BlueCross BlueShield of Texas

# : Blue Choice PPO MMB1

**Coverage for: Individual/Family | 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/member/policy-forms/2017 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 https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf 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 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?** | Doesn't apply to In-Network Preventive Care, In-Network office visits, or Prescription Drugs. Copays and prescription drug costs don't count toward the overall 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 for specific services?** | No. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | Yes. For Network $4,000 Individual/$10,200 Family. For Out-of-Network $8,000 Individual/$24,000 Family. Rx Out-of-Pocket expense limit: $1,000 Individual/$3,000 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?** | Pharmacy/drugs, Preauthorization penalties, Premiums, balance-billed 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 or call **1-800-810-2583** 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 services (such as lab work). Check with your provider before you get services. |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **Do you need a referral to see a specialist?** | No. You don't need a Referral to see a Specialist. | You can see the 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 | $20 copay/visit | 30% coinsurance | In addition to the office visit copay/coinsurance, Network services are subject to 20% coinsurance and Out-of-Network services are subject to 40% coinsurance. |
| | Specialist visit | $20 copay/visit | 30% coinsurance | |
| | Preventive care/screening/ immunization | No Charge | 30% coinsurance | There is No Charge for Out-of-Network immunizations from birth through the day of the 6th birthday. You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance | 30% coinsurance | none |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 40% coinsurance | |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at www.bcbstx.com/member/rx_drugs.html | Generic drugs | Retail - $15/$20 copay/prescription<br>Mail - $45 copay/prescription | 20% coinsurance plus copay | Lower copay applies at preferred Participating pharmacies. One copay per 30-day supply - up to a 90-day supply for generic and brand drugs, up to a 30-day supply for Specialty Drugs. 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 women's preventive services will be covered with no cost to the member. Rx Out-of-Pocket expense limit: $1,000 Individual/$3,000 Family. |
| | Preferred brand drugs | Retail - $40/$50 copay/prescription<br>Mail - $120 copay/prescription | 20% coinsurance plus copay | |
| | Non-preferred brand drugs | Retail - $55/$65 copay/prescription<br>Mail - $165 copay/prescription | 20% coinsurance plus copay | |

| 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) | |
| | Specialty drugs | Retail - $55/$65 copay/prescription<br>Mail - $165 copay/prescription | 20% coinsurance plus copay | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 40% coinsurance | none |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | |
| **If you need immediate medical attention** | Emergency room care | 20% coinsurance after $100 copay/visit | 20% coinsurance after $100 copay/visit | Copay amount waived if admitted. |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | none |
| | Urgent care | $45 copay/visit | 30% coinsurance | In addition to the office visit copay/coinsurance, Network services are subject to 20% coinsurance and Out-of-Network services are subject to 40% coinsurance. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 40% coinsurance | Preauthorization required Out-of-Network; failure to preauthorize at least two business days prior to admission will result in $250 reduction in benefits. |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | none |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $20 copay for office visits or 20% coinsurance for other outpatient services | 40% coinsurance | Outpatient: Preauthorization required for psychological testing, neuropsychological testing, electroconvulsive therapy, repetitive transcranial magnetic stimulation, and intensive outpatient treatment; failure to preauthorize at least two business days prior to service will result in 50% reduction in benefits (not to exceed $500). Inpatient: Preauthorization required Out-of-Network; failure to preauthorize at least two business days prior to admission will result in $250 reduction in benefits. |
| | Inpatient services | 20% coinsurance | 40% coinsurance | |

* For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com/member/policy-forms/2017.

| 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 are pregnant** | Office visits | $20 copay/visit | 30% coinsurance | Copay applies to first prenatal visit (per pregnancy).Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
| | Childbirth/delivery professional services | 20% coinsurance | 40% coinsurance | none |
| | Childbirth/delivery facility services | 20% coinsurance | 40% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | No Charge | 30% coinsurance | 60 visit maximum per benefit period. Preauthorization required for Out-of-Network. |
| | Rehabilitation services | 20% coinsurance | 40% coinsurance | Limited to combined 35 visits per year, including Chiropractic. |
| | Habilitation services | 20% coinsurance | 40% coinsurance | |
| | Skilled nursing care | No Charge | 30% coinsurance | 25 day maximum per benefit period. Preauthorization required for Out-of-Network. |
| | Durable medical equipment | 20% coinsurance | 40% coinsurance | none |
| | Hospice services | No Charge | 30% coinsurance | Preauthorization required for Out-of-Network. |
| **If your child needs dental or eye care** | Children's eye exam | Covered | Not Covered | Eye Screenings only. Does not include refractions. One visit per year for members ages 17 and younger. |
| | Children's glasses | Not Covered | Not Covered | none |
| | Children's dental check-up | Not Covered | Not Covered | |

## 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.)**

- Abortions
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental Care(Adult)
- Long-term care
- Private-duty nursing
- Weight loss programs

* For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com/member/policy-forms/2017.

| Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.) | | |
|---|---|---|
| • Chiropractic care<br>• Hearing aids | • Infertility treatment (Invitro and artificial insemination are not covered unless shown in your Plan document)<br>• Non-emergency care when traveling outside the U.S. | • Routine eye care(Adult - One visit every two years for members ages 18 and older)<br>• Routine foot care (Only covered in connection with diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency) |

**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 1-800-521-2227, 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 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 and Blue Shield of Texas at 1-800-521-2227 or visit **www.bcbstx.com**, or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit **www.dol.gov/ebsa/healthreform.**

**Does this plan provide Minimum Essential Coverage? Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**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): 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 plan might cover costs for a sample medical situation, see the next section.*

* For more information about limitations and exceptions, see the plan or policy document at **www.bcbstx.com/member/policy-forms/2017**.

## 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** | $1,000 |
| **Specialist copayment** | $20 |
| **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* | |
|---|---|
| Deductibles | $1,000 |
| Copayments | $100 |
| Coinsurance | $2,300 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$3,460** |

### 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** | $20 |
| **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** | **$7,400** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $100 |
| Copayments | $1,600 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Joe would pay is** | **$1,760** |

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

| | |
|---|---|
| **The plan's overall deductible** | $1,000 |
| **Specialist copayment** | $20 |
| **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** | **$2,000** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,000 |
| Copayments | $60 |
| Coinsurance | $100 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,160** |

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

BlueCross BlueShield of Texas

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 888-697-0683

| | |
|---|---|
| العربية<br>Arabic | إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 888-697-0683. |
| 繁體中文<br>Chinese | 如果您, 或您正在協助的對象, 對此有疑問, 您有權利免費以您的母語獲得幫助和訊息。 洽詢一位翻譯員, 請撥電話 號碼 888-697-0683. |
| Français<br>French | Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 888-697-0683. |
| Deutsch<br>German | Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 888-697-0683 an. |
| ગુજરાતી<br>Gujarati | જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ.બી.એમ. કાર્યક્રમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 888-697-0683 પર કૉલ કરો. |
| हिंदी<br>Hindi | यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 888-697-0683 पर कॉल करें।. |
| 日本語<br>Japanese | ご本人様、またはお客様の身の回りの方でも、ご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したり することができます。料金はかかりません。通訳とお話される場合、888-697-0683 までお電話ください。 |
| 한국어<br>Korean | 만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 888-697-0683 로 전화하십시오. |
| ພາສາລາວ<br>Laotian | ຖ້າທ່ານ ຫຼື ຄົນທີ່ທ່ານກໍາລັງໃຫ້ການຊ່ວຍເຫຼືອມີຄໍາຖາມ, ທ່ານມີສິດຂໍເອົາການຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໄດ້ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອລົມກັບນາຍແປພາສາ, ໃຫ້ໂທຫາເບີ 888-697-0683. |
| Diné<br>Navajo | T'áá ni, éí doodago ła'da bíká anánílwo'ígíí, na'ídíłkidgo, ts'ídá bee ná ahóóti'i' t'áá níík'e níká a'doolwoł dóó bína'ídíłkidígíí bee nił hodoonih. Ata'dahalne'ígíí bich'į' hodíílnih kwe'é 888-697-0683. |

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|---|---|
| فارسی<br>Persian | اگر شما، یا کسی که شما به او کمک مي کنید، سؤالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی،با شمار888-697-0683 تماس حاصل نمایید. |
| Русский<br>Russian | Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 888-697-0683. |
| Español<br>Spanish | Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 888-697-0683. |
| Tagalog<br>Tagalog | Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 888-697-0683. |
| اردو<br>Urdu | اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کررہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 888-697-0683 پر کال کریں۔ |
| Tiếng Việt<br>Vietnamese | Nếu quý vị, hoặc người mà quý vị đang giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 888-697-0683. |

**Health care coverage is important for everyone.**

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 or disability.

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

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, Illinois 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960
Email: CivilRightsCoordinator@hcsc.net

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/portal/lobby.jsf
Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html