




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, call 1-866-882-2034 or at [www.bcbstx.com/ut](http://www.bcbstx.com/ut). 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/](http://www.healthcare.gov/sbc-glossary/) or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	Out-of-Area: \$600 Individual/\$1,800 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> .
<b>Are there services covered before you meet your deductible?</b>	Yes. Certain <u>preventive care</u> is covered before you meet your overall <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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	Yes. Bariatric surgery deductible \$3,000/person. Progyny fertility services: \$1,000. <u>Prescription drug deductible</u> \$200/person. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	Overall Out of Pocket: \$9,200 Individual/\$18,400 Family. <u>Coinsurance</u> Limit: \$5,000 Individual/\$15,000 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.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<u>Premiums</u> , bariatric <u>deductible</u> , <u>balance-billing</u> charges, Progyny fertility services and certain <u>specialty drugs</u> considered non-essential health benefits, and healthcare 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> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes.	You pay the least if you use a <u>provider in-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 charge</u> 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.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	25% <u>coinsurance</u>	Virtual visits are available, please refer to your <u>plan</u> policy for more details.
	<u>Specialist</u> visit	25% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No Charge; <u>deductible</u> does not apply	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	25% <u>coinsurance</u>	<u>Deductible</u> and <u>coinsurance</u> may apply if rendered in a facility setting.
	Imaging (CT/PET scans, MRIs)	25% <u>coinsurance</u>	None
<b>If you need drugs to treat your illness or condition</b> More information about <b>prescription drug coverage</b> is available at <a href="http://www.express-scripts.com/ut">www.express-scripts.com/ut</a>	Generic drugs	\$10 (retail) \$20 (mail/Smart90®) <u>copayment/prescription</u>	Annual <u>deductible</u> : \$200 per person; 30-day supply retail; 90-day supply mail or Smart90®. Smart90® is a feature of your prescription <u>plan</u> allowing a 90 day fill at Walgreens locations and UT pharmacies.
	Preferred brand drugs	\$35 (retail) \$87.50 (mail/Smart90®) <u>copayment/prescription</u>	
	Non-preferred brand drugs	\$60 (retail) \$150 (mail/Smart90®) <u>copayment/prescription</u>	Specialty medications must be filled by Accredo Specialty Pharmacy to allow <u>in-network copayments</u> .
	<u>Specialty drugs</u>	Same as above if filled by Accredo or a UT Specialty pharmacy	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	25% <u>coinsurance</u>	Bariatric surgery is covered, subject to a \$3,000 per person <u>deductible</u> . Member must have been continuously enrolled in UT SELECT or UT CONNECT for 36 months prior to date of surgery.
	Physician/surgeon fees	25% <u>coinsurance</u>	None
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	Facility Charges: 25% <u>coinsurance</u> ER Physician Charges: 25% <u>coinsurance</u>	None
	<u>Emergency medical transportation</u>	25% <u>coinsurance</u>	Ground and air transportation covered.
	<u>Urgent care</u>	25% <u>coinsurance</u>	None

Common Medical Event	Services You May Need	What You Will Pay	Limitations, Exceptions, & Other Important Information
If you have a hospital stay	Facility fee (e.g., hospital room)	25% <u>coinsurance</u>	<u>Preauthorization</u> is required.
	Physician/surgeon fees	25% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	25% <u>coinsurance</u>	Certain services must be preauthorized; refer to your benefit booklet* for details. Virtual visits are available, please refer to your <u>plan</u> policy for more details. <u>Coinurance</u> applies to office visits and outpatient facilities.
	Inpatient services	25% <u>coinsurance</u>	<u>Preauthorization</u> is required.
If you are pregnant	Office visits	25% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, a <u>coinsurance</u> or <u>deductible</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	25% <u>coinsurance</u>	
	Childbirth/delivery facility services	25% <u>coinsurance</u>	<u>Preauthorization</u> is required.
If you need help recovering or have other special health needs	<u>Home health care</u>	25% <u>coinsurance</u>	<u>Preauthorization</u> is required. Limited to 120 visits per <u>plan</u> year.
	<u>Rehabilitation services</u>	25% <u>coinsurance</u>	Limited to 35 days per condition per <u>plan</u> year each if physical therapy modalities or occupational therapy is billed. Limited to 60 days per condition per <u>plan</u> year for speech and hearing therapy.
	<u>Habilitation services</u>	25% <u>coinsurance</u>	
	<u>Skilled nursing care</u>	25% <u>coinsurance</u>	<u>Preauthorization</u> is required. Limited to 180 days per <u>plan</u> year.
	<u>Durable medical equipment</u>	25% <u>coinsurance</u>	<u>Preauthorization</u> required for wheelchairs and certain other <u>durable medical equipment</u> over \$5,000.
	<u>Hospice services</u>	25% <u>coinsurance</u>	<u>Preauthorization</u> is required.
If your child needs dental or eye care	Children's eye exam	Not Covered	None
	Children's glasses	Not Covered	None
	Children's dental check-up	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.)

- Acupuncture
- Cosmetic surgery (except specific conditions)
- Dental care (Adult/Child, except when medically necessary)
- Long term care
- Routine eye care (Adult/Child)
- Routine foot care (except for diagnosis of diabetes)
- 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 (separate deductible applies; pre-determination recommended)
- Chiropractic care (35 visits per year)
- Hearing aids (36-month period max of \$1,000/per ear for hearing aid. Children 18 and under are covered one hearing aid per ear per every 36 months with no dollar max)
- Infertility treatment (Fertility benefits through Progyny. Contact Patient Care Advocates at 1-844-535-0711)
- Non-emergency care when traveling outside the U.S. ([www.bluecardworldwide.com](http://www.bluecardworldwide.com))
- Private-duty nursing (except inpatient private duty nursing) limited to 90 visits per year

**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: For group health coverage contact the plan, Blue Cross and Blue Shield of Texas at 1-800-521-2227 or visit [www.bcbstx.com](http://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](http://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](http://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](http://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: For group health coverage subject to ERISA: Blue Cross and Blue Shield of Texas at 1-800-521-2227 or visit [www.bcbstx.com](http://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](http://www.dol.gov/ebsa/healthreform), and the Texas Department of Insurance, Consumer Protection at 1-800-252-3439 or [www.tdi.texas.gov](http://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 1-800-521-2227 or [www.bcbstx.com](http://www.bcbstx.com) or contact the Texas Department of Insurance, Consumer Protection at 1-800-252-3439 or [www.tdi.texas.gov](http://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](http://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 1-866-882-2034.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-882-2034.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-866-882-2034.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-866-882-2034.

*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 <u>plan's</u> overall <u>deductible</u>	\$600
■ <u>Specialist</u> <u>coinsurance</u>	25%
■ Hospital (facility) <u>coinsurance</u>	25%
■ Other <u>coinsurance</u>	25%

**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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
---------------------------	-----------------

In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$600
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$3,000
<u>What isn't covered</u>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,660</b>

### Managing Joe's Type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$600
■ <u>Specialist</u> <u>coinsurance</u>	25%
■ Hospital (facility) <u>coinsurance</u>	25%
■ Other <u>coinsurance</u>	25%

**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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
---------------------------	----------------

In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles*</u>	\$800
<u>Copayments</u>	\$600
<u>Coinsurance</u>	\$300
<u>What isn't covered</u>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,720</b>

### Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$600
■ <u>Specialist</u> <u>coinsurance</u>	25%
■ Hospital (facility) <u>coinsurance</u>	25%
■ Other <u>coinsurance</u>	25%

**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>	<b>\$2,800</b>
---------------------------	----------------

In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$600
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$500
<u>What isn't covered</u>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,100</b>

\*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.



**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., 35<sup>th</sup> Floor  
Chicago, IL 60601

Phone: 855-664-7270 (voicemail)  
TTY/TDD: 855-661-6965  
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  
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/smartscreen/main.jsf>  
Complaint Forms: <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	لنلقى المساعدة اللغوية أو التواصل مجاناً، 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	બાધા 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 dinit's'á'góó, shá ata' hodooni nínízingo, t'áájíik'eh bee náhaz'á. 1-866-560-4042 jì' 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، براہ 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.