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, visit www.bcbstx.com/member/policy-forms/2025 or by calling 1-800-521-2227. 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 https://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?	Network: $5,000 Individual/$10,000 Family. Out-of-Network: $10,000 Individual/$20,000 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. In-Network Preventive Care.	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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Yes. Network: $5,000 Individual/$10,000 Family. Out-of-Network: $20,000 Individual/$40,000 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?	Preauthorization penalties, premiums, balance billed charges, and health care 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.	This plan uses a provider network. You will pay less if you use a provider in the plan's 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
		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 deductible	30% coinsurance	None
	Specialist visit	No Charge after deductible	30% coinsurance	
	Preventive care/screening/ immunization	No Charge	30% coinsurance	There is No Charge for Out-of-Network immunizations from birth through the day of the 6th birthday. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge after deductible	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No Charge after deductible	30% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at 1-800-521-2227	Preferred generic drugs	No Charge after deductible	No Charge after deductible	Up to a 90-day supply for generic and brand drugs. Up to a 30-day supply for Specialty drugs, except for certain FDA-designated dosing regimens. Certain women's preventive services will be covered with no cost to the member. Cost Sharing 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.
	Non-preferred generic drugs	No Charge after deductible	No Charge after deductible	
	Preferred brand drugs	No Charge after deductible	No Charge after deductible	
	Non-preferred brand drugs	No Charge after deductible	No Charge after deductible	
	Specialty drugs	No Charge after deductible	No Charge after deductible	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No Charge after deductible	30% coinsurance	None
	Physician/surgeon fees	No Charge after deductible	30% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	No Charge after deductible	No Charge after deductible	None
	Emergency medical transportation	No Charge after deductible	No Charge after deductible	
	Urgent care	No Charge after deductible	30% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge after deductible	30% coinsurance	Preauthorization required Out-of-Network; failure to preauthorize at least two business days prior to admission will result in $250 reduction in benefits.
	Physician/surgeon fees	No Charge after deductible	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge after deductible	30% coinsurance	Outpatient: Preauthorization required for psychological testing, neuropsychological testing, electroconvulsive therapy, repetitive transcranial magnetic stimulation, and intensive outpatient treatment; failure to preauthorize at least two business days prior to service will result in 50% reduction in benefits (not to exceed $500). Inpatient: Preauthorization required Out-of-Network; failure to preauthorize at least two business days prior to admission will result in $250 reduction in benefits.
	Inpatient services	No Charge after deductible	30% coinsurance	
If you are pregnant	Office visits	No Charge after deductible	30% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No Charge after deductible	30% coinsurance	
	Childbirth/delivery facility services	No Charge after deductible	30% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	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 after deductible	30% coinsurance	60 visit maximum per benefit period. Preauthorization required for Out-of-Network.
	Rehabilitation services	No Charge after deductible	30% coinsurance	For Outpatient, limited to combined 35 visits per year, including Chiropractic.
	Habilitation services	No Charge after deductible	30% coinsurance	
	Skilled nursing care	No Charge after deductible	30% coinsurance	25 day maximum per benefit period. Preauthorization required for Out-of-Network.
	Durable medical equipment	No Charge after deductible	30% coinsurance	None
	Hospice services	No Charge after deductible	30% coinsurance	Preauthorization required for Out-of-Network.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	None
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

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)
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Private-duty nursing
- Routine eye care (Adult and Child)
- 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
- Hearing aids
- Infertility treatment (Invitro and artificial insemination are not covered unless shown in your Plan document)
- Non-emergency care when traveling outside the U.S.
- Routine foot care (Only covered in connection with diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency)

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: For group health coverage contact the plan, Blue Cross and Blue Shield of Texas at 1-800-521-2227 or visit www.bcbstx.com. You may also contact your state insurance department at 1-800-252-3439 or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 OR state health insurance marketplace or SHOP.

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: the Claim review section at Blue Cross and Blue Shield of Texas or visit www.bcbstx.com or the Texas Department of Insurance, or www.tdi.texas.gov.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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	$5,000
Specialist	$0
Hospital (facility)	$0
Other	$0

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:

Cost Sharing	
Deductibles	$5,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,060**

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

The plan's overall deductible	$5,000
Specialist	$0
Hospital (facility)	$0
Other	$0

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:

Cost Sharing	
Deductibles	$2,300
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,620**

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

The plan's overall deductible	$5,000
Specialist	$0
Hospital (facility)	$0
Other	$0

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:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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

BlueCross BlueShield of Texas

Health care coverage is important for everyone.

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984. 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. 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
300 E. Randolph St., 35th Floor
Chicago, IL 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960

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
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf
Complaint Forms: https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html

	To receive language or communication assistance free of charge, please call us at 855-710-6984.
Español	Llámenos al 855-710-6984 para recibir asistencia lingüística o comunicación en otros formatos sin costo.
العربية	لتلقي المساعدة اللغوية أو التواصل مجانًا، يرجى الاتصال بنا على الرقم 855-710-6984.
繁體中文	如欲獲得免費語言或溝通協助，請撥打855-710-6984與我們聯絡。
Français	Pour bénéficier gratuitement d'une assistance linguistique ou d'une aide à la communication, veuillez nous appeler au 855-710-6984.
Deutsch	Um kostenlose Sprach- oder Kommunikationshilfe zu erhalten, rufen Sie uns bitte unter 855-710-6984 an.
[illegible]	[illegible] 855-710-6984 [illegible]
[illegible]	[illegible] 855-710-6984 [illegible]
Italiano	Per assistenza gratuita alla lingua o alla comunicazione, chiami il numero 855-710-6984.
[illegible]	언어 또는 의사소통 지원을 무료로 받으려면 855-710-6984번으로 전화해 주세요.
Navajo	Nin1: Doo bilag1ana bizaad dinits'1'g00, sh1 ata' hodooni n7n7zingo, t'11j77k'eh bee n1haz'1. 1-866-560-4042 j8' hod7lni.
فارسی	برای دریافت کمک زبانی یا ارتباطی رایگان، لطفاً با شماره 855-710-6984 تماس بگیرید.
Polski	Aby uzyskać bezpłatną pomoc językową lub komunikacyjną, prosimy o kontakt pod numerem 855-710-6984.
Русский	Чтобы бесплатно воспользоваться услугами перевода или получить помощь при общении, звоните нам по телефону 855-710-6984.
Tagalog	Para makatanggap ng tulong sa wika o komunikasyon nang walang bayad, pakitawagan kami sa 855-710-6984.
اردو	مفت میں زبان یا مواصلت کی مدد موصول کرنے کے لیے، براہِ کرم ہمیں 855-710-6984 پر کال کریں۔
Tiếng Việt	Để được hỗ trợ ngôn ngữ hoặc giao tiếp miễn phí, vui lòng gọi cho chúng tôi theo số 855-710-6984.