

Coverage Period: 01/01/2014-12/31/2014

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

Coverage for: Individual/Family | Plan Type: PPO



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/coverage/Individual/index.html or by calling 1-888-697-0683.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	Network \$6,350 Individual/ \$12,700 Family Out-of-Network \$12,700 Individual/ \$25,400 Family Doesn't apply to certain preventive care.	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket</u> <u>limit</u> on my expenses?	Yes. For Network \$6,350 Individual/ \$12,700 Family For Out-of-Network \$12,700 Individual/ \$25,400 Family	The <u>out-of-pocket</u> 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 <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges, and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Does this plan use a <u>network</u> of <u>providers</u> ?	Yes. See www.bcbstx.com or call 1-888-697-0683 for a list of Network Providers.	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 2 for how this plan pays different kinds of providers .
Do I need a referral to see a <u>specialist</u> ?	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 4. See your policy or plan document for additional information about <u>excluded services</u> .



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

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider		Limitations & Exceptions
If you visit a health care provider's office or	Primary care visit to treat an injury or illness	No Charge	20% coinsurance	First 3 Office Visits are at \$40, ded/ coins for subsequent visits
clinic	Specialist visit	No Charge	20% coinsurance	none
	Other practitioner office visit	No Charge	20% coinsurance	Acupuncture not covered.
	Preventive care/screening/immunization	No Charge	20% coinsurance	none
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	20% coinsurance	
	Imaging (CT / PET scans, MRIs)	No Charge	20% coinsurance	none
If you need drugs to	Generic Drugs	No Charge	No Charge	Prescriptions per 30-Day Supply, up
treat your illness or	Preferred Brand Drugs	No Charge	No Charge	to a 90-Day Supply. Standard
condition More information about prescription drug	Non-Preferred Brand Drugs	No Charge	No Charge	Formulary and Calendar year deductible applies. certain women's preventative services will be covered with no cost to the member.
coverage is available at www.bcbstx.com/ member/rx_drugs.html	Specialty Drugs	No Charge	No Charge	Standard Formulary and Calendar year deductible applies. certain women's preventative services will be covered with no cost to the member.
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	No Charge	20% coinsurance	
surgery	Physician/surgeon fees	No Charge	20% coinsurance	none



BlueCross BlueShield of Texas

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If you need immediate	Emergency room services	No Charge	No Charge	
medical attention	Emergency medical transportation	No Charge	No Charge	none
	Urgent care	No Charge	20% coinsurance	
If you have a hospital	Facility fee (e.g., hospital room)	No Charge	20% coinsurance	none
stay	Physician/surgeon fee	No Charge	20% coinsurance	
If you have mental	Mental/Behavioral health outpatient services	No Charge	20% coinsurance	Certain services must be preauthorized.
health, behavioral	Mental/Behavioral health inpatient services	No Charge	20% coinsurance	All services must be preauthorized.
health, or substance	Substance use disorder outpatient services	No Charge	20% coinsurance	Certain services must be preauthorized.
abuse needs	Substance use disorder inpatient services	No Charge	20% coinsurance	All services must be preauthorized.
If you are pregnant	Prenatal and postnatal care	No Charge	20% coinsurance	
	Delivery and all inpatient services	No Charge	20% coinsurance	none
If you need help	Home health care	No Charge	20% coinsurance	Limited to 60 visits per year.
recovering or have other	Rehabilitation services	No Charge	20% coinsurance	Limited to combined 35 visits per year,
special health needs	Habilitation services	No Charge	20% coinsurance	including Chiropractic.
	Skilled nursing care	No Charge	20% coinsurance	Limited to 25 days per year.
	Durable medical equipment	No Charge	20% coinsurance	none
	Hospice service	No Charge	20% coinsurance	110110
If your child needs	Eye exam	No Charge	Covered	Reimbursed up to \$30
dental or eye care				Out-of-Network. One visit per
				calendar year. Up to age 19.
	Glasses	No Charge	Covered	Reimbursed up to \$30 frames/\$25
				single vision lenses Out-of-Network.
				One pair per calendar year. Up to age 19.
	Dental check-up	Not Covered	Not Covered	none

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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.)			
Acupuncture	Dental Care (Adult)	 Private-duty nursing (Only covered for extended 	
Bariatric surgery	Long-term care	care expenses)	
_		 Weight loss programs 	
		ant for other covered services and your costs for these services)	

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	• Infertility treatment (Diagnosis covered but	Routine eye care (Adult)
Cosmetic surgery (Only for the correction of	treatment and Invitro not covered)	 Routine foot care (Only covered Network
congenital deformities or for conditions resulting	• Non-emergency care when traveling outside the	connection with diabetes, circulatory disorders of
from accidental injuries, scars, tumors or diseases.	U.S.	the lower extremities, peripheral vascular disease,
When Medically Necessary.)		peripheral neuropathy, or chronic arterial or venous
• Hearing aids (Limited to 2 per 3 years)		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 http://www.tdi.texas.gov.

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.

Questions: Call 1-888-697-0683 or visit us at www.bcbstx.com/coverage/Individual/index.html. 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 1-888-697-0683 to request a copy.

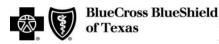


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Language Access Services:

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,请拨打这个号码 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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Coverage Examples:

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.



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 \$1,040
 Patient pays \$6,500

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	\$6,350
Copays	\$0
Coinsurance	\$0
Limits or exclusions	\$150
Total	\$6,500

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

Amount owed to providers: \$5,400

■ Plan pays \$50

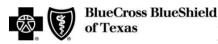
■ Patient pays \$5,350

Sample care costs:

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

Patient pays:

Deductibles	\$5,270
Copays	\$0
Coinsurance	\$0
Limits or exclusions	\$80
Total	\$5,350



Coverage Examples:

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 <u>deductibles</u>, <u>copayments</u>, and <u>coinsurance</u> 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.