BlueCross BlueShield of Texas : B9E1ADT Blue Advantage Bronze HMO<sup>SM</sup> 905

Coverage Period: 09/01/2025-08/31/2026

Coverage for: All | Plan Type: HMO

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 <a href="https://www.bcbstx.com/bb/grp/bb\_bhsa01bavstxo\_tx\_2025.pdf">www.bcbstx.com/bb/grp/bb\_bhsa01bavstxo\_tx\_2025.pdf</a> or by calling 1-877-299-2377. 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?	\$6,750 Individual/\$13,500 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> .
Are there services covered before you meet your deductible?	Yes. In-Network Preventive Health Care services 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 <u>www.healthcare.gov/coverage/preventive-care-benefits/</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	\$7,750 Individual/\$15,500 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 limits</u> until the overall family <u>out-of-pocket limits</u> and the pocket limit has been met.
What is not included in the out-of-pocket limit?	<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 out-of-pocket limit.
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="https://www.bcbstx.com/go/bahmo">www.bcbstx.com/go/bahmo</a> or call 1-877-299-2377 for a list of Participating <a href="providers">providers</a> .	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.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	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> .

		What You Will Pay		
Common Medical Event	Services You May Need	Participating Providers (You will pay the least)	Non-Participating Providers (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Primary care visit to treat an injury or illness	30% coinsurance	Not Covered	Virtual Visits are available. See your benefit booklet* (Your PCP) for details.
If you visit a health care	Specialist visit	30% coinsurance	Not Covered	Referral required.
provider's office or clinic	Preventive care/screening/ immunization	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.
lf vou house a test	Diagnostic test (x-ray, blood work)	30% coinsurance	Not Covered	Referral may be required. Preauthorization may also be required; see your benefit booklet* (Outpatient Lab and X-Ray services) for details.
If you have a test	Imaging (CT/PET scans, MRIs)	30% <u>coinsurance</u>	Not Covered	
	Generic drugs (Preferred)	Retail - Preferred Participating - 10% coinsurance Participating - 20% coinsurance	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
If you need drugs to treat	Generic drugs (Non- preferred)	Retail - Preferred Participating - 10% coinsurance Participating - 20% coinsurance	Not Covered	order. Specialty drugs limited to a 30-day supply except for certain FDA-designated dosing regimens. Payment of the difference between the cost of a brand name drug and a
More information about prescription drug coverage is available at www.bcbstx.com/rx25/6T	Brand drugs (Preferred)	Retail - Preferred Participating - 20% coinsurance Participating - 30% coinsurance	Not Covered	generic may also be required if a generic drug is available. Certain drugs require approval before they will be covered. Cost
	Brand drugs (Non- preferred)	Retail - Preferred Participating - 30% coinsurance Participating - 40% coinsurance	Not Covered	sharing 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
	Specialty drugs (Preferred)	40% coinsurance	Not Covered	insulin needed to fill the prescription.
	Specialty drugs (Non-preferred)	50% coinsurance	Not Covered	

<sup>\*</sup>For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.bcbstx.com/bb/grp/bb\_bhsa01bavstxo\_tx\_2025.pdf</u>.

		What You Will Pay		
Common Medical Event	Services You May Need	Participating Providers (You will pay the least)	Non-Participating Providers (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	Not Covered	Referral required. Preauthorization may also be required. For Outpatient Infusion Therapy, see your benefit booklet* (Outpatient Facility Services) for details.
surgery	Physician/surgeon fees	30% coinsurance	Not Covered	
	Emergency room care	\$650 copayment/visit plus 30% coinsurance	\$650 <u>copayment</u> /visit plus 30% <u>coinsurance</u>	Copayment waived if admitted.
If you need immediate medical attention	Emergency medical transportation	30% coinsurance	30% coinsurance	<u>Preauthorization</u> may be required for non- emergency transportation; see your benefit booklet* (Ambulance Services) for details.
	<u>Urgent care</u>	30% coinsurance	Not Covered	None
	Facility fee (e.g., hospital room)	30% coinsurance	Not Covered	Referral required. Preauthorization may also be required; see your benefit booklet* (Inpatient Hospital Services) for details.
If you have a hospital stay	Physician/surgeon fees	30% coinsurance	Not Covered	Referral required. Preauthorization may also be required; see your benefit booklet* (Inpatient Professional Services) for details.
If you need mental health,	Outpatient services	30% coinsurance	Not Covered	<u>Preauthorization</u> may be required; see your benefit booklet* (Behavioral Health Services) for details.
behavioral health, or substance abuse services	Inpatient services	30% coinsurance	Not Covered	Referral required. Preauthorization may also be required; see your benefit booklet* (Behavioral Health Services) for details.
	Office visits	30% coinsurance	Not Covered	Cost sharing does not apply for preventive
If you are pregnant	Childbirth/delivery professional services	30% coinsurance	Not Covered	services. Depending on the type of services, a coinsurance or deductible may apply.  Maternity care may include tests and service
	Childbirth/delivery facility services	30% coinsurance	Not Covered	described elsewhere in the SBC (i.e., ultrasound).
If you need help recovering or have other special health needs	Home health care	30% coinsurance	Not Covered	60 visits/year. Referral required. Preauthorization may also be required; see your benefit booklet* (Extended Care Services) for details.

<sup>\*</sup>For more information about limitations and exceptions, see the  $\underline{plan}$  or policy document at  $\underline{www.bcbstx.com/bb/grp/bb\_bhsa01bavstxo\_tx\_2025.pdf}$ .

		What You Will Pay		
Common Medical Event	Services You May Need	Participating Providers (You will pay the least)	Non-Participating Providers (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Rehabilitation services	30% coinsurance	Not Covered	Separate 35-visit maximum per benefit period for Habilitation and Rehabilitation services,
	Habilitation services	30% coinsurance	Not Covered	including chiropractic care. Referral required. Preauthorization may also be required; see your benefit booklet* (Rehabilitation Services and Habilitation Services) for details.
	Skilled nursing care	30% coinsurance	Not Covered	25 days/year. Referral required. Preauthorization may also be required; see your benefit booklet* (Extended Care Services) for details.
	Durable medical equipment	30% coinsurance	Not Covered	Referral required. Preauthorization may also be required; see your benefit booklet* (Durable Medical Equipment) for details.
	Hospice services	30% coinsurance	Not Covered	Referral required. Preauthorization may also be required; see your benefit booklet* (Extended Care Services) for details.
	Children's eye exam	No Charge; deductible does not apply	Up to a \$30 reimbursement is available; deductible does not apply	One visit per year. Out-of-Network reimbursement will not exceed the retail cost. See your benefit booklet* (Pediatric Vision Care Benefits) for details.
If your child needs dental or eye care	Children's glasses	No Charge after <u>deductible</u>	Up to a \$75 reimbursement is available after deductible	One pair of glasses every 12 months. 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	30% coinsurance	30% <u>coinsurance</u>	Oral exams are limited to two every benefit period. Benefits for periodic and comprehensive oral evaluations are limited to a combined maximum of two every 12 months. See your benefit booklet* (Pediatric Dental Benefits Rider) for details.

#### **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 for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors, or diseases when medically necessary)
- Dental care (Adult)
- 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 <u>medically necessary</u>)
- 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 <a href="www.bcbstx.com">www.bcbstx.com</a>. 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 <a href="www.dol.gov/ebsa/healthreform">www.dol.gov/ebsa/healthreform</a>. 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 <a href="www.cciio.cms.gov">www.cciio.cms.gov</a>. 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 <a href="Health-Insurance Marketolace">Health Insurance Marketolace</a>. For more information about the Marketolace, visit <a href="https://www.HealthCare.gov">www.HealthCare.gov</a> 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 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: For group health coverage subject to ERISA: Blue Cross and Blue Shield of Texas at or visit <a href="https://www.bcbstx.com">www.bcbstx.com</a>, the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <a href="https://www.bcbstx.com">www.dol.gov/ebsa/healthreform</a>, and the Texas Department of Insurance, Consumer Protection at 1-800-252-3439 or <a href="https://www.bcbstx.com">www.bcbstx.com</a> or <a href="https://www.bcbstx.com">www.bcbstx

## 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 <u>credit</u> to help you pay for a <u>plan</u> through the <u>Marketplace</u>.

# **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): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-299-2377.

To see examples of how this <u>plan</u> 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 <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost-sharing</u> amounts (<u>deductibles</u>, <u>copayments</u>, and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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 plan's overall deductible	\$6,750
Specialist coinsurance	30%
Hospital (facility) coinsurance	30%
Other coinsurance	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)

Total Example Cost	\$12,700

# In this example, Peg would pay:

Cost sharing	
<u>Deductibles</u>	\$6,750
Copayments	\$0
Coinsurance	\$1,000
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$7,810

# **Managing Joe's Type 2 Diabetes**

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

■ The plan's overall deductible	\$6,750
■ Specialist coinsurance	30%
Hospital (facility) coinsurance	30%
Other coinsurance	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)

Total Example Cost	\$5,600

### In this example, Joe would pay:

\$2,300
\$300
\$0
\$20
\$2,620

# **Mia's Simple Fracture**

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

■ The plan's overall deductible	\$6,750
Specialist coinsurance	30%
■ Hospital (facility) coinsurance	30%
Other coinsurance	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>	\$2,800
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### In this example, Mia would pay:

Cost sharing		
<u>Deductibles</u>	\$2,400	
Copayments	\$400	
Coinsurance	\$0	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$2,800	

#### 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 Phone: 855-664-7270 (voicemail)

300 E. Randolph St., 35th Floor TTY/TDD: 855-661-6965 Chicago, IL 60601 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 Phone: 800-368-1019 200 Independence Avenue SW TTY/TDD: 800-537-7697

Room 509F, HHH Building 1019 Complaint Portal: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf

Washington, DC 20201 Complaint Forms: https://www.hhs.gov/civil-rights/filing-acomplaint/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 مجانًا، يرجى الاتصال بنا على الرقم 6984-710-855.	
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 કૉલ 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 dinits'á'góó, shá ata' hodooni nínízingo, t'áájíík'eh bee náhaz'á. 1-866-560-4042 jį' hodíilni.	
فارسى	بر ای دریافت کمک زیادی یا ارتباطی رایگان، لطفاً با شماره 6984-710-855 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	مغت میں زبان یا مواصلت کی مدد موصول کرنے کے لیے، براہِ کرم ہمیں 6984-710-855 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.	