

 <p><b>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.</b> For more information about your coverage, or to get a copy of the complete terms of coverage, visit <a href="http://www.bcbstx.com/bb/grp/bb-ghsa02bavstxo-tx-2023.pdf">www.bcbstx.com/bb/grp/bb-ghsa02bavstxo-tx-2023.pdf</a> or by calling 1-877-299-2377. 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 underlined terms, see the Glossary. You can view the Glossary at <a href="http://www.healthcare.gov/sbc-glossary/">www.healthcare.gov/sbc-glossary/</a> or call 1-855-756-4448 to request a copy.</p>		
Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	\$1,500 Individual/\$4,500 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.
<b>Are there services covered before you meet your deductible?</b>	Yes. In-Network Preventive Health Care services, services with a <u>copayment</u> , and <u>prescription drugs</u> 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 <u>copayment</u> or <u>coinsurance</u> may apply. For example, this plan covers certain preventive services without <u>cost-sharing</u> and before you meet your deductible. See a list of covered preventive services at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet deductibles for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	\$6,000 Individual/\$12,000 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 <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the out-of-pocket limit?</b>	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://www.bcbstx.com/go/bahmo">www.bcbstx.com/go/bahmo</a> or call 1-877-299-2377 for a list of Participating 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 charge</u> and what your <u>plan</u> pays ( <u>balance billing</u> ). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
<b>Do you need a referral to see a specialist?</b>	Yes.	This plan will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Providers (You will pay the least)	Non-Participating Providers (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/visit; <u>deductible</u> does not apply	Not Covered	Virtual Visits are available. See your benefit booklet* (Your PCP) for details.
	<u>Specialist</u> visit	\$80/visit; <u>deductible</u> does not apply	Not Covered	<u>Referral</u> required.
	<u>Preventive care/screening/immunization</u>	No Charge; <u>deductible</u> does not apply	Not Covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	Diagnostic test (X-ray, blood work)	Lab: 20% coinsurance X-Rays: \$50/test plus 20% <u>coinsurance</u>	Not Covered	<u>Referral</u> may be required. <u>Preauthorization</u> may also be required; see your benefit booklet* (Outpatient Lab and X-Ray services) for details.
	Imaging (CT/PET scans, MRIs)	\$100/test plus 20% <u>coinsurance</u>	Not Covered	<u>Referral</u> may be required. <u>Preauthorization</u> may also be required; see your benefit booklet* (Outpatient Lab and X-Ray services) for details.
	Preferred generic drugs	Retail - Preferred Participating - No Charge Participating - \$10/prescription Mail - No Charge; <u>deductible</u> does not apply	Not Covered	Limited to a 30-day supply at retail (or a 90-day supply at a <u>network</u> of select retail pharmacies). Up to a 90-day supply at mail order. <u>Specialty drugs</u> limited to a 30-day supply. Payment of the difference between the cost of a brand name drug and a generic may also be required if a generic drug is available. Certain drugs require approval before they will be covered. <u>Cost sharing</u> for insulin included in the drug list will not exceed \$25 per prescription for a 30-day supply, regardless of the amount or type of insulin needed to fill the prescription.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at <a href="http://www.bcbstx.com/rx23/6I">www.bcbstx.com/rx23/6I</a>	Non-preferred generic drugs	Retail - Preferred Participating - \$10/prescription Participating - \$20/prescription Mail - \$30/prescription; <u>deductible</u> does not apply	Not Covered	
	Preferred brand drugs	Retail - Preferred Participating - \$50/prescription Participating - \$70/prescription Mail - \$150/prescription; <u>deductible</u> does not apply	Not Covered	

\*For more information about limitations and exceptions, see the plan or policy document at [www.bcbstx.com/bb/grp/bb-ghsa02bavstxo-tx-2023.pdf](http://www.bcbstx.com/bb/grp/bb-ghsa02bavstxo-tx-2023.pdf).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Providers (You will pay the least)	Non-Participating Providers (You will pay the most)	
	Non-preferred brand drugs	Retail - Preferred Participating - \$100/prescription Participating - \$120/prescription Mail - \$300/prescription; <u>deductible</u> does not apply	Not Covered	
	Preferred <u>specialty</u> drugs	\$150/prescription; <u>deductible</u> does not apply	Not Covered	
	Non-preferred <u>specialty</u> drugs	\$250/prescription; <u>deductible</u> does not apply	Not Covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	Not Covered	Referral required. <u>Preauthorization</u> may also be required. For Outpatient Infusion Therapy, see your benefit booklet* (Outpatient Facility Services) for details.
	Physician/surgeon fees	20% <u>coinsurance</u>	Not Covered	
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	\$500/visit plus 20% <u>coinsurance</u>	\$500/visit plus 20% <u>coinsurance</u>	<u>Copayment</u> waived if admitted.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>Preauthorization</u> may be required for non-emergency transportation; see your benefit booklet* (Ambulance Services) for details.
	<u>Urgent care</u>	\$75/visit; <u>deductible</u> does not apply	Not Covered	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	Not Covered	<u>Referral</u> required. <u>Preauthorization</u> may also be required; see your benefit booklet* (Inpatient Hospital Services) for details.
	Physician/surgeon fees	20% <u>coinsurance</u>	Not Covered	<u>Referral</u> required. <u>Preauthorization</u> may also be required; see your benefit booklet* (Inpatient Professional Services) for details.
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$40/office visit; <u>deductible</u> does not apply; 20% <u>coinsurance</u> for other outpatient services	Not Covered	<u>Referral</u> required. <u>Preauthorization</u> may also be required; see your benefit booklet* (Behavioral Health Services) for details.
	Inpatient services	20% <u>coinsurance</u>	Not Covered	<u>Referral</u> required. <u>Preauthorization</u> may also be required; see your benefit booklet* (Behavioral Health Services) for details.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Providers (You will pay the least)	Non-Participating Providers (You will pay the most)	
<b>If you are pregnant</b>	Office visits	Primary Care: \$40/initial visit Specialist: \$80/initial visit; <u>deductible</u> does not apply	Not Covered	<u>Copayment</u> applies to first prenatal visit (per pregnancy). <u>Cost sharing</u> does not apply for preventive services. Depending on the type of services, <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. <u>Maternity care</u> may include <u>tests</u> and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	Not Covered	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	Not Covered	
	<u>Home health care</u>	20% <u>coinsurance</u>	Not Covered	
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	Not Covered	
<b>If you need help recovering or have other special health needs</b>	<u>Habilitation services</u>	20% <u>coinsurance</u>	Not Covered	60 visits/year. <u>Referral</u> required. <u>Preauthorization</u> may also be required; see your <u>benefit booklet*</u> (Extended Care Services) for details.  Separate 35-visit maximum per benefit period for <u>Habilitation</u> and <u>Rehabilitation</u> services, including <u>chiropractic care</u> . <u>Referral</u> required. <u>Preauthorization</u> may also be required; see your <u>benefit booklet*</u> ( <u>Rehabilitation Services</u> and <u>Habilitation Services</u> ) for details.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	Not Covered	
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	Not Covered	
	<u>Hospice services</u>	20% <u>coinsurance</u>	Not Covered	
	Children's eye exam	No Charge; <u>deductible</u> does not apply	Up to a \$30 reimbursement is available; <u>deductible</u> does not apply	

\*For more information about limitations and exceptions, see the plan or policy document at [www.bcbstx.com/bb/grp/bb-ghsa02bavstxo-tx-2023.pdf](http://www.bcbstx.com/bb/grp/bb-ghsa02bavstxo-tx-2023.pdf).

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Providers (You will pay the least)	Non-Participating Providers (You will pay the most)	
	Children's glasses	No Charge; <u>deductible</u> does not apply	Up to a \$75 reimbursement is available; <u>deductible</u> does not apply	One pair of glasses every 12 months. Reimbursement for frames, lenses, and lens options purchased Out-of-Network is available (not to exceed the retail cost). See your benefit booklet* (Pediatric Vision Care Benefits) for details.
	Children's dental check-up	30% <u>coinsurance</u>	30% <u>coinsurance</u>	Oral exams are limited to two every benefit period. Benefits for periodic and comprehensive oral evaluations are limited to a combined maximum of two every 12 months. See your benefit booklet* (Pediatric Dental Benefits Rider) for details.

**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
- Cosmetic surgery (except for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors, or diseases when medically necessary)
- Dental care (Adult)
- Infertility treatment (diagnosis and treatment covered; in vitro not covered)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (unless medically necessary)
- Routine eye care (Adult)
- Routine foot care (except when medically necessary)
- 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 (35 visits/year combined with habilitation and rehabilitation services)
- Hearing aids (limited to one hearing aid per ear every 36 months)

\*For more information about limitations and exceptions, see the plan or policy document at [www.bcbstx.com/bb/grp/bb-ghsa02bavstxo-tx-2023.pdf](http://www.bcbstx.com/bb/grp/bb-ghsa02bavstxo-tx-2023.pdf).

**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 Blue Cross and Blue Shield of Texas at 1-888-697-0683 or visit [www.bcbstx.com](http://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](http://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.ccoio.cms.gov](http://www.ccoio.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](http://www.HealthCare.gov). For more information about the [Marketplace](http://www.HealthCare.gov), visit [www.HealthCare.gov](http://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: For group health coverage subject to ERISA: Blue Cross and Blue Shield of Texas at or visit [www.bcbstx.com](http://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](http://www.dol.gov/ebsa/healthreform), and the Texas Department of Insurance, Consumer Protection at 1-800-252-3439 or [www.tdi.texas.gov](http://www.tdi.texas.gov). For non-federal governmental group health plans and church plans that are group health plans, Blue Cross and Blue Shield of Texas at 1-877-299-2377 or [www.bcbstx.com](http://www.bcbstx.com) or contact the Texas Department of Insurance, Consumer Protection at 1-800-252-3439 or [www.tdi.texas.gov](http://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](http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/tx.html).

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

[Minimum Essential Coverage](http://www.bcbstx.com) generally includes [plans](http://www.bcbstx.com), [health insurance](http://www.bcbstx.com) available through the [Marketplace](http://www.bcbstx.com) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](http://www.bcbstx.com), you may not be eligible for the [premium tax credit](http://www.bcbstx.com).

**Does this plan meet the Minimum Value Standards? Yes**

If your plan doesn't meet the [Minimum Value Standards](http://www.bcbstx.com), you may be eligible for a [premium tax credit](http://www.bcbstx.com) to help you pay for a plan through the [Marketplace](http://www.bcbstx.com).

**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): Dine'kehgo shika at'ohwol ninisingo, kwijigo 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 \$1,500
- Specialist copayment \$80
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

**This EXAMPLE event includes services like:**

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
 Specialist visit (*anesthesia*)

**Total Example Cost** \$12,700

**In this example, Peg would pay:**

	<i>Cost sharing</i>
<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$2,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,960</b>

**Managing Joe's Type 2 Diabetes**

(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible \$1,500
- Specialist copayment \$80
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

**This EXAMPLE event includes services like:**

Primary care physician office visits (*including disease education*)  
 Diagnostic tests (*blood work*)  
 Prescription drugs  
 Durable medical equipment (*glucose meter*)

**Total Example Cost** \$5,600

**In this example, Joe would pay:**

	<i>Cost sharing</i>
<u>Deductibles</u>	\$900
<u>Copayments</u>	\$800
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,720</b>

**Mia's Simple Fracture**

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

- The plan's overall deductible \$1,500
- Specialist copayment \$80
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

**This EXAMPLE event includes services like:**

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

**Total Example Cost** \$2,800

**In this example, Mia would pay:**

	<i>Cost sharing</i>
<u>Deductibles</u>	\$900
<u>Copayments</u>	\$1,400
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$400
<b>The total Mia would pay is</b>	<b>\$2,700</b>

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

**Health care coverage is important for everyone.**

We provide free communication aids and services for anyone with a disability or who needs language assistance. We do not discriminate on the basis of race, color, national origin, sex, gender identity, age, sexual orientation, health status or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator      Phone: 855-664-7270 (voicemail)  
300 E. Randolph St.                      TTY/TDD: 855-661-6965  
35th Floor                                      Fax: 855-661-6960  
Chicago, Illinois 60601

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>





