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 visit 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.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Encompass providers: $0 Individual / $0 Family In-Network: $500 Individual / $1,000 Family Out-of-Network: $2,000 Individual / $4,000 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 copay, prescription drugs, and In-Network 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 / $200 Family prescription drugs. Per occurrence: $300 In-Network inpatient admission. 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?	Encompass providers: $0 Individual / $0 Family In-Network: $4,000 Individual / $8,000 Family Out-of-Network: $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 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, preauthorization penalties, balance-billed charges, and healthcare 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.	You pay the least if you use a provider in Encompass provider network. You pay more if you use a provider in-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
		Encompass Provider (you will pay the least)	In-Network Provider	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	N/A	$30 copay/visit; deductible does not apply	50% coinsurance	None
	Specialist visit	N/A	$30 copay/visit; deductible does not apply	50% coinsurance	Chiropractic services limited to 26 visits per calendar year.
	Preventive care/screening/ immunization	N/A	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)	N/A	10% coinsurance	50% coinsurance	No Charge after office visit copay. Coinsurance may vary if services rendered in an outpatient hospital setting.
	Imaging (CT/PET scans, MRIs)	N/A	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
		Encompass Provider (you will pay the least)	In-Network Provider	Out-of-Network 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 www.bcbstx.com	Generic drugs	N/A	$10 retail / $30 mail order copay/prescription	Not Covered	Prescription drug deductible: $100 Individual / $200 Family Retail covers a 30 day supply. With appropriate prescription, up to a 90 day supply is available. Mail order covers a 90 day supply Specialty drugs must be obtained from Prime Specialty Pharmacy. Mail order is not covered.
	Preferred brand drugs	N/A	$45 retail / $135 mail order copay/prescription	Not Covered	
	Non-preferred brand drugs	N/A	$60 retail / $180 mail order copay/prescription	Not Covered	
	Specialty drugs	N/A	$100 copay/prescription	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	N/A	10% coinsurance	50% coinsurance	None
	Physician/surgeon fees	N/A	10% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	N/A	Emergency room $200 copay; deductible does not apply Emergency room services 10% coinsurance.	Emergency room $200 copay; deductible does not apply Emergency room services 10% coinsurance.	Copay waived if admitted.
	Emergency medical transportation	N/A	10% coinsurance	10% coinsurance	None
	Urgent care	N/A	$30 copay/visit; deductible does not apply	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
		Encompass Provider (you will pay the least)	In-Network Provider	Out-of-Network Provider (you will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	N/A	10% coinsurance	50% coinsurance	All services must be preauthorized; 50% penalty if not preauthorized Out-of-Network.
	Physician/surgeon fees	N/A	10% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	N/A	$30 copay/visit; deductible does not apply	50% coinsurance	Certain services must be preauthorized; refer to benefits booklet for details.
	Inpatient services	N/A	10% coinsurance	50% coinsurance	All services must be preauthorized; 50% penalty if not preauthorized Out-of-Network.
If you are pregnant	Office visits	N/A	$30 copay/visit; deductible does not apply	50% coinsurance	Copay 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	N/A	10% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	N/A	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
		Encompass Provider (you will pay the least)	In-Network Provider	Out-of-Network Provider (you will pay the most)	
If you need help recovering or have other special health needs	Home health care	No Charge	10% coinsurance	50% coinsurance	Preauthorization required.
	Rehabilitation services	No Charge	10% coinsurance	50% coinsurance	None
	Habilitation services	No Charge	10% coinsurance	50% coinsurance	None
	Skilled nursing care	N/A	10% coinsurance	50% coinsurance	Preauthorization required. Limited to 90 days per calendar year.
	Durable medical equipment	N/A	10% coinsurance	50% coinsurance	None
	Hospice services	N/A	10% coinsurance	50% coinsurance	Preauthorization required.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	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.)

- Cosmetic surgery
- Dental care (Adult, only for accidents)
- Hearing aids
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Weight loss programs

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

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Infertility treatment (assisted reproductive technology lifetime max: $5,000 medical / $5,000 pharmacy)
- Non-emergency care when traveling outside the U.S.
- Routine foot care

* 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: the plan at 1-800-521-2227, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Blue Cross and Blue Shield of Texas at 1-800-521-2227 or visit www.bcbstx.com, or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. 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.texashealthoptions.com.

Does this plan provide Minimum Essential Coverage? Yes
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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	$500
Specialist copayment	$30
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	**$12,800**

In this example, Peg would pay:

Cost sharing	
Deductibles*	$800
Copayments	$100
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,160**

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

The plan's overall deductible	$500
Specialist copayment	$30
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	**$7,400**

In this example, Joe would pay:

Cost sharing	
Deductibles*	$600
Copayments	$1,200
Coinsurance	$100
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,980**

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

The plan's overall deductible	$500
Specialist copayment	$30
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	**$1,900**

In this example, Mia would pay:

Cost sharing	
Deductibles	$500
Copayments	$300
Coinsurance	$90
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$890**

*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.