

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	\$0	See the chart starting on page 2 for your other costs for services this plan covers.
deductible?		
Are there other	No.	You don't have to meet <b><u>deductibles</u></b> for specific services, but see the chart starting on page 2
deductibles for specific		for other costs for services this plan covers.
services?		
Is there an <u>out-of-pocket</u>	No.	There's no limit on how much you could pay during a policy period for your share of the cost
<u>limit</u> on my expenses?		of covered services.
What is not included in	This plan has no <u>out-of-pocket</u>	Not applicable because there's no <b><u>out-of-pocket limit</u></b> on your expense.
the <u>out-of-pocket limit</u> ?	<u>limit</u> .	
Does this plan use a	Yes. See www.bcbstx.com or call	If you use an in-network doctor or other health care <b>provider</b> , this plan will pay some or all of
network of providers?	1-888-697-0683 for a list of	the costs of covered services. Be aware, your in-network doctor or hospital may use an
_	Network Providers.	out-of-network <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or
		participating for <b>providers</b> in their <b><u>network</u></b> . See the chart starting on page 2 for how this
		plan pays different kinds of <b>providers</b> .
Do I need a referral to see	No. You don't need a referral to	You can see the <b>specialist</b> you choose without permission from this plan.
a <u>specialist</u> ?	see a specialist.	
Are there services this plan	Yes.	Some of the services this plan doesn't cover are listed on page 3. See your policy or plan
doesn't cover?		document for additional information about <u>excluded services</u> .



### BCBS Premier 1, a Multi-State Plan

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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 an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or	Primary care visit to treat an injury or illness Specialist visit	No Charge No Charge	No Charge No Charge	none
clinic	Other practitioner office visit	No Charge	No Charge	Acupuncture not covered. Chiropractic care limited to 35 visits per year.
	Preventive care/screening/immunization	No Charge	No Charge	none
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	No Charge	none
	Imaging (CT / PET scans, MRIs)	No Charge	No Charge	110110
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
<b>condition</b> More information about	Non-Preferred Brand Drugs	No Charge	No Charge	Formulary applies. certain women's preventative services will be covered with no cost to the member.
prescription drug coverage is available at www.bcbstx.com/ member/rx_drugs.html	Specialty Drugs	No Charge	No Charge	Standard Formulary 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	No Charge	none
surgery	Physician/surgeon fees	No Charge	No Charge	none
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	No Charge	

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.



### BlueCross BlueShield

# BCBS Premier 1, a Multi-State Plan

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

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Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider		Limitations & Exceptions	
If you have a hospital	Facility fee (e.g., hospital room)	No Charge	No Charge	none	
stay	Physician/surgeon fee	No Charge	No Charge		
If you have mental	Mental/Behavioral health outpatient services	No Charge	No Charge	Certain services must be preauthorized.	
health, behavioral	Mental/Behavioral health inpatient services	No Charge	No Charge	All services must be preauthorized.	
health, or substance	Substance use disorder outpatient services	No Charge	No Charge	Certain services must be preauthorized.	
abuse needs	Substance use disorder inpatient services	No Charge	No Charge	All services must be preauthorized.	
If you are pregnant	Prenatal and postnatal care	No Charge	No Charge		
	Delivery and all inpatient services	No Charge	No Charge	none	
If you need help	Home health care	No Charge	No Charge	Limited to 60 visits per year.	
recovering or have other	Rehabilitation services	No Charge	No Charge	Limited to 35 visits per year.	
special health needs	Habilitation services	No Charge	No Charge	Limited to 35 visits per year.	
	Skilled nursing care	No Charge	No Charge	Limited to 25 days per year.	
	Durable medical equipment	No Charge	No Charge		
	Hospice service	No Charge	No Charge	none	
If your child needs dental or eye care	Eye exam	No Charge	No Charge	Reimbursed up to \$30 Out-of-Network. One visit per calendar year. Up to age 19.	
	Glasses	No Charge	No Charge	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	

### **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)	<ul> <li>Private-duty nursing (Only covered for extended</li> </ul>	
Bariatric surgery	Long-term care	care expenses)	
	τ, τ	Weight loss programs	
Questions: Call <b>1-888-697-0683</b> c	or visit us at <b>www.bcbstx.com/coverage/Individual/in</b>		

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### 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	٠	Infertility treatment (Diagnosis covered but	٠	Routine eye care (Adult)
•	• Cosmetic surgery (Only for the correction of		treatment and Invitro not covered)	٠	Routine foot care (Only covered Network
	congenital deformities or for conditions resulting	٠	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.

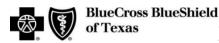


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#### Language Access Services:

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.—



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 \$7,390
 Patient pays \$150

#### 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	\$0
Copays	\$0
Coinsurance	\$0
Limits or exclusions	\$150
Total	\$150

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

#### Amount owed to providers: \$5,400

■ Plan pays \$5,320

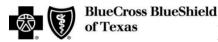
■ Patient pays \$80

#### 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 Copays	\$0
Coinsurance	\$0
Limits or exclusions	\$80
Total	\$80



**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.