



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	No Charge after <u>deductible</u>	30% <u>coinsurance</u>	Virtual visits are available, please refer to your <u>plan</u> policy for more details.
	<u>Specialist</u> visit	No Charge after <u>deductible</u>	30% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No Charge; <u>deductible</u> does not apply	30% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for. No Charge for child immunizations <u>Out-of-Network</u> through the 6th birthday.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No Charge after <u>deductible</u>	30% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	No Charge after <u>deductible</u>	30% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.bcbstx.com	Generic drugs	No Charge after <u>deductible</u>	20% <u>coinsurance</u>	Retail covers a 30-day supply. With appropriate prescription, up to a 90-day supply is available. Mail order covers a 90-day supply. <u>Out-of-Network</u> 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 <u>Out-of-Network</u> pharmacy, member must file <u>claim</u> .
	Preferred brand drugs	No Charge after <u>deductible</u>	20% <u>coinsurance</u>	
	Non-preferred brand drugs	No Charge after <u>deductible</u>	20% <u>coinsurance</u>	
	<u>Specialty</u> drugs	No Charge after <u>deductible</u>	20% <u>coinsurance</u>	For <u>In-Network</u> benefit, <u>specialty drugs</u> must be obtained from <u>In-Network</u> specialty pharmacy <u>provider</u> . Specialty retail limited to a 30-day supply. Mail order is not covered.



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: \$4,000 Individual / \$8,000 Family Out-of-Network: \$10,000 Individual / \$20,000 Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. Certain <u>preventive care</u> is covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	In-Network: \$4,000 Individual / \$8,000 Family Out-of-Network: \$20,000 Individual / \$40,000 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , 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.
What is not included in the <u>out-of-pocket limit</u>?	Premiums, <u>balance-billing</u> charges, <u>preauthorization</u> penalties, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See www.bcbstx.com or call 1-800-810-2583 for a list of <u>network providers</u> .	This <u>plan</u> 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</u> charge 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.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

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)	No Charge after <u>deductible</u>	30% <u>coinsurance</u>	None
	Physician/surgeon fees	No Charge after <u>deductible</u>	30% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	Facility Charges: No Charge after <u>deductible</u> ER Physician Charges: No Charge after <u>deductible</u>	Facility Charges: No Charge after <u>deductible</u> ER Physician Charges: No Charge after <u>deductible</u>	None
	<u>Emergency medical transportation</u>	No Charge after <u>deductible</u>	No Charge after <u>deductible</u>	Ground and air transportation covered.
	<u>Urgent care</u>	No Charge after <u>deductible</u>	30% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge after <u>deductible</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required: \$250 penalty if not preauthorized <u>Out-of-Network</u> .
	Physician/surgeon fees	No Charge after <u>deductible</u>	30% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge after <u>deductible</u>	30% <u>coinsurance</u>	Certain services must be preauthorized; refer to your benefit booklet* for details. Virtual visits are available, please refer to your <u>plan</u> policy for more details.
	Inpatient services	No Charge after <u>deductible</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required: \$250 penalty if not preauthorized <u>Out-of-Network</u> .
If you are pregnant	Office visits	No Charge after <u>deductible</u>	30% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No Charge after <u>deductible</u>	30% <u>coinsurance</u>	
	Childbirth/delivery facility services	No Charge after <u>deductible</u>	30% <u>coinsurance</u>	<u>Preauthorization</u> is required: \$250 penalty if not preauthorized <u>Out-of-Network</u> .

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