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/grp/bb_phsk03bavstxo_tx_2025.pdf 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?	$600 Individual/$1,200 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. In-Network Preventive Health Care services, certain services with a copayment, and prescription drugs are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
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?	$1,800 Individual/$3,600 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges, and health care this plan 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 network provider?	Yes. See www.bcbstx.com/go/bahmo or call 1-877-299-2377 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.

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
		Participating Providers (You will pay the least)	Non-Participating Providers (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	$35 copayment/visit; deductible does not apply	Not Covered	Virtual Visits are available. See your benefit booklet* (Your PCP) for details.
	Specialist visit	$70 copayment/visit; deductible does not apply	Not Covered	Referral required.
	Preventive care/screening/ immunization	No Charge; deductible does not apply	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Not Covered	Referral may be required. Preauthorization may also be required; see your benefit booklet* (Outpatient Lab and X-Ray services) for details.
	Imaging (CT/PET scans, MRIs)	$250 copayment/test; deductible does not apply	Not Covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbstx.com/rx25/6T	Generic drugs (Preferred)	Retail - Preferred Participating - No Charge Participating - $10 copayment/prescription Mail - No Charge; deductible does not apply	Not Covered	Limited to a 30-day supply at retail (or a 90-day supply at a network of select retail pharmacies). Up to a 90-day supply at mail 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 generic may also be required if a generic drug is available. Certain drugs require approval before they will be covered. Cost 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 insulin needed to fill the prescription.
	Generic drugs (Non-preferred)	Retail - Preferred Participating - $10 copayment/prescription Participating - $20 copayment/prescription Mail - $30 copayment/prescription; deductible does not apply	Not Covered	
	Brand drugs (Preferred)	Retail - Preferred Participating - $50 copayment/prescription Participating - $70 copayment/prescription Mail - $150 copayment/prescription; deductible does not apply	Not Covered	
	Brand drugs (Non-preferred)	Retail - Preferred Participating - $100 copayment/prescription Participating - $120 copayment/prescription Mail - $300 copayment/prescription; deductible does not apply	Not Covered	

*For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com/bb/grp/bb_phsk03bavstxo_tx_2025.pdf.

Common Medical Event	Services You May Need	What You Will Pay: Participating Providers (You will pay the least)	What You Will Pay: Non-Participating Providers (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Specialty drugs (Preferred)	$150 copayment/prescription; deductible does not apply	Not Covered	
	Specialty drugs (Non-preferred)	$250 copayment/prescription; deductible does not apply	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$100 copayment/visit plus 20% coinsurance	Not Covered	Referral required. Preauthorization may also be required. For Outpatient Infusion Therapy, see your benefit booklet* (Outpatient Facility Services) for details.
	Physician/surgeon fees	20% coinsurance	Not Covered	
If you need immediate medical attention	Emergency room care	$300 copayment/visit plus 20% coinsurance	$300 copayment/visit plus 20% coinsurance	Copayment waived if admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Preauthorization may be required for non-emergency transportation; see your benefit booklet* (Ambulance Services) for details.
	Urgent care	$75 copayment/visit; deductible does not apply	Not Covered	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$150 copayment/visit plus 20% coinsurance	Not Covered	Referral required. Preauthorization may also be required; see your benefit booklet* (Inpatient Hospital Services) for details.
	Physician/surgeon fees	20% coinsurance	Not Covered	Referral required. Preauthorization 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	$35 copayment/office visit; deductible does not apply; 20% coinsurance for other outpatient services	Not Covered	Preauthorization may be required; see your benefit booklet* (Behavioral Health Services) for details.
	Inpatient services	$150 copayment/visit plus 20% coinsurance	Not Covered	Referral required. Preauthorization may also be required; see your benefit booklet* (Behavioral Health Services) for details.
If you are pregnant	Office visits	Primary Care: $35 copayment/initial visit; deductible does not apply Specialist: $70 copayment/initial visit; deductible does not apply	Not Covered	Copayment applies to first prenatal visit (per pregnancy). Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or

Common Medical Event	Services You May Need	What You Will Pay: Participating Providers (You will pay the least)	What You Will Pay: Non-Participating Providers (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Childbirth/delivery professional services	20% coinsurance	Not Covered	deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery facility services	$150 copayment/visit plus 20% coinsurance	Not Covered	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not Covered	60 visits/year. Referral required. Preauthorization may also be required; see your benefit booklet* (Extended Care Services) for details.
	Rehabilitation services	20% coinsurance	Not Covered	Separate 35-visit maximum per benefit period for Habilitation and Rehabilitation services, including chiropractic care. Referral required. Preauthorization may also be required; see your benefit booklet* (Rehabilitation Services and Habilitation Services) for details.
	Habilitation services	20% coinsurance	Not Covered	
	Skilled nursing care	20% 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	20% coinsurance	Not Covered	Referral required. Preauthorization may also be required; see your benefit booklet* (Durable Medical Equipment) for details.
	Hospice services	20% coinsurance	Not Covered	Referral required. Preauthorization 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; 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.
	Children's glasses	No Charge; deductible does not apply	Up to a $75 reimbursement is available; deductible does not apply	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.

*For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com/bb/grp/bb_phsk03bavstxo_tx_2025.pdf.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Providers (You will pay the least)	Non-Participating Providers (You will pay the most)	
	Children's dental check-up	30% coinsurance	30% coinsurance	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 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. 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. 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. 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 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 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, and the Texas Department of Insurance, Consumer Protection at 1-800-252-3439 or 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 or contact the Texas Department of Insurance, Consumer Protection at 1-800-252-3439 or 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.

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): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo 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 plan's overall deductible** **$600**
- **Specialist copayment** **$70**
- **Hospital (facility) copayment/coinsurance** **$150+20%**
- **Other coinsurance** **20%**

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	
Deductibles	$600
Copayments	$400
Coinsurance	$800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,860**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$600**
- **Specialist copayment** **$70**
- **Hospital (facility) copayment/coinsurance** **$150+20%**
- **Other coinsurance** **20%**

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:

Cost sharing	
Deductibles	$600
Copayments	$700
Coinsurance	$60
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,380**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$600**
- **Specialist copayment** **$70**
- **Hospital (facility) copayment/coinsurance** **$150+20%**
- **Other coinsurance** **20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost sharing	
Deductibles	$600
Copayments	$600
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,500**

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

BlueCross BlueShield of Texas

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: TTY/TDD: Fax:	855-664-7270 (voicemail) 855-661-6965 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: TTY/TDD: Complaint Portal: Complaint Forms:	800-368-1019 800-537-7697 https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf 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 مجانًا، 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 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.
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، براہِ 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.