



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](http://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](http://www.healthcare.gov/sbc-glossary) or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	In-Network: \$2,500 Individual / \$7,500 Family Out-of-Network: \$4,000 Individual / \$12,000 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> .
<b>Are there services covered before you meet your deductible?</b>	Yes. Services that charge a <u>copay</u> , <u>prescription drugs</u> , emergency room services, and certain <u>preventive care</u> , <u>diagnostic test</u> , <u>home health</u> , <u>skilled nursing</u> , and <u>hospice</u> are 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 <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	In-Network: \$7,500 Individual / \$15,000 Family Out-of-Network: \$16,000 Individual / \$48,000 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.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	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> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="http://www.bcbstx.com">www.bcbstx.com</a> 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.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	No.	You can see the <u>specialist</u> you choose without a <u>referral</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
		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	\$35 <u>copay</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	Virtual visits are available, please refer to your <u>plan</u> policy for more details.
	Specialist visit	\$50 <u>copay</u> /visit; <u>deductible</u> does not apply	40% <u>coinsurance</u>	None
	Preventive care/screening/immunization	No Charge; <u>deductible</u> does not apply	40% <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	Diagnostic test (x-ray, blood work)	No Charge; <u>deductible</u> does not apply	40% <u>coinsurance</u>	Office visit <u>copay</u> may apply.
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	40% <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 <a href="http://www.bcbstx.com">www.bcbstx.com</a>	Generic drugs	\$10 retail/\$30 mail order <u>copay/prescription</u> ; <u>deductible</u> does not apply	\$10 <u>copay/prescription</u> plus 20% <u>coinsurance</u> ; <u>deductible</u> does not apply	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	\$50 retail/\$150 mail order <u>copay/prescription</u> ; <u>deductible</u> does not apply	\$50 <u>copay/prescription</u> plus 20% <u>coinsurance</u> ; <u>deductible</u> does not apply	
	Non-preferred brand drugs	\$100 retail/\$300 mail order <u>copay/prescription</u> ; <u>deductible</u> does not apply	\$100 <u>copay/prescription</u> plus 20% <u>coinsurance</u> ; <u>deductible</u> does not apply	
	Specialty drugs	\$50 <u>copay/prescription</u> ; <u>deductible</u> does not apply	\$50 <u>copay/prescription</u> plus 20% <u>coinsurance</u> ; <u>deductible</u> does not apply	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.

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)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	<u>Emergency room care</u>	Facility Charges: \$350 copay/visit plus 20% coinsurance; <u>deductible</u> does not apply ER Physician Charges: 20% coinsurance	Facility Charges: \$350 copay/visit plus 20% coinsurance; <u>deductible</u> does not apply ER Physician Charges: 20% coinsurance	<u>Emergency room copay</u> waived if admitted.
	<u>Emergency medical transportation</u>	20% coinsurance	20% coinsurance	Ground and air transportation covered.
	<u>Urgent care</u>	\$75 copay/visit; <u>deductible</u> does not apply	40% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	<u>Preadmission</u> is required; \$250 penalty if not preauthorized <u>Out-of-Network</u> .
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$35 copay/office visit; <u>deductible</u> does not apply 20% coinsurance for other outpatient services	40% coinsurance	Certain services must be preauthorized; refer to your benefit booklet* for details. Virtual visits are available, please refer to your plan policy for more details.
	Inpatient services	20% coinsurance	40% coinsurance	<u>Preadmission</u> is required; \$250 penalty if not preauthorized <u>Out-of-Network</u> .
If you are pregnant	Office visits	\$35 PCP/\$50 SPC copay/visit; <u>deductible</u> does not apply	40% coinsurance	<u>Copay</u> applies to first prenatal visit (per pregnancy). <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	<u>Preadmission</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](http://www.bcbstx.com).