal: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf
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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.

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 1-800-521-2227 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: $5,000 Individual / $10,000 Family Out-of-Network: $10,000 Individual / $20,000 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, prescription drugs, emergency room services, and certain preventive care, and diagnostic test 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. $100 Individual prescription 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 out-of-pocket limit for this plan?	In-Network: $7,500 Individual / $15,000 Family Out-of-Network: $20,000 Individual / $40,000 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, 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.
Will you pay less if you use a network provider?	Yes. See www.bcbstx.com or call 1-800-810-2583 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 an out-of-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 an out-of-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)	Out-of-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	$40 copayment/visit; deductible does not apply	30% coinsurance	Virtual visits are available, please refer to your plan policy for more details.
	Specialist visit	$100 copayment/visit; deductible does not apply	30% coinsurance	None
	Preventive care/screening/ immunization	No Charge; deductible does not apply	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	Diagnostic test (x-ray, blood work)	$40 copayment/visit; deductible does not apply	30% coinsurance	Office visit copayment may apply.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbstx.com	Generic drugs	No Charge; deductible does not apply	No Charge; deductible does not apply	Prescription drug deductible: $100 Individual Retail covers a 30-day supply. With appropriate prescription, up to a 90-day supply is available. Mail order covers a 90-day supply. Out-of-Network mail order is not covered. Payment of the difference between the cost of a brand name drug and a generic may be required if a generic drug is available. For Out-of-Network pharmacy, member must file claim.
	Preferred brand drugs	$50 retail/$125 mail order copayment/prescription	$50 copayment/prescription	
	Non-preferred brand drugs	$100 retail/$250 mail order copayment/prescription	$100 copayment/prescription	
	Specialty drugs	50% coinsurance	Not Covered	Specialty drugs must be obtained from In-Network specialty pharmacy provider. Specialty retail limited to a 30-day supply. Mail order is not covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	None
	Physician/surgeon fees	30% coinsurance	50% coinsurance	None

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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)	
If you need immediate medical attention	Emergency room care	Facility Charges: $250 copayment/visit plus 30% coinsurance; deductible does not apply ER Physician Charges: 30% coinsurance	Facility Charges: $250 copayment/visit plus 30% coinsurance; deductible does not apply ER Physician Charges: 30% coinsurance	Emergency room copayment waived if admitted.
	Emergency medical transportation	30% coinsurance	30% coinsurance	Ground and air transportation covered.
	Urgent care	$50 copayment/visit; deductible does not apply	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	Preauthorization is required; $250 penalty if not preauthorized Out-of-Network.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$40 copayment/office visit; deductible does not apply 30% coinsurance for other outpatient services	30% coinsurance for office visit 50% coinsurance for other outpatient services	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	30% coinsurance	50% coinsurance	Preauthorization is required; $250 penalty if not preauthorized Out-of-Network.
If you are pregnant	Office visits	$40 PCP/$100 SPC copayment/visit; deductible does not apply	30% 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	30% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	Preauthorization is required; $250 penalty if not preauthorized Out-of-Network.

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		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	Limited to 60 visits per calendar year. Preauthorization is required.
	Rehabilitation services	$40 PCP/$100 SPC copayment/visit; deductible does not apply 30% coinsurance for other outpatient services	30% coinsurance for office visit 50% coinsurance for other outpatient services	None
	Habilitation services	$40 PCP/$100 SPC copayment/visit; deductible does not apply 30% coinsurance for other outpatient services	30% coinsurance for office visit 50% coinsurance for other outpatient services	
	Skilled nursing care	30% coinsurance	50% coinsurance	Limited to 60 days per calendar year. Preauthorization is required.
	Durable medical equipment	30% coinsurance	50% coinsurance	None
	Hospice services	30% coinsurance	50% coinsurance	Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	$40 PCP/$100 SPC copayment/visit; deductible does not apply	30% coinsurance	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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment (diagnosis of infertility covered)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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 plan document.)

- Chiropractic care (limited to 35 visits per calendar year)
- Hearing aids (limited to 1 per ear per 36-month period)
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Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

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Deductibles	$5,000
Copayments	$500
Coinsurance	$1,900
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Limits or exclusions	$60
The total Peg would pay is	**$7,460**

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

The plan's overall deductible	**$5,000**
Specialist copayment	**$100**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**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)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$900
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Coinsurance	$0
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Limits or exclusions	$20
The total Joe would pay is	**$2,220**

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

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Specialist copayment	**$100**
Hospital (facility) coinsurance	**30%**
Other coinsurance	**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)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,800
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,500**

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

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Room 509F, HHH Building 1019
Washington, DC 20201

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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

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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 1-800-521-2227 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: $2,000 Individual / $5,500 Family Out-of-Network: $3,000 Individual / $9,000 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, prescription drugs, emergency room services, and certain preventive care, and diagnostic test 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. $100 Individual prescription 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 out-of-pocket limit for this plan?	In-Network: $5,000 Individual / $13,000 Family Out-of-Network: $16,800 Individual / $33,600 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, 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.
Will you pay less if you use a network provider?	Yes. See www.bcbstx.com or call 1-800-810-2583 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 an out-of-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 an out-of-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)	Out-of-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	$30 copayment/visit; deductible does not apply	30% coinsurance	Virtual visits are available, please refer to your plan policy for more details.
	Specialist visit	$45 copayment/visit; deductible does not apply	30% coinsurance	None
	Preventive care/screening/ immunization	No Charge; deductible does not apply	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	Diagnostic test (x-ray, blood work)	$40 copayment/visit; deductible does not apply	30% coinsurance	Office visit copayment may apply.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	50% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbstx.com	Generic drugs	No Charge; deductible does not apply	No Charge; deductible does not apply	Prescription drug deductible: $100 Individual Retail covers a 30-day supply. With appropriate prescription, up to a 90-day supply is available. Mail order covers a 90-day supply. Out-of-Network mail order is not covered. Payment of the difference between the cost of a brand name drug and a generic may be required if a generic drug is available. For Out-of-Network pharmacy, member must file claim.
	Preferred brand drugs	$50 retail/$125 mail order copayment/prescription	$50 copayment/prescription	
	Non-preferred brand drugs	$100 retail/$250 mail order copayment/prescription	$100 copayment/prescription	
	Specialty drugs	50% coinsurance	Not Covered	Specialty drugs must be obtained from In-Network specialty pharmacy provider. Specialty retail limited to a 30-day supply. Mail order is not covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	50% coinsurance	None
	Physician/surgeon fees	10% coinsurance	50% coinsurance	None

* For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com.

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)	
If you need immediate medical attention	Emergency room care	Facility Charges: $200 copayment/visit plus 10% coinsurance; deductible does not apply ER Physician Charges: 10% coinsurance	Facility Charges: $200 copayment/visit plus 10% coinsurance; deductible does not apply ER Physician Charges: 10% coinsurance	Emergency room copayment waived if admitted.
	Emergency medical transportation	10% coinsurance	10% coinsurance	Ground and air transportation covered.
	Urgent care	$40 copayment/visit; deductible does not apply	30% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	50% coinsurance	Preauthorization is required; $250 penalty if not preauthorized Out-of-Network.
	Physician/surgeon fees	10% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copayment/office visit; deductible does not apply 10% coinsurance for other outpatient services	30% coinsurance for office visit 50% coinsurance for other outpatient services	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	10% coinsurance	50% coinsurance	Preauthorization is required; $250 penalty if not preauthorized Out-of-Network.
If you are pregnant	Office visits	$30 PCP/$45 SPC copayment/visit; deductible does not apply	30% 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	10% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	50% coinsurance	Preauthorization is required; $250 penalty if not preauthorized Out-of-Network.

* For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com.

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)	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	50% coinsurance	Limited to 60 visits per calendar year. Preauthorization is required.
	Rehabilitation services	$30 PCP/$45 SPC copayment/visit; deductible does not apply 10% coinsurance for other outpatient services	30% coinsurance for office visit 50% coinsurance for other outpatient services	None
	Habilitation services	$30 PCP/$45 SPC copayment/visit; deductible does not apply 10% coinsurance for other outpatient services	30% coinsurance for office visit 50% coinsurance for other outpatient services	
	Skilled nursing care	10% coinsurance	50% coinsurance	Limited to 60 days per calendar year. Preauthorization is required.
	Durable medical equipment	10% coinsurance	50% coinsurance	None
	Hospice services	10% coinsurance	50% coinsurance	Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	$30 PCP/$45 SPC copayment/visit; deductible does not apply	30% coinsurance	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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment (diagnosis of infertility covered)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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 plan document.)

- Chiropractic care (limited to 35 visits per calendar year)
- Hearing aids (limited to 1 per ear per 36-month period)
- Routine eye care (Adult)

* For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com.

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. 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 1-800-521-2227 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 1-800-521-2227 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 1-800-521-2227.
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 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	**$2,000**
Specialist copayment	**$45**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

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	$2,000
Copayments	$500
Coinsurance	$900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,460**

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

The plan's overall deductible	**$2,000**
Specialist copayment	**$45**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

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	$900
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,020**

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

The plan's overall deductible	**$2,000**
Specialist copayment	**$45**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

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	$1,900
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,400**

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.
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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。
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Русский	Чтобы бесплатно воспользоваться услугами перевода или получить помощь при общении, звоните нам по телефону 855-710-6984.
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