

 The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE:** Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.bcbstx.com/bb/ind/bb_sh2d50bftitxp_tx_2025.pdf or by calling 1-888-697-0683. 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/ or call 1-855-756-4448 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|--|
| What is the overall deductible? | \$0 | See the Common Medical Events chart below for your costs for services this plan covers. |
| Are there services covered before you meet your deductible? | Yes. | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. |
| Are there other deductibles for specific services? | No. | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan? | Not Applicable | This plan does not have an out-of-pocket limit on your expenses. |
| What is not included in the out-of-pocket limit? | Not Applicable. | This plan does not have an out-of-pocket limit on your expenses. |
| Will you pay less if you use a network provider? | Yes. See www.bcbstx.com/go/mbh or call 1-888-697-0683 for a list of Participating providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| Do you need a referral to see a specialist? | Yes. | This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|--|--|---|--|
| | | Indian Health Care Provider (IHCP) or other In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you visit a health care provider's office or clinic | Primary care visit to treat an injury or illness | No Charge | Not Covered | Virtual Visits are available. See your benefit booklet* (Your PCP) for details. |
| | <u>Specialist</u> visit | No Charge | Not Covered | <u>Referral</u> required. |
| | <u>Preventive care/screening/immunization</u> | No Charge | 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) | No Charge | Not Covered | <u>Referral</u> may be required. <u>Preauthorization</u> may also be required; see your benefit booklet* (Outpatient Lab and X-Ray services) for details. |
| | Imaging (CT/PET scans, MRIs) | No Charge | Not Covered | <u>Referral</u> may be required. <u>Preauthorization</u> may also be required; See your benefit booklet* (Outpatient Lab and X-Ray services) for details. |
| If you need drugs to treat your illness or condition | Generic drugs | No Charge | Not Covered | Limited to a 30-day supply at retail (or a 90-day supply at a <u>network</u> of select retail pharmacies). Up to a 90-day supply at mail order. <u>Specialty drugs</u> limited to a 30-day supply except for certain FDA-designated dosing regimens. Certain drugs require approval before they will be covered. <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. |
| | Brand drugs (Preferred) | No Charge | Not Covered | |
| | Brand drugs (Non-Preferred) | No Charge | Not Covered | |
| | <u>Specialty drugs</u> | No Charge | Not Covered | |
| More information about <u>prescription drug coverage</u> is available at www.bcbstx.com/rx/25/4T | | | | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No Charge | Not Covered | <u>Referral</u> required. <u>Preauthorization</u> may also be required. For Outpatient Infusion Therapy, see your benefit booklet* (Outpatient Facility Services) for details. |
| | Physician/surgeon fees | No Charge | Not Covered | |

*For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com/bb/ind/bb_sh2d50bfittxp_tx_2025.pdf

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|---|--|---|--|
| | | Indian Health Care Provider (IHCP) or other In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you need immediate medical attention | <u>Emergency room care</u> | No Charge | No Charge | None |
| | <u>Emergency medical transportation</u> | No Charge | No Charge | <u>Preauthorization</u> may be required for non-emergency transportation; see your benefit booklet* (Ambulance Services) for details. |
| | <u>Urgent care</u> | No Charge | Not Covered | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No Charge | Not Covered | <u>Referral</u> required. <u>Preauthorization</u> may also be required; see your benefit booklet* (Inpatient Hospital Services) for details. |
| | Physician/surgeon fees | No Charge | Not Covered | <u>Referral</u> required. <u>Preauthorization</u> may also be required; see your benefit booklet* (Inpatient Professional Services) for details. |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | No Charge | Not Covered | <u>Preauthorization</u> may be required; See your benefit booklet* (Behavioral Health Services) for details. |
| | Inpatient services | No Charge | Not Covered | <u>Referral</u> required. <u>Preauthorization</u> may also be required; see your benefit booklet* (Behavioral Health Services) for details. |
| If you are pregnant | Office visits | No Charge | Not Covered | Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). |
| | Childbirth/delivery professional services | No Charge | Not Covered | |
| | Childbirth/delivery facility services | No Charge | Not Covered | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|--|----------------------------------|--|---|--|
| | | Indian Health Care Provider (IHCP) or other In-Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you need help recovering or have other special health needs | <u>Home health care</u> | No Charge | Not Covered | 60 visits/year. <u>Referral</u> required. <u>Preauthorization</u> may also be required; see your benefit booklet* (Extended Care Services) for details. |
| | <u>Rehabilitation services</u> | No Charge | Not Covered | Separate 35-visit maximum per benefit period for <u>Habilitation services</u> and <u>Rehabilitation services</u> , including chiropractic care. <u>Referral</u> required. <u>Preauthorization</u> may also be required; see your benefit booklet* (<u>Rehabilitation Services</u> and <u>Habilitation Services</u>) for details. |
| | <u>Habilitation services</u> | No Charge | Not Covered | |
| | <u>Skilled nursing care</u> | No Charge | Not Covered | 25 days/year. <u>Referral</u> required. <u>Preauthorization</u> may also be required; see your benefit booklet* (Extended Care Services) for details. |
| | <u>Durable medical equipment</u> | No Charge | Not Covered | <u>Referral</u> required. <u>Preauthorization</u> may also be required; see your benefit booklet* (<u>Durable Medical Equipment</u>) for details. |
| | <u>Hospice services</u> | No Charge | Not Covered | <u>Referral</u> required. <u>Preauthorization</u> may also be required; see your benefit booklet* (Extended Care Services) for details. |
| If your child needs dental or eye care | Children's eye exam | No Charge | Up to a \$30 reimbursement is available | One visit per year. Out-of-Network reimbursement will not exceed the retail cost. See your benefit booklet* (Pediatric Vision Care Benefits) for details. |
| | Children's glasses | No Charge | Up to a \$75 reimbursement is available | One pair of glasses per year. Reimbursement for frames, lenses, and lens options purchased Out-of-Network is available (not to exceed the retail cost). See your benefit booklet* (Pediatric Vision Care Benefits) for details. |
| | Children's dental check-up | Not Covered | Not Covered | None |

*For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com/bb/ind/bb_sh2d50bfittx_tx_2025.pdf

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Abortion (Except for a pregnancy that, as certified by a physician, places the woman in danger of death)
- Acupuncture
- Bariatric surgery
- Cosmetic surgery (Except when medically necessary)
- Dental care (Adult and child)
- Infertility treatment (Diagnosis and treatment covered; in vitro not covered)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (Unless medically necessary)
- Routine eye care (Adult)
- Routine foot care (Except when medically necessary)
- 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 (35 visits/year combined with habilitation and rehabilitation services)
- Hearing aids (Limited to 1 hearing aid per ear every 36 months)

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: the plan at Blue Cross and Blue Shield of Texas at 1-888-697-0683 or visit www.bcbstx.com. You may also contact your state insurance department at 1-800-252-3439 or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596 OR state Health Insurance Marketplace or SHOP.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Texas Department of Insurance at 1-800-578-4677 or visit <https://tdi.texas.gov>.

Does this plan provide Minimum Essential Coverage? Yes.

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

Does this plan meet the Minimum Value Standards? Not Applicable.

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 1-888-697-0683.

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, kwijijigo holne' 1-888-697-0683.

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) | | Managing Joe's Type 2 Diabetes (a year of routine in-network care of a well-controlled condition) | | Mia's Simple Fracture (in-network emergency room visit and follow up care) | |
|---|-----------------|--|----------------|--|----------------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$0 | ■ The <u>plan's</u> overall <u>deductible</u> | \$0 | ■ The <u>plan's</u> overall <u>deductible</u> | \$0 |
| ■ <u>Specialist copayment</u> | \$0 | ■ <u>Specialist copayment</u> | \$0 | ■ <u>Specialist copayment</u> | \$0 |
| ■ <u>Hospital (facility) copayment</u> | \$0 | ■ <u>Hospital (facility) copayment</u> | \$0 | ■ <u>Hospital (facility) copayment</u> | \$0 |
| ■ <u>Other copayment</u> | \$0 | ■ <u>Other copayment</u> | \$0 | ■ <u>Other copayment</u> | \$0 |
| This EXAMPLE event includes services like: <u>Specialist</u> office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services <u>Diagnostic tests</u> (<i>ultrasounds and blood work</i>) <u>Specialist</u> visit (<i>anesthesia</i>) | | This EXAMPLE event includes services like: <u>Primary care physician</u> office visits (<i>including disease education</i>) <u>Diagnostic tests</u> (<i>blood work</i>) <u>Prescription drugs</u> <u>Durable medical equipment</u> (<i>glucose meter</i>) | | This EXAMPLE event includes services like: <u>Emergency room care</u> (<i>including medical supplies</i>) <u>Diagnostic test</u> (<i>x-ray</i>) <u>Durable medical equipment</u> (<i>crutches</i>) <u>Rehabilitation services</u> (<i>physical therapy</i>) | |
| Total Example Cost | \$12,700 | Total Example Cost | \$5,600 | Total Example Cost | \$2,800 |
| In this example, Peg would pay: | | In this example, Joe would pay: | | In this example, Mia would pay: | |
| <i>Cost Sharing</i> | | <i>Cost Sharing</i> | | <i>Cost Sharing</i> | |
| <u>Deductibles</u> | \$0 | <u>Deductibles</u> | \$0 | <u>Deductibles</u> | \$0 |
| <u>Copayments</u> | \$0 | <u>Copayments</u> | \$0 | <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$0 | <u>Coinsurance</u> | \$0 | <u>Coinsurance</u> | \$0 |
| <i>What isn't covered</i> | | <i>What isn't covered</i> | | <i>What isn't covered</i> | |
| Limits or exclusions | \$60 | Limits or exclusions | \$20 | Limits or exclusions | \$0 |
| The total Peg would pay is | \$60 | The total Joe would pay is | \$20 | The total Mia would pay is | \$0 |

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



Health care coverage is important for everyone.

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984. We provide free communication aids and services for anyone with a disability or who needs language assistance.

We do not discriminate on the basis of race, color, national origin, sex, gender identity, age, sexual orientation, health status or disability. If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St., 35th Floor
Chicago, IL 60601

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

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

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

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

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

| | |
|------------|---|
| Español | Llámenos al 855-710-6984 para recibir asistencia lingüística o comunicación en otros formatos sin costo. |
| العربية | لتلقي المساعدة اللغوية أو التواصل مجاناً، يرجى الاتصال بنا على الرقم 855-710-6984. |
| 繁體中文 | 如欲獲得免費語言或溝通協助，請撥打855-710-6984與我們聯絡。 |
| Français | Pour bénéficier gratuitement d'une assistance linguistique ou d'une aide à la communication, veuillez nous appeler au 855-710-6984. |
| Deutsch | Um kostenlose Sprach- oder Kommunikationshilfe zu erhalten, rufen Sie uns bitte unter 855-710-6984 an. |
| ગુજરાતી | ભાષા અથવા સંચાર સહાય મફતમાં મેળવવા માટે, કૃપા કરીને અમને 855-710-6984 પર કોલ કરો. |
| हिंदी | निःशुल्क भाषा या संचार सहायता प्राप्त करने के लिए, कृपया हमें 855-710-6984 पर कॉल करें। |
| Italiano | Per assistenza gratuita alla lingua o alla comunicazione, chiami il numero 855-710-6984. |
| 한국어 | 언어 또는 의사소통 지원을 무료로 받으려면 855-710-6984번으로 전화해 주세요. |
| Navajo | Niná: Doo bilagáana bizaad dinit's'á'góó, shá ata' hodooni nínízingo, t'áájíík'eh bee náhaz'á. 1-866-560-4042 jí' hodíilni. |
| فارسی | برای دریافت کمک زبانی یا ارتباطی رایگان، لطفاً با شماره 855-710-6984 تماس بگیرید. |
| Polski | Aby uzyskać bezpłatną pomoc językową lub komunikacyjną, prosimy o kontakt pod numerem 855-710-6984. |
| Русский | Чтобы бесплатно воспользоваться услугами перевода или получить помощь при общении, звоните нам по телефону 855-710-6984. |
| Tagalog | Para makatanggap ng tulong sa wika o komunikasyon nang walang bayad, pakitawagan kami sa 855-710-6984. |
| اردو | مفت میں زبان یا مواصلت کی مدد موصول کرنے کے لیے، براہ کرم ہمیں 855-710-6984 پر کال کریں۔ |
| Tiếng Việt | Để được hỗ trợ ngôn ngữ hoặc giao tiếp miễn phí, vui lòng gọi cho chúng tôi theo số 855-710-6984. |