BlueCross BlueShield of Texas

P.O. Box 3238 • Naperville, Illinois 60566-7238

November 05, 2015

Thank you for choosing Blue Cross and Blue Shield of Texas. We take pride in providing the highest level of service to our customers and look forward to supporting you in the future -- through it all.

The attached Summary of Benefits and Coverage provides a clear and concise overview of the coverage you have selected. The Summary of Benefits and Coverage is not your actual policy, nor is it a guarantee or confirmation of your coverage. It is, however, a helpful tool providing you with a simple and straightforward explanation of the benefits included in the plan you have selected.

Please note: If you have a benefit period deductible you must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use.

In addition to the Summary of Benefits and Coverage, please be on the lookout for a subsequent mailing from Blue Cross and Blue Shield of Texas which will include your policy documents.

Again, thank you for choosing Blue Cross and Blue Shield of Texas. If you have any questions you can call 1-888-697-0683 at any time for more information.

Sincerely,

Blue Cross and Blue Shield of Texas

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Blue Cross Blue Shield Solution 102, a Multi-State Plan℠

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

Coverage Period: 01/01/2016 - 12/31/2016
Coverage for: Individual | **Plan Type:** HMO

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 www.bcbstx.com/pdf/policy-forms/33602TX0780002-06.pdf or by calling 1-888-697-0683.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	Network: **$100** Individual/**$300** Family. Out-of-Network: **$15,000** Individual/**$45,000** Family. Doesn't apply to non-specialty prescription drugs, or to the following In-Network services: preventive care, first four PCP office visits, urgent care, or mental health/substance use disorder office visits. Copays and non-specialty prescription drug costs don't count toward the overall deductible.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 3 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. Network: **$600** Individual/**$1,800** Family. Out-of-Network: **Unlimited** Individual/**Unlimited** Family.	The **out-of-pocket** 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 out-of-pocket limit?	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**.
Does this plan use a network of providers?	Yes. For a list of Network providers please call **1-888-697-0683** or see www.bcbstx.com.	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 3 for how this plan pays different kinds of **providers**.

Questions: Call **1-888-697-0683** or visit us at www.bcbstx.com/coverage.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why this Matters:
Do I need a referral to see a specialist?	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?	Yes.	Some of the services this plan doesn't cover are listed on page 6. See your policy or plan document for additional information about **excluded services**.

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

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	50% coinsurance	First four Network office visits are no charge; deductible and coinsurance apply for subsequent visits.
	Specialist visit	20% coinsurance	50% coinsurance	---none---
	Other practitioner office visit	20% coinsurance	50% coinsurance	Acupuncture is not covered. Chiropractic care limited to 35 visits per year.
	Preventive care/screening/immunization	No Charge	50% coinsurance	---none---
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	---none---
	Imaging (CT / PET scans, MRIs)	20% coinsurance	50% coinsurance	

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.myprime.com/content/dam/prime/memberportal/forms/AuthorForms/IVL/2016/2016_TX_5T_EX.pdf	Preferred generic drugs	Retail – No Charge/ $5 copay Mail – No Charge	Retail – 50% coinsurance plus $5 copay	Lower copay applies at preferred Network pharmacies. One copay per 30-day supply, up to a 90-day supply. Generics Plus formulary applies. Certain women's preventive services will be covered with no cost to the member.
	Non-preferred generic drugs	Retail – $10/$15 copay Mail – $30 copay	Retail – 50% coinsurance plus $15 copay	
	Preferred brand drugs	Retail – $50/$60 copay Mail – $150 copay	Retail – 50% coinsurance plus $60 copay	
	Non-preferred brand drugs	Retail – $100/$110 copay Mail – $300 copay	Retail – 50% coinsurance plus $110 copay	
	Specialty drugs	30% coinsurance	50% coinsurance	Generics Plus formulary applies. Certain women's preventive services will be covered with no cost to the member.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	$1,500 copay/ procedure plus 50% coinsurance	Copay is charged in addition to the overall deductible. Elective abortion is not covered except in limited circumstances. Preauthorization required Out-of-Network; failure to preauthorize will result in reduction or denial of benefits.
	Physician/surgeon fees	20% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room services	20% coinsurance	20% coinsurance	---none---
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	$75 copay/visit	50% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	$1,500 copay/admit plus 50% coinsurance	Copay is charged in addition to the overall deductible. Preauthorization required Out-of-Network; failure to preauthorize will result in reduction or denial of benefits.
	Physician/surgeon fee	20% coinsurance	50% coinsurance	---none---

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	No charge for office visits or 20% coinsurance for other outpatient services	50% coinsurance	Outpatient: Preauthorization required Out-of-Network for psychological testing, neuropsychological testing, electroconvulsive therapy, repetitive transcranial magnetic stimulation, and intensive outpatient treatment; failure to preauthorize will result in reduction or denial of benefits. Inpatient: Copay is charged in addition to the overall deductible. Preauthorization required Out-of-Network; failure to preauthorize will result in reduction or denial of benefits.
	Mental/Behavioral health inpatient services	20% coinsurance	$1,500 copay/admit plus 50% coinsurance	
	Substance use disorder outpatient services	No charge for office visits or 20% coinsurance for other outpatient services	50% coinsurance	
	Substance use disorder inpatient services	20% coinsurance	$1,500 copay/admit plus 50% coinsurance	
If you are pregnant	Prenatal and postnatal care	20% coinsurance	50% coinsurance	---none---
	Delivery and all inpatient services	20% coinsurance	$1,500 copay/admit plus 50% coinsurance	Copay is charged in addition to the overall deductible.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	60 visit maximum per benefit period.
	Rehabilitation services	20% coinsurance	50% coinsurance	Combined 70 visit limit per benefit period for rehabilitation and habilitation services.
	Habilitation services	20% coinsurance	50% coinsurance	
	Skilled nursing care	20% coinsurance	50% coinsurance	25 day maximum per benefit period. Preauthorization required Out-of-Network; failure to preauthorize will result in reduction or denial of benefits.
	Durable medical equipment	20% coinsurance	50% coinsurance	---none---
	Hospice service	20% coinsurance	50% coinsurance	Preauthorization required Out-of-Network; failure to preauthorize will result in reduction or denial of benefits.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	No Charge	No Charge	One visit per year. Reimbursed up to $30 out-of-network. See benefit booklet for network details.
	Glasses	No Charge	No Charge	One pair of glasses per year. Up to $150 in-network. See benefit booklet for network details.
	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.)

- Abortions (except where a pregnancy is the result of rape or incest, or for a pregnancy which, as certified by a physician, places the woman in danger of death unless an abortion is performed)
- Acupuncture
- Bariatric surgery
- Dental Care (Adult and Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (Except when determined to be Medically Necessary and ordered or authorized by the PCP)
- Routine eye care (Adult)
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Cosmetic surgery (Only for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors or diseases. When Medically Necessary.)
- Hearing aids (Limited to one for each ear every three years)
- Infertility treatment (Diagnosis covered but treatment and Invitro not covered)
- 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:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-888-697-0683. You may also contact your state insurance department at http://www.tdi.texas.gov..

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: Texas Department of Insurance at (800) 578-4677 or visit www.tdi.texas.gov. The MSP Program External Review Process enables every MSP enrollee to obtain an additional, independent level of review of any adverse benefit determination. More information is available at http://www.opm.gov/healthcare-insurance/multi-state-plan-program/external-review/. You may also call OPM toll free at (855) 318-0714 if you need help with your request for External Review.

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.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-697-0683.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-697-0683.
Chinese (中文): 如果需要中文的帮助， 打这个号 1-888-697-0683.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-888-697-0683.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

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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.

This is not a cost estimator.

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** $6,740
- **Patient pays** $800

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	$100
Copays	$0
Coinsurance	$500
Limits or exclusions	$200
Total	**$800**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $4,920
- **Patient pays** $480

Sample care costs:

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

Patient pays:

Deductibles	$100
Copays	$0
Coinsurance	$300
Limits or exclusions	$80
Total	**$480**

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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 **deductibles**, **copayments**, and **coinsurance** 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.

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