



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

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>                             | \$2,000 Individual / \$4,000 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>copayment</u> , <u>prescription drugs</u> , and In-Network <u>preventive care</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 deductibles for specific services?</b>          | No.                                                                                                                                                                   | You don't have to meet <u>deductibles</u> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>What is the out-of-pocket limit for this plan?</b>              | \$7,000 Individual / \$14,000 Family<br>Prescription drug limit:<br>\$1,000 Individual/\$3,000 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 out-of-pocket limit?</b>            | <u>Premiums</u> , <u>balance-billing</u> charges, 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 network provider?</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 referral to see a specialist?</b>                 | Yes.                                                                                                                                                                  | This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</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<br>(You will pay the least)                | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                         |
| If you visit a health care <u>provider's</u> office or clinic | Primary care visit to treat an injury or illness | \$30 <u>copayment</u> /visit; <u>deductible</u> does not apply | Not Covered                                        | None                                                                                                                                                                    |
|                                                               | <u>Specialist</u> visit                          | \$50 <u>copayment</u> /visit; <u>deductible</u> does not apply | Not Covered                                        | <u>Referral</u> required.                                                                                                                                               |
|                                                               | <u>Preventive care/screening/immunization</u>    | No Charge; <u>deductible</u> does not apply                    | Not Covered                                        | You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. |
| If you have a test                                            | <u>Diagnostic test</u> (x-ray, blood work)       | 30% <u>coinsurance</u> after <u>deductible</u>                 | Not Covered                                        | None                                                                                                                                                                    |
|                                                               | Imaging (CT/PET scans, MRIs)                     | 30% <u>coinsurance</u> after <u>deductible</u>                 | Not Covered                                        | None                                                                                                                                                                    |

\*For more information about limitations and exceptions, see the plan or policy document at

| Common Medical Event                                                                                                                                                                       | Services You May Need                          | What You Will Pay                                                                                                                                                                |                                                                                                                                                                                  | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                            |                                                | In-Network Provider<br>(You will pay the least)                                                                                                                                  | Out-of-Network Provider<br>(You will pay the most)                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <b>prescription drug coverage</b> is available at <a href="http://www.bcbstx.com">www.bcbstx.com</a> | Preferred generic drugs                        | \$5 retail and mail order <u>copayment/prescription</u> ; <u>deductible</u> does not apply                                                                                       | Not Covered                                                                                                                                                                      | <u>Prescription drug out-of-pocket limit</u> :<br>\$1,000 Individual /\$3,000 Family<br><br>Retail covers a 30-day supply. With appropriate prescription, up to a 90-day supply is available. Mail order covers a 90-day supply.<br><br>Payment of the difference between the cost of a brand name drug and a generic may be required if a generic drug is available. Certain drugs require approval before they will be covered.<br>The <u>cost-sharing</u> 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.<br><br><u>Specialty drugs</u> are limited to a 30-day supply except for certain FDA-designated dosing regimens. Mail order is not covered. |
|                                                                                                                                                                                            | Non-preferred generic drugs                    | \$30 retail and mail order <u>copayment/prescription</u> ; <u>deductible</u> does not apply                                                                                      | Not Covered                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                                                                                                                                            | Preferred brand drugs                          | \$75 retail and mail order <u>copayment/prescription</u> ; <u>deductible</u> does not apply                                                                                      | Not Covered                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                                                                                                                                            | Non-preferred brand drugs                      | \$100 retail and mail order <u>copayment/prescription</u> ; <u>deductible</u> does not apply                                                                                     | Not Covered                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|                                                                                                                                                                                            | <u>Specialty drugs</u>                         | \$150 <u>copayment/prescription</u> ; <u>deductible</u> does not apply                                                                                                           | Not Covered                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>If you have outpatient surgery</b>                                                                                                                                                      | Facility fee (e.g., ambulatory surgery center) | 30% <u>coinsurance</u> after <u>deductible</u>                                                                                                                                   | Not Covered                                                                                                                                                                      | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|                                                                                                                                                                                            | Physician/surgeon fees                         | 30% <u>coinsurance</u> after <u>deductible</u>                                                                                                                                   | Not Covered                                                                                                                                                                      | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
| <b>If you need immediate medical attention</b>                                                                                                                                             | <u>Emergency room care</u>                     | Facility Charges:<br>\$500 <u>copayment/visit</u> plus 30% <u>coinsurance</u> after <u>deductible</u><br>ER Physician Charges:<br>30% <u>coinsurance</u> after <u>deductible</u> | Facility Charges:<br>\$500 <u>copayment/visit</u> plus 30% <u>coinsurance</u> after <u>deductible</u><br>ER Physician Charges:<br>30% <u>coinsurance</u> after <u>deductible</u> | Emergency room <u>copayment</u> waived if admitted.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|                                                                                                                                                                                            | <u>Emergency medical transportation</u>        | 30% <u>coinsurance</u> after <u>deductible</u>                                                                                                                                   | 30% <u>coinsurance</u> after <u>deductible</u>                                                                                                                                   | Ground and air transportation covered.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|                                                                                                                                                                                            | <u>Urgent care</u>                             | \$100 <u>copayment/visit</u> ; <u>deductible</u> does not apply                                                                                                                  | Not Covered                                                                                                                                                                      | You may have to pay for services that are not covered by the visit fee. For an example, see "If you have a test" on page 2.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |

| Common Medical Event                                                      | Services You May Need                     | What You Will Pay                                                                                                                                     |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                               |
|---------------------------------------------------------------------------|-------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                           | In-Network Provider<br>(You will pay the least)                                                                                                       | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                      |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)        | 30% <u>coinsurance</u> after <u>deductible</u>                                                                                                        | Not Covered                                        | None                                                                                                                                                                                                                                                                                                                                                 |
|                                                                           | Physician/surgeon fees                    | 30% <u>coinsurance</u> after <u>deductible</u>                                                                                                        | Not Covered                                        | None                                                                                                                                                                                                                                                                                                                                                 |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | \$30 <u>copayment</u> /office visit; <u>deductible</u> does not apply<br>30% <u>coinsurance</u> after <u>deductible</u> for other outpatient services | Not Covered                                        | Certain services must be preauthorized; refer to your benefit booklet* for details.                                                                                                                                                                                                                                                                  |
|                                                                           | Inpatient services                        | 30% <u>coinsurance</u> after <u>deductible</u>                                                                                                        | Not Covered                                        | None                                                                                                                                                                                                                                                                                                                                                 |
| If you are pregnant                                                       | Office visits                             | \$30 <u>copayment</u> PCP/<br>\$50 <u>copayment</u> SPC;<br><u>deductible</u> does not apply                                                          | Not Covered                                        | <u>Copayment</u> applies to first prenatal visit (per pregnancy).<br><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 service described elsewhere in the SBC (i.e. ultrasound). |
|                                                                           | Childbirth/delivery professional services | 30% <u>coinsurance</u> after <u>deductible</u>                                                                                                        | Not Covered                                        |                                                                                                                                                                                                                                                                                                                                                      |
|                                                                           | Childbirth/delivery facility services     | 30% <u>coinsurance</u> after <u>deductible</u>                                                                                                        | Not Covered                                        | None                                                                                                                                                                                                                                                                                                                                                 |

| Common Medical Event                                                  | Services You May Need            | What You Will Pay                                                                                                                                                           |                                                    | Limitations, Exceptions, & Other Important Information |
|-----------------------------------------------------------------------|----------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|--------------------------------------------------------|
|                                                                       |                                  | In-Network Provider<br>(You will pay the least)                                                                                                                             | Out-of-Network Provider<br>(You will pay the most) |                                                        |
| <b>If you need help recovering or have other special health needs</b> | <u>Home health care</u>          | 30% <u>coinsurance</u> after deductible                                                                                                                                     | Not Covered                                        | <u>Preauthorization</u> is required.                   |
|                                                                       | <u>Rehabilitation services</u>   | \$30 PCP/<br>\$50 SPC <u>copayment</u> /visit;<br>deductible does not apply<br>30% <u>coinsurance</u> after deductible for other outpatient services and inpatient services | Not Covered                                        | None                                                   |
|                                                                       | <u>Habilitation services</u>     | \$30 PCP/<br>\$50 SPC <u>copayment</u> /visit;<br>deductible does not apply<br>30% <u>coinsurance</u> after deductible for other outpatient services and inpatient services | Not Covered                                        |                                                        |
|                                                                       | <u>Skilled nursing care</u>      | 30% <u>coinsurance</u> after deductible                                                                                                                                     | Not Covered                                        | Limited to 60 days per calendar year.                  |
|                                                                       | <u>Durable medical equipment</u> | 30% <u>coinsurance</u> after deductible                                                                                                                                     | Not Covered                                        | None                                                   |
|                                                                       | <u>Hospice services</u>          | 30% <u>coinsurance</u> after deductible                                                                                                                                     | Not Covered                                        | None                                                   |
|                                                                       |                                  |                                                                                                                                                                             |                                                    |                                                        |
| <b>If your child needs dental or eye care</b>                         | Children's eye exam              | \$30 <u>copayment</u> PCP/\$50 <u>copayment</u> SPC;<br>deductible does not apply                                                                                           | Not Covered                                        | None                                                   |
|                                                                       | Children's glasses               | Not Covered                                                                                                                                                                 | Not Covered                                        | None                                                   |
|                                                                       | Children's dental check-up       | Not Covered                                                                                                                                                                 | Not Covered                                        | None                                                   |

## 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.)

- Acupuncture
- Bariatric surgery
- Dental care (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- 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
- Cosmetic surgery
- Hearing aids (1 per ear per 36-month period)
- Infertility treatment
- Routine eye care (Adult)

**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 1-877-299-2377 or visit [www.bcbstx.com](http://www.bcbstx.com). For group health coverage subject to ERISA, contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). For non-federal governmental group health plans, contact Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law. 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](http://www.HealthCare.gov) or call 1-800-318-2596.

**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 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: For group health coverage subject to ERISA: Blue Cross and Blue Shield of Texas at 1-877-299-2377 or visit [www.bcbstx.com](http://www.bcbstx.com), the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), and the Texas Department of Insurance, Consumer Protection at 1-800-252-3439 or [www.tdi.texas.gov](http://www.tdi.texas.gov). For non-federal governmental group health plans and church plans that are group health plans, Blue Cross and Blue Shield of Texas at 1-877-299-2377 or [www.bcbstx.com](http://www.bcbstx.com) or contact the Texas Department of Insurance, Consumer Protection at 1-800-252-3439 or [www.tdi.texas.gov](http://www.tdi.texas.gov). Additionally, a consumer assistance program can help you file your appeal. Contact the Texas Department of Insurance's Consumer Health Assistance Program at 1-800-252-3439 or visit [www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/tx.html](http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/tx.html).

**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 1-877-299-2377.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-299-2377.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-877-299-2377.

Navajo (Dine): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-299-2377.

*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 <u>plan's</u> overall <u>deductible</u> | \$2,000 |
| ■ <u>Specialist copayment</u>                 | \$50    |
| ■ Hospital (facility) <u>coinsurance</u>      | 30%     |
| ■ Other <u>coinsurance</u>                    | 30%     |

#### 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

#### In this example, Peg would pay:

| <i>Cost Sharing</i> |         |
|---------------------|---------|
| <u>Deductibles</u>  | \$2,000 |
| <u>Copayments</u>   | \$40    |
| <u>Coinsurance</u>  | \$2,900 |

| <i>What isn't covered</i>         |                |
|-----------------------------------|----------------|
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$5,000</b> |

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|                                               |         |
|-----------------------------------------------|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$2,000 |
| ■ <u>Specialist copayment</u>                 | \$50    |
| ■ Hospital (facility) <u>coinsurance</u>      | 30%     |
| ■ Other <u>coinsurance</u>                    | 30%     |

#### 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

#### In this example, Joe would pay:

| <i>Cost Sharing</i> |       |
|---------------------|-------|
| <u>Deductibles</u>  | \$900 |
| <u>Copayments</u>   | \$800 |
| <u>Coinsurance</u>  | \$0   |

| <i>What isn't covered</i>         |                |
|-----------------------------------|----------------|
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$1,720</b> |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

|                                               |         |
|-----------------------------------------------|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$2,000 |
| ■ <u>Specialist copayment</u>                 | \$50    |
| ■ Hospital (facility) <u>coinsurance</u>      | 30%     |
| ■ Other <u>coinsurance</u>                    | 30%     |

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

#### In this example, Mia would pay:

| <i>Cost Sharing</i> |         |
|---------------------|---------|
| <u>Deductibles</u>  | \$1,700 |
| <u>Copayments</u>   | \$600   |
| <u>Coinsurance</u>  | \$0     |

| <i>What isn't covered</i>         |                |
|-----------------------------------|----------------|
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,300</b> |

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

## Non-Discrimination Notice

### Health Care Coverage Is Important For Everyone

We do not discriminate on the basis of race, color, national origin (including limited English knowledge and first language), age, disability, or sex (as understood in the applicable regulation). We provide people with disabilities with reasonable modifications and free communication aids to allow for effective communication with us. We also provide free language assistance services to people whose first language is not English.

To receive reasonable modifications, communication aids or language assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, you can file a grievance with:

|                                          |          |                                   |
|------------------------------------------|----------|-----------------------------------|
| Office of Civil Rights Coordinator       | Phone:   | 855-664-7270 (voicemail)          |
| Attn: Office of Civil Rights Coordinator | TTY/TDD: | 855-661-6965                      |
| 300 E. Randolph St., 35th Floor          | Fax:     | 855-661-6960                      |
| Chicago, IL 60601                        | Email:   | civilrightscoordinator@bcbsil.com |

You can file a grievance by mail, fax or email. If you need help filing a grievance, please call the toll-free phone number listed on the back of your ID card (TTY: 711).

You may file a civil rights complaint with the US Department of Health and Human Services, Office for Civil Rights, at:

|                                    |                                                    |              |
|------------------------------------|----------------------------------------------------|--------------|
| US Dept of Health & Human Services | Phone:                                             | 800-368-1019 |
| 200 Independence Avenue SW         | TTY/TDD:                                           | 800-537-7697 |
| Room 509F, HHH Building            | Complaint Portal:                                  |              |
| Washington, DC 20201               | ocrportal.hhs.gov/ocr/smartscreen/main.jsf         |              |
|                                    | Complaint Forms:                                   |              |
|                                    | hhs.gov/civil-rights/filing-a-complaint/index.html |              |

This notice is available on our website at [bcbstx.com/legal-and-privacy/non-discrimination-notice](http://bcbstx.com/legal-and-privacy/non-discrimination-notice)

ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 855-710-6984 (TTY: 711) or speak to your provider.

|                    |                                                                                                                                                                                                                                                                                                        |
|--------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Español<br>Spanish | ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 855-710-6984 (TTY: 711) o hable con su proveedor. |
| العربية<br>Arabic  | تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 855-710-6984 (TTY: 711) أو تحدث إلى مقدم الخدمة.                                                               |



|                     |                                                                                                                                                                                                                                                                                                                                       |
|---------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 中文<br>Chinese       | 注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 855-710-6984（文本电话：711）或咨询您的服务提供商。                                                                                                                                                                                                                                           |
| Français<br>French  | ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 855-710-6984 (TTY : 711) ou parlez à votre fournisseur.    |
| Deutsch<br>German   | ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentendienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 855-710-6984 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.        |
| ગુજરાતી<br>Gujarati | ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઓફિસિયલ સહાય અને એક્સેસિબલ ફોર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 855-710-6984 (TTY: 711) પર કોલ કરો અથવા તમારા પ્રદાતા સાથે ચાત કરો.                                                                         |
| हिंदी<br>Hindi      | ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 855-710-6984 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।                                                                       |
| Italiano<br>Italian | ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'855-710-6984 (tty: 711) o parla con il tuo fornitore.                                                |
| 한국어<br>Korean       | 주의: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 855-710-6984(TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.                                                                                                                                                                                       |
| Diné<br>Navajo      | SHOOH: Diné bee yáníłt'i'gogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jiik'eh ná hóló. Bee ahił hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'í' ahoot'í'ígíí éí t'áá jiik'eh hóló. Kohj'í' 855-710-6984 (TTY: 711) hodíilnih doodago nika'análwo'í bich'í' hanidziih. |
| Farsi<br>فارسي      | توجه: اگر فارسی صحبت می کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب های قابل دسترس، به طور رایگان موجود می باشند. با شماره 855-710-6984 (تله تایپ: 711) تماس بگیرید یا با ارائه دهنده خود صحبت کنید.                                                    |
| Polski<br>Polish    | UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 855-710-6984 (TTY: 711) lub porozmawiaj ze swoim dostawcą.                                                                   |
| РУССКИЙ<br>Russian  | ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 855-710-6984 (TTY: 711) или обратитесь к своему поставщику услуг.                |
| Tagalog<br>Tagalog  | PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 855-710-6984 (TTY: 711) o makipag-usap sa iyong provider.                        |
| Urdu<br>اردو        | توجه دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔ 855-710-6984 (TTY: 711) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔                                                                              |
| Việt<br>Vietnamese  | LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 855-710-6984 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.                      |