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 or by calling 1-855-357-5228. 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 https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/ or call 1-800-456-5974 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: $1,500 Individual / $3,000 Family Out-of-Network: $3,000 Individual / $6,000 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. Services that charge a copay, Tier 1 prescription drugs, and, home health are covered before you meet 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 https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles or copayments for specific services?	Yes. Morbid Obesity Surgery Copayment - $3,500	Limited to one (1) surgery per lifetime.
What is the out-of-pocket limit for this plan?	For In-Network providers $5,500 individual / $11,000 family; for Out-of-Network providers $17,000 individual / $32,000 family	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, preauthorization penalties, and health care this plan doesn't cover. Morbid Obesity Copayment.	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 or call 1-855-357-5228 for a list of network 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

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Important Questions	Answers	Why This Matters:
		services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see a specialist you choose without a referral.

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
		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 Citizens Convenient Care	20% coinsurance after plan year deductible (PYD) $40 copay/office visit	70% coinsurance after plan year deductible Not Applicable	Virtual visits available through MDLive $0 copay. In-Network.
	Specialist visit	20% coinsurance after plan year deductible	70% coinsurance after plan year deductible	None
	Preventive care/screening/ immunization	No charge; deductible does not apply	70% coinsurance after plan year deductible	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. No Charge for child immunizations Out-of-Network through the 6th birthday.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after plan year deductible	70% coinsurance after plan year deductible	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance after plan year deductible	70% coinsurance after plan year deductible	
If you need drugs to treat your illness or condition More information about **prescription drug**	Tier 1	**Retail:** $15 copay / prescription **Mail:** $30 copay/prescription (2-month supply) $45* copay/prescription	Total Cost of Prescription	$1,500 Individual / $3,000 Family deductible combined with Medical. *Up to a 90-day supply at In-Network Retail or Mail Service Pharmacy. Members electing to purchase brand name

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
coverage is available at www.mybenefits.org		(3-month supply)		drugs when a generic is available will be required to pay the difference between the cost of the Generic drug and Brand Name drug, plus the Brand Name Copayment. Specialty drug prescriptions must be filled through Lumicera Specialty Pharmacy. One copay per 30-day supply. **Step Therapy Program** The Victoria County Employees' Primary Healthcare Clinic will provide a Step Therapy Program for asthma, cholesterol, diabetic and high blood pressure medications. After the patient has attempted and failed all viable generic medications, the clinic staff will make the determination to prescribe the more expensive brand name medication (Tier 2 / Tier 3). All copays in the Step Therapy Program are at a 30-day supply and the copay for Tier 2 / Tier 3 Brands is $25.
	Tier 2	20% coinsurance after plan year deductible	Total Cost of Prescription	
	Tier 3	20% coinsurance after plan year deductible	Total Cost of Prescription	
	Specialty drugs	20% coinsurance after plan year deductible	Total Cost of Prescription	
If you have outpatient surgery	Citizens Medical Center facility fee (e.g., ambulatory surgery center) All other facilities	No charge; deductible does not apply 20% coinsurance after plan year deductible	Not Applicable 70% coinsurance after plan year deductible	Preauthorization is required.
	Physician/surgeon fees	20% coinsurance after plan year deductible	70% coinsurance after plan year deductible	Preauthorization is required.
If you need immediate medical attention	Emergency room care Citizens Medical Center facility charge	No charge after $100 copay/visit	Not Applicable	Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	All other	20% coinsurance after $500 copay/visit & plan year deductible	20% coinsurance after $500 copay/visit & plan year deductible	Non-Emergency care = Network 20% coinsurance after deductible, Out of Network 70% coinsurance after deductible. The copay is waived if patient is admitted or visit is for Emergency Care as defined by the plan. 50% coinsurance for non-emergencies both Network & Out of Network.
	Emergency medical transportation	20% coinsurance after plan year deductible	20% coinsurance after plan year deductible	
	Urgent care	20% coinsurance after plan year deductible	70% coinsurance after plan year deductible	
If you have a hospital stay	Citizens Medical Center Facility fee (e.g., hospital room) All Other Facilities	No charge: deductible does not apply 20% coinsurance after plan year deductible	Not Applicable 70% coinsurance after plan year deductible	Preauthorization is required.
	Physician/surgeon fees	20% coinsurance after plan year deductible	70% coinsurance after plan year deductible	Preauthorization is required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance after plan year deductible	70% coinsurance after plan year deductible	Preauthorization is required.
	Inpatient services	20% coinsurance after plan year deductible	70% coinsurance after plan year deductible	
If you are pregnant	Office visits	20% coinsurance after plan year deductible	70% coinsurance after plan year deductible	
	Childbirth/delivery professional services	20% coinsurance after plan year deductible	70% coinsurance after plan year deductible	
	Childbirth/delivery facility services	20% coinsurance after plan year deductible	70% coinsurance after plan year deductible	All services must be preauthorized; $250 penalty applies Out-of-Network for failure to preauthorize.
If you need help recovering or have other special health needs	Home health care	No charge: deductible does not apply	No charge: deductible does not apply	All services must be preauthorized; Unlimited
	Rehabilitation services	20% coinsurance after	70% coinsurance after	Some services must be preauthorized

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		plan year deductible	plan year deductible	
	Habilitation services	20% coinsurance after plan year deductible	70% coinsurance after plan year deductible	
	Skilled nursing care	20% coinsurance after plan year deductible	70% coinsurance after plan year deductible	All services must be preauthorized; Limited to 90 days.
	Durable medical equipment	20% coinsurance after plan year deductible	70% coinsurance after plan year deductible	Some services must be preauthorized
	Hospice services	20% coinsurance after plan year deductible	70% coinsurance after plan year deductible	All services must be preauthorized; Unlimited
If your child needs dental or eye care	Children's eye exam	Not Covered	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.)

- Abortion (except in cases of rape, incest, or when the life of the mother is endangered)
- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Hearing Aids
- Infertility Treatment
- Long-Term Care
- Non-emergency care when traveling outside the U.S.
- Routine Eye Care (Adult)
- 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.)

- Bariatric Surgery
- Chiropractic Care

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 contact information for those agencies is: the plan at 1-855-357-5228, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform , or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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: Blue Cross Blue Shield of Texas at 1-855-357-5228 or visit www.bcbstx.com, or contact the U.S. Department of Labor's Employee Benefits Security Administrations at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Contact the Texas Department of Insurance at 1-800-252-3439 or visit www.texashealthoptions.com.

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 1-855-357-5228.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-357-5228.]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-855-357-5228.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-357-5228.]

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** **$1,500**
- **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	**$12,500**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,500
Copayments	$360
Coinsurance	$2,480
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,400**

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

- **The plan's overall deductible** **$1,500**
- **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	**$9,400**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$1,500
Copayments	$160
Coinsurance	$1,300
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,980**

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

- **The plan's overall deductible** **$1,500**
- **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	**$5,520**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,500
Copayments	$80
Coinsurance	$804
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,384**

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

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