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/2022 or by calling 1-877-299-2377. 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?	$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. Network office visits, prescription drugs and preventive care services 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. ER $500. 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?	$7,350 Individual/$14,700 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-billed 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/go/be or call 1-877-299-2377 for a list of Participating 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
		Participating Provider (You will pay the least)	Non-Participating 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	$50/visit; deductible does not apply	Not Covered	Virtual visits are available. See your benefit booklet* for details.
	Specialist visit	$100/visit; deductible does not apply	Not Covered	None
	Preventive care/screening/ immunization	No Charge; deductible does not apply	Not Covered	
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	Not Covered	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance	Not Covered	

*For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com/member/policy-forms/2022.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.bcbstx.com/member/prescription-drug-plan-information/drug-lists	Preferred generic drugs	Retail - Preferred - No Charge Non-Preferred - $10/prescription Mail - No Charge; deductible does not apply	Not Covered	Cost Sharing 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	Retail - Preferred - $10/prescription Non-Preferred - $20/prescription Mail - $30/prescription; deductible does not apply	Not Covered	
	Preferred brand drugs	Retail - Preferred - $50/prescription Non-Preferred - $70/prescription Mail - $150/prescription; deductible does not apply	Not Covered	
	Non-preferred brand drugs	Retail - Preferred - $100/prescription Non-Preferred - $120/prescription Mail - $300/prescription; deductible does not apply	Not Covered	
	Preferred specialty drugs	$150/prescription; deductible does not apply	Not Covered	
	Non-preferred specialty drugs	$250/prescription; deductible does not apply	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	Not Covered	None
	Physician/surgeon fees	30% coinsurance	Not Covered	
If you need immediate medical attention	Emergency room care	$500/visit plus 30% coinsurance	$500/visit plus 30% coinsurance	Per Occurrence Deductible waived if admitted.
	Emergency medical transportation	30% coinsurance	30% coinsurance	None
	Urgent care	$75/visit; deductible does not apply	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	Not Covered	None
	Physician/surgeon fees	30% coinsurance	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$50/office visits or 30% coinsurance for other outpatient services	Not Covered	None
	Inpatient services	30% coinsurance	Not Covered	
If you are pregnant	Office visits	Primary Care: $35/initial visit Specialist: $70/initial visit; deductible does not apply	Not Covered	Copay applies to first prenatal visit (per pregnancy). Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance 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	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	Not Covered	None
	Rehabilitation services	30% coinsurance	Not Covered	
	Habilitation services	30% coinsurance	Not Covered	
	Skilled nursing care	30% coinsurance	Not Covered	60 day maximum per calendar year.
	Durable medical equipment	30% coinsurance	Not Covered	None
	Hospice services	30% coinsurance	Not Covered	
If your child needs dental or eye care	Children's eye exam	Primary Care: $35 Specialist: $70; deductible does not apply	Not Covered	None
	Children's glasses	Not Covered	Not Covered	
	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 (Except for a pregnancy that, as certified by a physician, places the woman in danger of death or a serious risk of substantial impairment of a major bodily function unless an abortion is performed)
- Acupuncture
- Bariatric surgery
- Children's dental check-up
- Children's glasses
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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 (Limited to one hearing aid per ear every 36 months)
- Infertility treatment (In vitro and artificial insemination are not covered unless shown in your plan document)
- Private-duty nursing (Only when ordered or authorized by the Primary Care Physician)
- 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 1-877-299-2377 or visit 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. 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 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 or the Texas Department of Insurance, or 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 1-877-299-2377.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-299-2377.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-877-299-2377.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-299-2377.

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	$3,000
Specialist Copayment	$10
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	**12700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	3000
Copayments	40
Coinsurance	2900
What isn't covered	
Limits or exclusions	60
The total Peg would pay is	**6000**

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

The plan's overall deductible	$3,000
Specialist Copayment	$10
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	**5600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	900
Copayments	900
Coinsurance	0
What isn't covered	
Limits or exclusions	20
The total Joe would pay is	**1820**

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

The plan's overall deductible	$3,000
Specialist Copayment	$10
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	**2800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	2100
Copayments	600
Coinsurance	0
What isn't covered	
Limits or exclusions	0
The total Mia would pay is	**2700**

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

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