Coverage Period: 12/01/2025-11/30/2026

Coverage for: All | Plan Type: PPO

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_ppso01bcastxo_tx_2025.pdf or by calling 1-800-521-2227. 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?	Network: \$1,000 Individual/\$3,000 Family Out-of-Network: \$2,000 Individual/\$6,000 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> .
Are there services covered before you meet your deductible?	Yes. In-Network Preventive Health Care services, services with a copayment, and prescription drugs are covered before you meet your deductible.	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> ?	Network: \$3,000 Individual/\$6,000 Family Out-of-Network: Unlimited Individual/Unlimited 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.
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 <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.bcbstx.com/go/bcppo or call 1-800-521-2227 for a list of network providers .	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> ?	No.	You can see the specialist you choose without a referral.

		What You Will Pay		
Common Medical Event	Services You May Need	Network Providers (You will pay the least)	Out-of-Network Providers (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Primary care visit to treat an injury or illness	No Charge; <u>deductible</u> does not apply	50% <u>coinsurance</u>	Virtual Visits are available. See your benefit booklet* (Your PCP) for details.
If you visit a health care	Specialist visit	\$40 copayment/visit; deductible does not apply	50% coinsurance	None
provider's office or clinic	Preventive care/screening/ immunization	No Charge; <u>deductible</u> does not apply	50% <u>coinsurance</u>	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	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	Preauthorization may be required. See your benefit booklet* (Outpatient Lab and X-Ray
If you have a test	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	services) for details.
If you need drugs to treat	Generic drugs (Preferred)	Retail - Preferred Participating - No Charge Participating - \$10 copayment/prescription Mail - No Charge; deductible does not apply	Retail - \$10 copayment/prescription; deductible does not apply plus 50% additional charge	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
your illness or condition More information about prescription drug coverage is available at	Generic drugs (Non- preferred)	Retail - Preferred Participating - \$10 <u>copayment</u> /prescription Participating - \$20 <u>copayment</u> /prescription Mail - \$30 <u>copayment</u> /prescription; <u>deductible</u> does not apply	Retail - \$20 copayment/prescription; deductible does not apply plus 50% additional charge	dosing regimens. Payment of the difference between the cost of a brand name drug and generic may also be required if a generic drug is available. Additional Out-of-Network charge will not apply to any <u>deductible</u> or our of-pocket amounts. Certain drugs require
www.bcbstx.com/rx25/6T	Brand drugs (Preferred)	Retail - Preferred Participating - \$50 <u>copayment</u> /prescription Participating - \$70 <u>copayment</u> /prescription Mail - \$150 <u>copayment</u> /prescription; <u>deductible</u> does not apply	Retail - \$70 <u>copayment/prescription;</u> <u>deductible</u> does not apply plus 50% additional charge	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

^{*}For more information about limitations and exceptions, see the <u>plan</u> or policy document at <u>www.bcbstx.com/bb/grp/bb_ppso01bcastxo_tx_2025.pdf</u>.

		What You Will Pay		
Common Medical Event	Services You May Need	Network Providers (You will pay the least)	Out-of-Network Providers (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Brand drugs (Non- preferred)	Retail - Preferred Participating - \$100 <u>copayment</u> /prescription Participating - \$120 <u>copayment</u> /prescription Mail - \$300 <u>copayment</u> /prescription; <u>deductible</u> does not apply	Retail - \$120 copayment/prescription; deductible does not apply plus 50% additional charge	supply, regardless of the amount or type of insulin needed to fill the prescription.
	Specialty drugs (Preferred)	\$150 <u>copayment</u> /prescription; <u>deductible</u> does not apply	\$150 <u>copayment/prescription;</u> <u>deductible</u> does not apply plus 50% additional charge	
	Specialty drugs (Non-preferred)	\$250 <u>copayment</u> /prescription; <u>deductible</u> does not apply	\$250 <u>copayment/prescription;</u> <u>deductible</u> does not apply plus 50% additional charge	
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	Preauthorization may be required. For Outpatient Infusion Therapy, see your benefit booklet* (Outpatient Facility Services) for
surgery	Physician/surgeon fees	20% coinsurance	50% coinsurance	details.
	Emergency room care	20% coinsurance	20% coinsurance	None
If you need immediate medical attention	Emergency medical transportation	20% coinsurance	20% coinsurance	<u>Preauthorization</u> may be required for non- emergency transportation; see your benefit booklet* (Ambulance Services) for details.
	<u>Urgent care</u>	\$50 copayment/visit; deductible does not apply	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	<u>Preauthorization</u> required. <u>Preauthorization</u> penalty: \$250 Out-of-Network. See your benefit booklet* (Inpatient Hospital Services) for details.
	Physician/surgeon fees	20% coinsurance	50% <u>coinsurance</u>	<u>Preauthorization</u> required. See your benefit booklet* (Inpatient Professional Services) for details.

^{*}For more information about limitations and exceptions, see the \underline{plan} or policy document at $\underline{www.bcbstx.com/bb/grp/bb_ppso01bcastxo_tx_2025.pdf}$.

		What You Will Pay		
Common Medical Event	Services You May Need	Network Providers (You will pay the least)	Out-of-Network Providers (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need mental health,	Outpatient services	No Charge; <u>deductible</u> does not apply for office visits; 20% <u>coinsurance</u> for other outpatient services	50% coinsurance	<u>Preauthorization</u> may be required; see your benefit booklet* (Behavioral Health Services) for details.
behavioral health, or substance abuse services	Inpatient services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	Preauthorization required. Preauthorization penalty: \$250 Out-of-Network. See your benefit booklet* (Behavioral Health Services) for details.
	Office visits	Primary Care: No Charge/initial visit Specialist: \$40 copayment/initial visit; deductible does not apply	50% coinsurance	<u>Copayment</u> applies to first prenatal visit (per pregnancy). <u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type
If you are pregnant	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply. Maternity care may include tests and services described
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	elsewhere in the SBC (i.e., ultrasound).
	Home health care	20% coinsurance	50% coinsurance	60 visits/year. Preauthorization may be required; see your benefit booklet* (Extended Care Services) for details.
	Rehabilitation services	20% coinsurance	50% coinsurance	Separate 35-visit maximum per benefit period for Habilitation and Rehabilitation services,
If you need help recovering	Habilitation services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	including chiropractic care. <u>Preauthorization</u> may be required; see your benefit booklet* (<u>Rehabilitation Services</u> and <u>Habilitation</u> <u>Services</u>) for details.
or have other special health needs	Skilled nursing care	20% coinsurance	50% coinsurance	25 days/year. <u>Preauthorization</u> may be required; see your benefit booklet* (Extended Care Services) for details.
	Durable medical equipment	20% coinsurance	50% coinsurance	<u>Preauthorization</u> may be required. See your benefit booklet* (<u>Durable Medical Equipment</u>) for details.
	Hospice services	20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> may be required. See your benefit booklet* (Extended Care Services) for details.

		What You Will Pay		
Common Medical Event	Services You May Need	Network Providers (You will pay the least)	Out-of-Network Providers (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Children's eye exam	No Charge; <u>deductible</u> 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; <u>deductible</u> 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.
	Children's dental check-up	30% <u>coinsurance</u>	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 (Except for extended care)
- Routine eye care (Adult)
- Routine foot care (Except when <u>medically</u> 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 <a href="Health-Lealt

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.bcbstx.com or 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 credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-521-2227. Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-521-2227.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-521-2227.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-521-2227.

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:



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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	\$1,000
Specialist copayment	\$40
■ Hospital (facility) coinsurance	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			
<u>Deductibles</u>	\$1,000		
<u>Copayments</u>	\$0		

<u>Deductibles</u>	\$1,000		
Copayments	\$0		
Coinsurance	\$2,000		
What isn't covered			
Limits or exclusions	\$60		
The total Peg would pay is	\$3,060		

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$1,000
■ Specialist copayment	\$40
Hospital (facility) coinsurance	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	

Cost sharing	
<u>Deductibles</u>	\$900
<u>Copayments</u>	\$400
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,320

Mia's Simple Fracture

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

■ The plan's overall deductible	\$1,000
■ Specialist copayment	\$40
■ Hospital (facility) coinsurance	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
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In this example, Mia would pay:

Cost sharing		
<u>Deductibles</u>	\$1,000	
Copayments	\$100	
Coinsurance	\$300	
What isn't covered		
Limits or exclusions	\$0	
The total Mia would pay is	\$1,400	

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 بدا 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	برای 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.	