

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual/Family | Plan Type: PPO



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at <u>http://www.bcbstx.com/coverage/index.html</u> or by calling 1-800-521-2227.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	In-Network \$6,000 Individual/ \$12,700 Family Out-of-Network \$12,000 Individual/ \$25,400 Family Doesn't apply to certain preventive care.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket</u> <u>limit</u> on my expenses?	Yes. For In-Network \$6,000 Individual/ \$12,700 Family For Out-of-Network \$12,000 Individual/ \$25,400 Family Includes deductible.	The <u>out-of-pocket</u> limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance-billed 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> .
Does this plan use a <u>network</u> of <u>providers</u> ?	Yes. See <u>www.bcbstx.com</u> or call 1-800-810-2583 for a list of In-Network providers.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network . See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a <u>specialist</u> ?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	1	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about <u>excluded services</u> .

Questions: Call **1-800-521-2227** or visit us at <u>http://www.bcbstx.com/coverage/index.html</u>. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at <u>www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf</u> or call 1-855-756-4448 to request a copy. 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



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- <u>Coinsurance</u> is *your* share of the costs of a covered service, calculated as a percent of the <u>allowed amount</u> for the service. For example, if the health plan's <u>allowed amount</u> for an overnight hospital stay is \$1,000, your <u>coinsurance</u> payment of 20% would be \$200. This may change if you haven't met your <u>deductible</u>.
- The amount the plan pays for covered services is based on the <u>allowed amount</u>. If an out-of-network <u>provider</u> charges more than the <u>allowed</u> <u>amount</u>, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the <u>allowed</u> <u>amount</u> is \$1,000, you may have to pay the \$500 difference. (This is called <u>balance billing.</u>)
- The plan may encourage you to use In-Network **providers** by charging you lower **<u>deductibles</u>**, **<u>copayments</u>**, and <u>coinsurance</u> amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
provider's office or	Primary care visit to treat an injury or illness Specialist visit	No Charge No Charge	20% coinsurance 20% coinsurance	none
clinic	Other practitioner office visit	No Charge	20% coinsurance	Acupuncture not covered. Chiropractic care limited to 35 visits per year.
	Preventive care/screening/immunization	No Charge	20% coinsurance	none
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	20% coinsurance	none
	Imaging (CT / PET scans, MRIs)	No Charge	20% coinsurance	CT for heart disease screening maximum benefit of 1 test for EDT every 5 years.
If you need drugs to	Generic Drugs	No Charge	No Charge	
treat your illness or	Preferred Brand Drugs	No Charge	No Charge	
condition	Non-Preferred Brand Drugs	No Charge	No Charge	Standard Formulary and Calendar year
More information about prescription drug coverage is available at www.bcbstx.com/ member/rx_drugs.html	Specialty Drugs	No Charge	No Charge	deductible applies. Certain women's preventative services will be covered with no cost to the member.
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	No Charge	20% coinsurance	none
surgery	Physician/surgeon fees	No Charge	20% coinsurance	none



BlueCross BlueShield

B634CHC Blue Choice Bronze PPO 006

Coverage Period: 01/01/2014-12/31/2014

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If you need immediate	Emergency room services	No Charge	No Charge	
medical attention	Emergency medical transportation	No Charge	No Charge	none
	Urgent care	No Charge	20% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	20% coinsurance	\$500 penalty for failure to Preauthorize.
	Physician/surgeon fee	No Charge	20% coinsurance	none
If you have mental health, behavioral health, or substance	Mental/Behavioral health outpatient services	No Charge	20% coinsurance	Certain services must be preauthorized. \$500 penalty for failure to Preauthorize.
abuse needs	Mental/Behavioral health inpatient services	No Charge	20% coinsurance	All services must be preauthorized. \$500 penalty for failure to Preauthorize.
	Substance use disorder outpatient services	No Charge	20% coinsurance	Certain services must be preauthorized. \$500 penalty for failure to Preauthorize.
	Substance use disorder inpatient services	No Charge	20% coinsurance	All services must be preauthorized. \$500 penalty for failure to Preauthorize.
If you are pregnant	Prenatal and postnatal care	No Charge	20% coinsurance	2020
	Delivery and all inpatient services	No Charge	20% coinsurance	none



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Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need help recovering or have other	Home health care	No Charge	20% coinsurance	Limited to 60 visits per year. \$500 penalty for failure to Preauthorize.
special health needs	Rehabilitation services	No Charge	20% coinsurance	Limited to combined 35 visits per year,
	Habilitation services	No Charge	20% coinsurance	including Chiropractic.
	Skilled nursing care	No Charge	20% coinsurance	Limited to 25 days per year. \$500 penalty for failure to Preauthorize.
	Durable medical equipment	No Charge	20% coinsurance	none
	Hospice service	No Charge	20% coinsurance	\$500 penalty for failure to Preauthorize.
If your child needs dental or eye care	Eye exam	No Charge	20% coinsurance	Up to \$30 Out of Network. Limited to one visit per calendar year.
	Glasses	No Charge	20% coinsurance	\$30 frames/ \$25 single vision lenses Out-of-Network. Frames limited to one pair per calendar year.
	Dental check-up	Not Covered	Not Covered	none

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
Acupuncture	• Dental Care (Adult)	Private-duty nursing (Only covered for extended
Bariatric surgery	Long-term care	care expenses)
		 Weight loss programs



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Other Covered Services (Th	his isn't a complete list. Cheo	ck your policy o	r plan document	for other covered	d services and	your costs for these services.)

Chiropractic care	Infertility treatment (Diagnosis covered but	Routine eye care (Adult)	
• Cosmetic surgery (Only covered for the correction	treatment and Invitro not covered)	• Routine foot care (Only covered in connection with	
of congenital deformities or for conditions resulting •	Most coverage provided outside the United States.	diabetes, circulatory disorders of the lower	
from accidental injuries, scars, tumors or diseases.	See www.bcbstx.com	extremities, peripheral vascular disease, peripheral	
When Medically Necessary.) •	Non-emergency care when traveling outside the	neuropathy, or chronic arterial or venous	
• Hearing aids (Limited to 2 per 3 years)	U.S.	insufficiency)	

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **<u>premium</u>**, which may be significantly higher than the **<u>premium</u>** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-521-2227. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or <u>www.dol.gov/ebsa</u>, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or <u>www.cciio.cms.gov</u>.

Your Grievance and Appeals Rights:

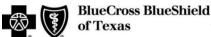
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact Blue Cross and Blue Shield of Texas at 1-800-521-2227 or visit <u>www.bcbstx.com</u>, or contact U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit <u>www.dol.gov/ebsa/healthreform</u>.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

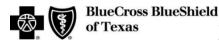


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Language Access Services:

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 page.—



Coverage Examples:

About These Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



Don't use these examples to estimate your actual costs under the plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

Amount owed to providers: \$7,540
 Plan pays \$1,390
 Patient pays \$6,150

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$6,000
Copays	\$0
Coinsurance	\$0
Limits or exclusions	\$150
Total	\$6,150

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Managing type 2 diabetes (routine maintenance of a well-controlled condition)

Amount owed to providers: \$5,400

■ Plan pays \$50

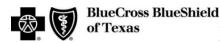
■ Patient pays \$5,350

Sample care costs:

Total	\$5,400
Vaccines, other preventive	\$100
Laboratory tests	\$100
Education	\$300
Office Visits and Procedures	\$700
Medical Equipment and Supplies	\$1,300
Prescriptions	\$2,900

Patient pays:

Deductibles	\$5,270
Copays	\$0
Coinsurance	\$0
Limits or exclusions	\$80
Total	\$5,350



Coverage Examples:

Questions and answers about Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **<u>deductibles</u>**, **<u>copayments</u>**, and <u>coinsurance</u> can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.