

# 2019 Required Notices

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If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see pages 4 and 5 for more details.

## HIPAA Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in the Oncor plan, provided that you request enrollment within 30 days after your or your dependents' other coverage ends. In addition, if you have a dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided you request enrollment within 30 days after the marriage, or 60 days for birth, adoption or placement for adoption. Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or a State health insurance ("SCHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify the company and enroll in the plan.

## HIPAA Privacy Notice

The HIPAA Privacy Notice is posted on the Online Resource Page HR Toolkit. Log onto [www.connect2epeople.com](http://www.connect2epeople.com), enter your user name and password. Then, click the HR Toolkit link in the upper right corner of the homepage. You will receive a prompt to enter an additional user name and password:

- User name: **EXTARINSO\EXT\_ONC\_EMP**
- Password: **ONC;2345**

## Women's Health and Cancer Rights Act of 1998 (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same appropriate deductibles and coinsurance applicable to other medical and surgical benefits provided under the option you choose.

If you would like more information on WHCRA benefits, call your ePeople HR Service Center at **1.888.812.5465**.

# The Newborns’ and Mothers’ Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

## Notice Regarding Wellness Program for All Employees

Oncor Electric Delivery Company LLC Employee Welfare Benefit Plan (the “Plan”) includes a voluntary wellness program available to all employees. The wellness program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. You will be asked to complete a biometric screening, which will include a blood test for low HDL cholesterol, high triglycerides, and high blood glucose. You are not required to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive of up to \$1,270 for participating in the Annual Physical with Biometric Screening Incentive. Although you are not required to participate in the Annual Physical with Biometric Screening, only employees who do so will receive up to \$1,270 for the Annual Physical with Biometric Screening Incentive.

If you are in an HRA or HSA option, you are eligible to receive a \$325 Healthy Incentive based on achieving healthy outcomes, as shown in this chart:

### Biometric Screening Risk Factors

| RISK FACTOR         | WHAT IT MEANS*                                                                                                                                                                                                         | THE HEALTHY TARGET                                                                             |
|---------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| Low HDL cholesterol | HDL cholesterol helps remove cholesterol from the arteries, so a high level of HDL is good. A low HDL cholesterol level raises your risk of heart disease.                                                             | For men: Greater than or equal to 40 mg/dL<br><br>For women: Greater than or equal to 50 mg/dL |
| High triglycerides  | Triglycerides are a type of fat found in the blood, and high triglycerides increase the risk of developing heart disease.                                                                                              | Less than 150 mg/dL                                                                            |
| High blood glucose  | Also known as blood sugar, glucose is what the body uses for energy. High glucose may be a sign of diabetes and can affect kidney functions.                                                                           | Less than 100 mg/dL                                                                            |
| High blood pressure | Blood pressure is the force of blood pushing against the walls of your arteries as your heart pumps blood. Your heart can be damaged and develop plaque buildup if your blood pressure rises and stays high over time. | Systolic less than 130 mmHg; diastolic less than 85                                            |
| Waist circumference | Abdominal obesity (excess fat in the stomach area) is a greater risk factor for heart disease than excess fat in other areas of the body, such as on the hips.                                                         | For men: Less than or equal to 40 inches<br><br>For women: Less than or equal to 35 inches     |

\* Source: National Heart, Lung, and Blood Institute



Determined by your biometric results, if you have:

- 0 to 2 factors outside of the healthy target: Receive \$325 funding.
- 3 or more factors outside the healthy target: May participate in a Health Coaching Program to earn \$325.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard, including one recommended by your doctor. You may request a reasonable accommodation or an alternative standard by contacting Evive at **1.800.475.8205** or email **Questions@EviveHealth.com**.

The results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as Naturally Slim or Ultimate Health Matters coaching programs. You also are encouraged to share your results or concerns with your own doctor.

## Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. In addition, such information is subject to Oncor's HIPAA Privacy Policy. Although the wellness program, the Plan, and Oncor may use aggregate information collected to design future programs based on identified health risks, we will never disclose any of your personal information either publicly or to your employer, except as necessary to (i) respond to a request from you for a reasonable accommodation needed to participate in the wellness program, (ii) to administer the Plan and the wellness program, or (iii) as otherwise expressly permitted by law, regulations, and other guidance. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive.

Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are Oncor's wellness vendor, currently Evive, the biometric screening provider, currently Cover-Tek, and Oncor personnel who need this information to administer the Plan and the wellness program.

In addition, (a) all medical information obtained through the wellness program will be maintained separate from your personnel records, (b) information stored electronically will be guarded against unauthorized access in accordance with Oncor's applicable privacy and security policies to ensure confidentiality of the data (for example, use of technical controls such as file level encryption, security monitoring, and Active Directory Rights Management Services), and (c) no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Oncor HR Advocacy at **ONCRES1@oncor.com**.

# Medicare Prescription Drug Creditable Coverage

(Applies to Health Plan Participants who are Medicare Eligible)

## Important Notice from Oncor About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage under the Oncor Electric Delivery Company LLC Employee Welfare Benefit Plan or the Oncor Retiree Welfare Plan (the "Plan") and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Oncor has determined that the prescription drug coverage offered by the Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is, therefore, considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

## When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

## What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?

Generally speaking, if you decide to join a Medicare drug plan while covered under the Plan due to your current or former Oncor employment (or someone else's employment, such as a spouse or parent), your coverage under the Plan will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed on page 5.

If you do decide to join a Medicare drug plan and drop your Oncor prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage, you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

## When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Oncor and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.



If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without Creditable Coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

#### **For More Information About This Notice or Your Current Prescription Drug Coverage**

Contact ePeople HR Service Center (see right column) for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through Oncor changes. You also may request a copy of this notice at any time.

#### **For More Information About Your Options Under Medicare Prescription Drug Coverage**

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov**.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call **1.800.MEDICARE (1.800.633.4227)**.  
**TTY users should call 1.877.486.2048.**

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov**, or call them at **1.800.772.1213**. **TTY users should call 1.800.325.0778.**

## **Important**

**Keep this Creditable Coverage Notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained Creditable Coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).**

|                                 |                                              |
|---------------------------------|----------------------------------------------|
| <b>Date:</b>                    | October 1, 2018                              |
| <b>Name of Entity/Sender:</b>   | Oncor Electric Delivery Company LLC          |
| <b>Contact Position/Office:</b> | ePeople HR Service Center                    |
| <b>Address:</b>                 | P.O. Box 44023<br>Jacksonville, FL 32231     |
| <b>Telephone:</b>               | <b>1.888.812.5465</b><br>(select option '0') |



# Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **[www.healthcare.gov](http://www.healthcare.gov)**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your state Medicaid or CHIP office or dial **1.877.KIDSNOW** or **[www.insurekidsnow.gov](http://www.insurekidsnow.gov)** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **[www.askebsa.dol.gov](http://www.askebsa.dol.gov)** or call **1.866.444.EBSA** (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2018. Contact your state for more information on eligibility.

## ALABAMA – Medicaid

**Website:** <http://myalhipp.com/>  
**Phone:** 1-855-692-5447

## ALASKA – Medicaid

The AK Health Insurance Premium Payment Program  
**Website:** <http://myakhipp.com/>  
**Phone:** 1-866-251-4861  
**Email:** [CustomerService@MyAKHIPP.com](mailto:CustomerService@MyAKHIPP.com)  
**Medicaid Eligibility:** <http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx>

## ARKANSAS – Medicaid

**Website:** <http://myarhipp.com/>  
**Phone:** 1-855-MyARHIPP (692-7447)

## COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

**Health First Colorado Website:**  
<https://www.healthfirstcolorado.com/>  
**Health First Colorado Member Contact Center:**  
1-800-221-3943 / State Relay 711

**CHP+:** [Colorado.gov/HCPF/Child-Health-Plan-Plus](http://Colorado.gov/HCPF/Child-Health-Plan-Plus)  
**CHP+ Customer Service:** 1-800-359-1991 / State Relay 711



#### FLORIDA – Medicaid

**Website:** <http://flmedicaidtplrecovery.com/hipp/>

**Phone:** 1-877-357-3268

#### GEORGIA – Medicaid

**Website:** <http://dch.georgia.gov/medicaid>

Click on **Health Insurance Premium Payment (HIPP)**

**Phone:** 1-404-656-4507

#### INDIANA – Medicaid

Healthy Indiana Plan for low-income adults 19–64

**Website:** <http://www.in.gov/fssa/hip/>

**Phone:** 1-877-438-4479

All other Medicaid

**Website:** <http://www.indianamedicaid.com>

**Phone:** 1-800-403-0864

#### IOWA – Medicaid

**Website:** <http://dhs.iowa.gov/hawk-i>

**Phone:** 1-800-257-8563

#### KANSAS – Medicaid

**Website:** <http://www.kdheks.gov/hcf/>

**Phone:** 1-785-296-3512

#### KENTUCKY – Medicaid

**Website:** <https://chfs.ky.gov>

**Phone:** 1-800-635-2570

#### LOUISIANA – Medicaid

**Website:** <http://dhh.louisiana.gov/index.cfm/subhome/1/n/331>

**Phone:** 1-888-695-2447

#### MAINE – Medicaid

**Website:**

<http://www.maine.gov/dhhs/ofi/public-assistance/index.html>

**Phone:** 1-800-442-6003

**TTY:** Maine relay 711

#### MASSACHUSETTS – Medicaid and CHIP

**Website:** <http://www.mass.gov/eohhs/gov/departments/masshealth/>

**Phone:** 1-800-862-4840

#### MINNESOTA – Medicaid

**Website:** <https://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/other-insurance.jsp>

**Phone:** 1-800-657-3739

#### MISSOURI – Medicaid

**Website:** <http://www.dss.mo.gov/mhd/participants/pages/hipp.htm>

**Phone:** 1-573-751-2005

#### MONTANA – Medicaid

**Website:** <http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP>

**Phone:** 1-800-694-3084

#### NEBRASKA – Medicaid

**Website:** <http://www.ACCESSNebraska.ne.gov>

**Phone:** 1-855-632-7633

**Lincoln:** 1-402-473-7000

**Omaha:** 1-402-595-1178

#### NEVADA – Medicaid

**Medicaid Website:** <https://dhcfp.nv.gov>

**Medicaid Phone:** 1-800-992-0900

#### NEW HAMPSHIRE – Medicaid

**Website:** <https://www.dhhs.nh.gov/ombp/nhhpp/>

**Phone:** 1-603-271-5218

**Hotline:** NH Medicaid Service Center at 1-888-901-4999

#### NEW JERSEY – Medicaid and CHIP

**Medicaid Website:** <http://www.state.nj.us/humanservices/dmahs/clients/medicaid/>

**Medicaid Phone:** 1-609-631-2392

**CHIP Website:** <http://www.njfamilycare.org/index.html>

**CHIP Phone:** 1-800-701-0710



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|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>NEW YORK – Medicaid</b><br><br><b>Website:</b> <a href="https://www.health.ny.gov/health_care/medicaid/">https://www.health.ny.gov/health_care/medicaid/</a><br><b>Phone:</b> 1-800-541-2831                                                                                                                                                                                                                                   | <b>NORTH CAROLINA – Medicaid</b><br><br><b>Website:</b> <a href="https://dma.ncdhhs.gov/">https://dma.ncdhhs.gov/</a><br><b>Phone:</b> 1-919-855-4100                                                                                                                                                            |
| <b>NORTH DAKOTA – Medicaid</b><br><br><b>Website:</b> <a href="http://www.nd.gov/dhs/services/medicalserv/medicaid/">http://www.nd.gov/dhs/services/medicalserv/medicaid/</a><br><b>Phone:</b> 1-844-854-4825                                                                                                                                                                                                                     | <b>OKLAHOMA – Medicaid and CHIP</b><br><br><b>Website:</b> <a href="http://www.insureoklahoma.org">http://www.insureoklahoma.org</a><br><b>Phone:</b> 1-888-365-3742                                                                                                                                             |
| <b>OREGON – Medicaid</b><br><br><b>Website:</b> <a href="http://healthcare.oregon.gov/Pages/index.aspx">http://healthcare.oregon.gov/Pages/index.aspx</a><br><a href="http://www.oregonhealthcare.gov/index-es.html">http://www.oregonhealthcare.gov/index-es.html</a><br><b>Phone:</b> 1-800-699-9075                                                                                                                            | <b>PENNSYLVANIA – Medicaid</b><br><br><b>Website:</b> <a href="http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm">http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm</a><br><b>Phone:</b> 1-800-692-7462      |
| <b>RHODE ISLAND – Medicaid</b><br><br><b>Website:</b> <a href="http://www.eohhs.ri.gov/">http://www.eohhs.ri.gov/</a><br><b>Phone:</b> 1-855-697-4347                                                                                                                                                                                                                                                                             | <b>SOUTH CAROLINA – Medicaid</b><br><br><b>Website:</b> <a href="https://www.scdhhs.gov">https://www.scdhhs.gov</a><br><b>Phone:</b> 1-888-549-0820                                                                                                                                                              |
| <b>SOUTH DAKOTA – Medicaid</b><br><br><b>Website:</b> <a href="http://dss.sd.gov">http://dss.sd.gov</a><br><b>Phone:</b> 1-888-828-0059                                                                                                                                                                                                                                                                                           | <b>TEXAS – Medicaid</b><br><br><b>Website:</b> <a href="http://gethipptexas.com/">http://gethipptexas.com/</a><br><b>Phone:</b> 1-800-440-0493                                                                                                                                                                   |
| <b>UTAH – Medicaid and CHIP</b><br><br><b>Medicaid Website:</b> <a href="https://medicaid.utah.gov/">https://medicaid.utah.gov/</a><br><b>CHIP Website:</b> <a href="http://health.utah.gov/chip">http://health.utah.gov/chip</a><br><b>Phone:</b> 1-877-543-7669                                                                                                                                                                 | <b>VERMONT– Medicaid</b><br><br><b>Website:</b> <a href="http://www.greenmountaincare.org/">http://www.greenmountaincare.org/</a><br><b>Phone:</b> 1-800-250-8427                                                                                                                                                |
| <b>VIRGINIA – Medicaid and CHIP</b><br><br><b>Medicaid Website:</b> <a href="http://www.coverva.org/programs_premium_assistance.cfm">http://www.coverva.org/programs_premium_assistance.cfm</a><br><b>Medicaid Phone:</b> 1-800-432-5924<br><b>CHIP Website:</b> <a href="http://www.coverva.org/programs_premium_assistance.cfm">http://www.coverva.org/programs_premium_assistance.cfm</a><br><b>CHIP Phone:</b> 1-855-242-8282 | <b>WASHINGTON – Medicaid</b><br><br><b>Website:</b> <a href="http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program">http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program</a><br><b>Phone:</b> 1-800-562-3022 ext. 15473 |
| <b>WEST VIRGINIA – Medicaid</b><br><br><b>Website:</b> <a href="http://mywvhipp.com/">http://mywvhipp.com/</a><br><b>Toll-Free Phone:</b> 1-855-MyWVHIP (1-855-699-8447)                                                                                                                                                                                                                                                          | <b>WISCONSIN – Medicaid and CHIP</b><br><br><b>Website:</b> <a href="https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf">https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf</a><br><b>Phone:</b> 1-800-362-3002                                                                                      |
| <b>WYOMING – Medicaid</b><br><br><b>Website:</b> <a href="https://wyequalitycare.acs-inc.com/">https://wyequalitycare.acs-inc.com/</a><br><b>Phone:</b> 1-307-777-7531                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                  |





To see if any other states have added a premium assistance program since July 31, 2018, or for more information on special enrollment rights, contact either:

**U.S. Department of Labor**

Employee Benefits Security Administration

[www.dol.gov/agencies/ebsa](http://www.dol.gov/agencies/ebsa)

**1.866.444.EBSA** (3272)

**U.S. Department of Health and Human Services**

Centers for Medicare & Medicaid Services

[www.cms.hhs.gov](http://www.cms.hhs.gov)

**1.877.267.2323**, Menu Option 4, Ext. 61565

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**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 1-888-812-5465 or visit [www.connect2epeople.com](http://www.connect2epeople.com). 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.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf](http://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:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
|--------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall deductible?</b>                             | For In-Network: \$1,500 Individual / \$3,000 Family<br>For Out-of-Network: \$3,000 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> .                                                                                                                                                 |
| <b>Are there services covered before you meet your deductible?</b> | Yes. <u>Preventive care</u> , generic <u>prescription drugs</u> , and <u>hospice</u> are covered before you meet your <u>deductible</u> .                                                                                                               | This plan 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="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                              |
| <b>Are there other deductibles for specific services?</b>          | Yes. <u>Prescription drug deductible</u> : \$200 Individual / \$400 Family. Does not apply to generic or value generic drugs. There are no other specific <u>deductibles</u> .                                                                          | 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 out-of-pocket limit for this plan?</b>              | For In-Network: \$4,300 Individual / \$8,600 Family<br>For Out-of-Network: \$8,600 Individual / \$17,200 Family<br><u>Prescription drug limit</u> : \$2,000 Individual / \$4,000 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 plan, 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 out-of-pocket limit?</b>            | <u>Premiums</u> , <u>preauthorization penalties</u> , <u>prescription drug deductible</u> , <u>balanced-billed charges</u> , 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 network provider?</b>            | Yes. See <a href="http://www.bcbstx.com">www.bcbstx.com</a> or call 1-800-810-2583 for a list of <u>network providers</u> . See <a href="http://www.caremark.com">www.caremark.com</a> for <u>prescription drug</u> information or call 1-877-775-5642. | This plan 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 provider's 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. |
| <b>Do you need a referral to see a specialist?</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                                                                                                                                                                                                                                                                                 |
|---------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------|----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                               |                                                  | In-Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                        |
| If you visit a health care <u>provider's</u> office or clinic | Primary care visit to treat an injury or illness | 20% <u>coinsurance</u>                          | 40% <u>coinsurance</u>                             | None                                                                                                                                                                                                                                                                                                                                   |
|                                                               | <u>Specialist</u> visit                          | 20% <u>coinsurance</u>                          | 40% <u>coinsurance</u>                             | None                                                                                                                                                                                                                                                                                                                                   |
|                                                               | <u>Preventive care/screening/immunization</u>    | No Charge; <u>deductible</u> does not apply     | No Charge; <u>deductible</u> does not apply        | Preventive colonoscopies and sigmoidoscopies- 1 covered every 5 years at 100%.<br><u>Out-of-Network providers</u> can <u>balance bill</u> .<br>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. |
| If you have a test                                            | <u>Diagnostic test</u> (x-ray, blood work)       | 20% <u>coinsurance</u>                          | 40% <u>coinsurance</u>                             | None                                                                                                                                                                                                                                                                                                                                   |
|                                                               | Imaging (CT/PET scans, MRIs)                     | 20% <u>coinsurance</u>                          | 40% <u>coinsurance</u>                             | None                                                                                                                                                                                                                                                                                                                                   |

\* For more information about limitations and exceptions, see the plan or policy document at [www.connect2epeople.com](http://www.connect2epeople.com).

| Common Medical Event                                                                                                                                                                                                  | Services You May Need                          | What You Will Pay                                                                                                                                               |                                                                                                         | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                       |                                                | In-Network Provider<br>(You will pay the least)                                                                                                                 | Out-of-Network Provider<br>(You will pay the most)                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>If you need drugs to treat your illness or condition</b><br><br>More information about <u>prescription drug coverage</u> is available at <a href="http://www.caremark.com">www.caremark.com</a> or 1-877-775-5642. | Generic drugs                                  | \$10 <u>copay/script</u> (30-day supply)<br>\$20 copay/script (90-day supply)                                                                                   | 20% <u>coinsurance</u>                                                                                  | Deductible waived for value/preventive drugs.<br><br>Value (preventive) generic drugs \$5 copay (30-day supply) for In-Network; \$10 copay (90-day supply) for In-Network<br><br>Preferred and Non-preferred drugs: If generic isn't chosen, member pays copay plus the difference between the price of generic and brand.<br><br>Anabolic steroids and specialty drugs must be approved prior to dispensing.<br><br>Specialty drugs are only covered when acquired through Caremark's mail order program.<br><br>Maintenance Choice: If use maintenance prescription drugs, they must be filled through the mail order drug program or at a CVS pharmacy location only. With each new maintenance prescription, you may fill your prescription 3 times at retail before you must transition to a 90-day supply through mail order. If you wish to opt out of this program, please call CVS. |
|                                                                                                                                                                                                                       | Preferred brand drugs                          | 30% <u>coinsurance</u><br><br>Up to \$100 max per script (30-day supply)<br>Up to \$200 max per script (90-day supply)                                          | 30% <u>coinsurance</u>                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                                                                                                                                                                       | Non-preferred brand drugs                      | 40% <u>coinsurance</u><br><br>Up to \$120 max per script (30-day supply)<br>Up to \$240 max per script (90-day supply)                                          | 40% <u>coinsurance</u>                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
|                                                                                                                                                                                                                       | <u>Specialty drugs</u>                         | \$20 copay/script (generic)<br>30% coinsurance up to \$200 max per script (preferred brand)<br>40% coinsurance up to \$240 max per script (non-preferred brand) | 20% coinsurance (generic)<br>30% coinsurance (preferred brand)<br>40% coinsurance (non-preferred brand) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>If you have outpatient surgery</b>                                                                                                                                                                                 | Facility fee (e.g., ambulatory surgery center) | 20% <u>coinsurance</u>                                                                                                                                          | 40% <u>coinsurance</u>                                                                                  | Acupuncture is covered only when used in lieu of anesthesia for surgery.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|                                                                                                                                                                                                                       | Physician/surgeon fees                         | 20% <u>coinsurance</u>                                                                                                                                          | 40% <u>coinsurance</u>                                                                                  | Bariatric (weight loss) surgery is covered with <u>In-Network</u> providers only and for a diagnosis of morbid obesity only.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |

\* For more information about limitations and exceptions, see the plan or policy document at [www.connect2epeople.com](http://www.connect2epeople.com).

| Common Medical Event                    | Services You May Need                   | What You Will Pay                               |                                                    | Limitations, Exceptions, & Other Important Information |
|-----------------------------------------|-----------------------------------------|-------------------------------------------------|----------------------------------------------------|--------------------------------------------------------|
|                                         |                                         | In-Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                        |
| If you need immediate medical attention | <u>Emergency room care</u>              | 20% <u>coinsurance</u>                          | 20% <u>coinsurance</u>                             | None                                                   |
|                                         | <u>Emergency medical transportation</u> | 20% <u>coinsurance</u>                          | 20% <u>coinsurance</u>                             | Ground and air transportation covered.                 |
|                                         | <u>Urgent care</u>                      | 20% <u>coinsurance</u>                          | 40% <u>coinsurance</u>                             | None                                                   |

\* For more information about limitations and exceptions, see the plan or policy document at [www.connect2epeople.com](http://www.connect2epeople.com).

| Common Medical Event                                                      | Services You May Need                     | What You Will Pay                               |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                  |
|---------------------------------------------------------------------------|-------------------------------------------|-------------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                           | In-Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                         |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)        | 20% <u>coinsurance</u>                          | 40% <u>coinsurance</u>                             | <u>Preauthorization</u> is required; \$250 penalty if services are not preauthorized <u>Out-of-Network</u> .                                                                                                                                                            |
|                                                                           | Physician/surgeon fees                    | 20% <u>coinsurance</u>                          | 40% <u>coinsurance</u>                             | None                                                                                                                                                                                                                                                                    |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | 20% <u>coinsurance</u>                          | 40% <u>coinsurance</u>                             | Certain services must be preauthorized; refer to benefits booklet for details.                                                                                                                                                                                          |
|                                                                           | Inpatient services                        | 20% <u>coinsurance</u>                          | 40% <u>coinsurance</u>                             | <u>Preauthorization</u> is required; \$250 penalty if services are not preauthorized <u>Out-of-Network</u> .                                                                                                                                                            |
| If you are pregnant                                                       | Office visits                             | 20% <u>coinsurance</u>                          | 40% <u>coinsurance</u>                             | <u>Cost sharing</u> does not apply for <u>preventive</u> services.<br>Depending on the type of services, a <u>coinsurance</u> or <u>deductible</u> may apply.<br><u>Maternity</u> care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) |
|                                                                           | Childbirth/delivery professional services | 20% <u>coinsurance</u>                          | 40% <u>coinsurance</u>                             |                                                                                                                                                                                                                                                                         |
|                                                                           | Childbirth/delivery facility services     | 20% <u>coinsurance</u>                          | 40% <u>coinsurance</u>                             | <u>Preauthorization</u> is required; \$250 penalty if services are not preauthorized <u>Out-of-Network</u> .                                                                                                                                                            |

\* For more information about limitations and exceptions, see the plan or policy document at [www.connect2epeople.com](http://www.connect2epeople.com).



| Common Medical Event                                           | Services You May Need            | What You Will Pay                               |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                     |
|----------------------------------------------------------------|----------------------------------|-------------------------------------------------|----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                |                                  | In-Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                            |
| If you need help recovering or have other special health needs | <u>Home health care</u>          | 20% <u>coinsurance</u>                          | 40% <u>coinsurance</u>                             | <u>Preauthorization</u> is required.                                                                                                                                                                                                                                                                                                                       |
|                                                                | <u>Rehabilitation services</u>   | 20% <u>coinsurance</u>                          | 40% <u>coinsurance</u>                             | Chiropractic care by Airrosti providers is subject to a \$25 <u>copay</u> . Limited to 25 visits per calendar year.                                                                                                                                                                                                                                        |
|                                                                | <u>Habilitation services</u>     | 20% <u>coinsurance</u>                          | 40% <u>coinsurance</u>                             | Dialysis is covered <u>In-Network only</u>                                                                                                                                                                                                                                                                                                                 |
|                                                                | <u>Skilled nursing care</u>      | 20% <u>coinsurance</u>                          | 40% <u>coinsurance</u>                             | <u>Preauthorization</u> is required.                                                                                                                                                                                                                                                                                                                       |
|                                                                | <u>Durable medical equipment</u> | 20% <u>coinsurance</u>                          | 40% <u>coinsurance</u>                             | Wigs covered at applicable deductible and <u>coinsurance</u> , up to \$500 calendar year max; combined <u>In-Network</u> and <u>Out-of-Network</u> . Hearing aids are covered 1 pair per 36 months at applicable deductible and <u>coinsurance</u> . Foot orthotics are covered at applicable deductible and <u>coinsurance</u> , regardless of diagnosis. |
|                                                                | <u>Hospice services</u>          | No Charge; deductible does not apply            | 40% <u>coinsurance</u>                             | <u>Preauthorization</u> is required.                                                                                                                                                                                                                                                                                                                       |
| If your child needs dental or eye care                         | Children's eye exam              | No Charge; deductible does not apply            | No Charge; deductible does not apply               | Limited to 1 exam per calendar year. Does not include vision care benefits/hardware. <u>Out-of-Network</u> can balance bill.                                                                                                                                                                                                                               |
|                                                                | Children's glasses               | Not Covered                                     | Not Covered                                        | None                                                                                                                                                                                                                                                                                                                                                       |
|                                                                | Children's dental check-up       | Not Covered                                     | Not Covered                                        | None                                                                                                                                                                                                                                                                                                                                                       |

\* For more information about limitations and exceptions, see the plan or policy document at [www.connect2epeople.com](http://www.connect2epeople.com).

## Excluded services & Other Covered Services:

| <b>Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u>.)</b>                  |                                                                                                                                                                                                                                                                                        |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"><li>• Dental care (Adult)</li><li>• Infertility treatment</li></ul>                                                                                         | <ul style="list-style-type: none"><li>• Long-term care</li><li>• Routine foot care</li><li>• Weight loss programs</li></ul>                                                                                                                                                            |
| <b>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)</b>                                                    |                                                                                                                                                                                                                                                                                        |
| <ul style="list-style-type: none"><li>• Acupuncture (only in lieu of anesthesia)</li><li>• Bariatric surgery (morbid obesity only)</li><li>• Chiropractic care (25 visits per year)</li></ul> | <ul style="list-style-type: none"><li>• Cosmetic surgery (specific medical conditions)</li><li>• Hearing aids (1 per ear per 36-month period)</li><li>• Non-emergency care when traveling outside the U.S.</li><li>• Private-duty nursing</li><li>• Routine eye care (Adult)</li></ul> |

**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](http://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.cms.gov](http://www.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](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: Blue Cross and Blue Shield of Texas at 1-800-521-2227 or visit [www.bcbstx.com](http://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](http://www.dol.gov/ebsa/healthreform). 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.texashealthoptions.com](http://www.texashealthoptions.com).

### **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): 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): Dineke'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-521-2227.

—————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 coinsurance 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,800</b> |
|---------------------------|-----------------|

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

| <u>Cost sharing</u>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$1,500        |
| <u>Copayments</u>                 | \$30           |
| <u>Coinsurance</u>                | \$2,200        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$3,790</b> |

**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 coinsurance 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$7,400</b> |
|---------------------------|----------------|

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

| <u>Cost sharing</u>               |                |
|-----------------------------------|----------------|
| <u>Deductibles*</u>               | \$1,700        |
| <u>Copayments</u>                 | \$300          |
| <u>Coinsurance</u>                | \$1,400        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Joe would pay is</b> | <b>\$3,460</b> |

**Mia's Simple Fracture**

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

- The plan's overall deductible \$1,500
- Specialist coinsurance 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$1,900</b> |
|---------------------------|----------------|

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

| <u>Cost sharing</u>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$1,500        |
| <u>Copayments</u>                 | \$0            |
| <u>Coinsurance</u>                | \$90           |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,590</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.

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 speak to an interpreter, call the customer service number on the back of your member card. If you are not a member, or don't have a card, call 855-710-6984.

|                          |                                                                                                                                                                                                                                                                                                                                                                                                  |
|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| العربية<br>Arabic        | اين كان لديك اول لدى شخص تساعد أمثالك، فذلك الحق في الحصول على المساعدة والمعلومات الضرورية بلك من دون أية تكلفة. للتحدث إلى مترجم فوري، اتصل على رقم خدمة العملاء المذكور على ظهر بطاقة عضويتك. فإن لم تكن عضواً، أو كنت لا تملك بطاقة، فاحصل على 855-710-6984.                                                                                                                                 |
| 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，請致電印在您的會員卡背面的客戶服務電話號碼。如果您不是會員，或沒有會員卡，請致電 855-710-6984。                                                                                                                                                                                                                                                                                            |
| 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, composez le numéro du service client indiqué au verso de votre carte de membre. Si vous n'êtes pas membre ou si vous n'avez pas de carte, veuillez composer le 855-710-6984.                      |
| 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 Kundenservicenummer auf der Rückseite Ihrer Mitgliedskarte an. Falls Sie kein Mitglied sind oder keine Mitgliedskarte besitzen, rufen Sie bitte 855-710-6984 an.                            |
| ગુજરાતી<br>Gujarati      | જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ બી એમ. ફલ્પિયા સાથે વાત કરવા માટે, તમારા સભ્યપદના કાર્ડની પાછળ આપેલ ગ્રાહક સેવા નંબર પર કોલ કરો કરો જો આપ સભ્યપદ ના ધરાવતા હોવ, અથવા આપની પાસે કાર્ડ નથી તો 855-710-6984 નંબર પર કોલ 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, अपने सदस्य कार्ड के पीछे दिए गए ग्राहक सेवा नंबर पर कॉल करें। यदि आप सदस्य नहीं हैं, या आपके पास कार्ड नहीं है, तो 855-710-6984 पर कॉल करें।                                                                              |
| 日本語<br>Japanese          | ご本人様、またはお客様の方でも、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、メンバーカードの裏のカスタマーサービス番号までお電話ください。メンバーでない場合は 855-710-6984 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. 회원 카드 뒷면에 있는 고객센터 번호로 전화하십시오. 회원이 아니거나 카드가 없으시면 855-710-6984 으로 전화하십시오.                                                                                                                                                                                                                                                |
| ລາວ<br>Laotian           | ຖ້າທ່ານ ຫຼື ຄົນທີ່ທ່ານກຳລັງໃຫ້ການຊ່ວຍເຫຼືອມີຄຳຖາມ, ທ່ານມີສິດຂໍອີກການຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໄດ້ໃດໆບໍ່ມີຄ່າໃຊ້ຈ່າຍ ເພື່ອພົວພັນພາສາຂອງທ່ານ. ໃຫ້ໃຫ້ທ່ານເບີ 855-710-6984. ການຊາກຄຳທີ່ມີຄູ່ດ້ານຫຼັງບໍ່ມີຄ່າຂອງທ່ານ. ຖ້າທ່ານບໍ່ມີແບບສະມາຊິກ, ຫຼື ບໍ່ມີບັດ, ໃຫ້ໃຫ້ທ່ານເບີ 855-710-6984.                                                                                                      |
| Diné<br>Navajo           | T'áá ni, éí doodago ía' da biká anánílwo 'ígíí, na 'ídiłkídag, ts'ídá bee ná ahóótí'í' t'áá níik' e níká a' doolwol. Ána' hahne'í bich'í' hahdeesdzih nínízingo éí kwe' é da' íniishgi áká anídaalwo' ígíí bich'í' hodíłniih, bee nééłhózinii bine' déé' bikaá'. Kojí atah naaltsoos ná hadir' éégoó éí doodago bee nééłhózinigíí ádingo kojí' hodíłniih 855-710-6984.                           |
| فارسی<br>Persian         | اگر شما، یا کسی که شما به او کمک می کنید، سؤالی داشته باشید، حتی این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با خدمات مترجمی به شماره ای که در پشت کارت عضویت شما درج شده است تماس بگیرید. اگر عضو نیستید، یا کارت عضویت ندارید، با شماره 855-710-6984 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 поговорить с переводчиком, позвоните в отдел обслуживания клиентов по телефону, указанному на обратной стороне вашей карточки участника. Если вы не являетесь участником или у вас нет карточки, позвоните по телефону 855-710-6984. |
| 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 comuníquese con el número del Servicio al Cliente que figura en el reverso de su tarjeta de miembro. Si usted no es miembro o no posee una tarjeta, llame al 855-710-6984.                                              |
| 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 wikang nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa numero ng serbisyo para sa kustomer sa likod ng iyong kard ng miyembro. Kung ikaw ay hindi isang miyembro, o kaya ay walang kard, tumawag sa 855-710-6984.                     |
| اردو<br>Urdu             | اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کر رہے ہیں، کوئی سوال درپیش آئے تو، آپ کو اپنی زبان میں مفت اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، کسٹمر سروس نمبر پر کال کریں جو آپ کے کارڈ کی پشت پر درج ہے۔ اگر آپ ممبر نہیں ہیں، یا آپ کے پاس کارڈ نہیں ہے تو، 855-710-6984 پر کال کریں۔                                                                                       |
| Tiếng Việt<br>Vietnamese | Nếu quý vị hoặc người mà quý vị giúp đỡ có bất kỳ câu hỏi nào, quý vị có quyền được hỗ trợ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để hỏi chuyện với thông dịch viên, gọi số dịch vụ khách hàng nằm ở phía sau thẻ hội viên của quý vị. Nếu quý vị không phải là hội viên hoặc không có thẻ, gọi số 855-710-6984.                                                                     |

|                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                       |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p style="text-align: center;"><b>Health care coverage is important for everyone.</b></p> <p>We provide free communication aids and services for anyone with a disability or who needs language assistance.<br/>We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.</p> |                                                                                                                                                                                                                                                                                                                       |
| <p>To receive language or communication assistance free of charge, please call us at 855-710-6984.</p>                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                       |
| <p>If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.</p>                                                                                                                                                                                         | <p>Office of Civil Rights Coordinator<br/>300 E. Randolph St.<br/>35th Floor<br/>Chicago, Illinois 60601</p> <p>Phone: 855-664-7270 (voicemail)<br/>TTY/TDD: 855-661-6965<br/>Fax: 855-661-6960<br/>Email: <a href="mailto:CivilRightsCoordinator@hcsc.net">CivilRightsCoordinator@hcsc.net</a></p>                   |
| <p>You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:</p> <p>U.S. Dept. of Health &amp; Human Services<br/>200 Independence Avenue SW<br/>Room 509F, HHH Building 1019<br/>Washington, DC 20201</p>                                                        | <p>Phone: 800-368-1019<br/>TTY/TDD: 800-537-7697<br/>Complaint Portal: <a href="https://ocrportal.hhs.gov/ocr/portal/lobby.jsf">https://ocrportal.hhs.gov/ocr/portal/lobby.jsf</a><br/>Complaint Forms: <a href="http://www.hhs.gov/ocr/office/file/index.html">http://www.hhs.gov/ocr/office/file/index.html</a></p> |



**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 1-888-812-5465 or visit [www.connect2epeople.com](http://www.connect2epeople.com). 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.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM1.pdf](http://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM1.pdf) or call 1-855-756-4448 to request a copy.

| Important Questions                                                | Answers                                                                                                                                                                                                                                                 | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
|--------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>What is the overall deductible?</b>                             | For <u>In-Network</u> : \$1,800 Individual / \$3,600 Family<br>For <u>Out-of-Network</u> : \$3,600 Individual / \$7,200 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 policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.                                                                                                                                                                                                                                                                        |
| <b>Are there services covered before you meet your deductible?</b> | Yes. <u>Preventive care</u> and <u>preventive prescription drugs</u> are covered before you meet your <u>deductible</u> .                                                                                                                               | This plan 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="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                                     |
| <b>Are there other deductibles for specific services?</b>          | No.                                                                                                                                                                                                                                                     | You don't have to meet <u>deductibles</u> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>What is the out-of-pocket limit for this plan?</b>              | For <u>In-Network</u> : \$4,800 Individual / \$9,600 Family<br>For <u>Out-of-Network</u> : \$9,600 Individual / \$19,200 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 out-of-pocket limit?</b>            | <u>Premiums</u> , <u>preauthorization penalties</u> , <u>balanced-billed charges</u> , and <u>healthcare</u> 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 network provider?</b>            | Yes. See <a href="http://www.bcbstx.com">www.bcbstx.com</a> or call 1-800-810-2583 for a list of <u>network providers</u> . See <a href="http://www.caremark.com">www.caremark.com</a> for <u>prescription drug</u> information or call 1-877-775-5642. | This plan 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 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 referral to see a specialist?</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                                                                                                                                                                                                                                                                                 |
|---------------------------------------------------------------|--------------------------------------------------|-------------------------------------------------|----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                               |                                                  | In-Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                        |
| If you visit a health care <u>provider's</u> office or clinic | Primary care visit to treat an injury or illness | 20% <u>coinsurance</u>                          | 40% <u>coinsurance</u>                             | None                                                                                                                                                                                                                                                                                                                                   |
|                                                               | <u>Specialist</u> visit                          | 20% <u>coinsurance</u>                          | 40% <u>coinsurance</u>                             | None                                                                                                                                                                                                                                                                                                                                   |
|                                                               | <u>Preventive care/screening/immunization</u>    | No Charge; <u>deductible</u> does not apply     | No Charge; <u>deductible</u> does not apply        | Preventive colonoscopies and sigmoidoscopies- 1 covered every 5 years at 100%.<br><u>Out-of-Network providers</u> can <u>balance bill</u> .<br>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. |
| If you have a test                                            | <u>Diagnostic test</u> (x-ray, blood work)       | 20% <u>coinsurance</u>                          | 40% <u>coinsurance</u>                             | None                                                                                                                                                                                                                                                                                                                                   |
|                                                               | Imaging (CT/PET scans, MRIs)                     | 20% <u>coinsurance</u>                          | 40% <u>coinsurance</u>                             | None                                                                                                                                                                                                                                                                                                                                   |

\* For more information about limitations and exceptions, see the plan or policy document at [www.connect2epeople.com](http://www.connect2epeople.com).

| Common Medical Event                                                                                                                                                                                              | Services You May Need                          | What You Will Pay                                                                                                                                                     |                                                                                                                 | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                                   |                                                | In-Network Provider<br>(You will pay the least)                                                                                                                       | Out-of-Network Provider<br>(You will pay the most)                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <u>prescription drug coverage</u> is available at <a href="http://www.caremark.com">www.caremark.com</a> or 1-877-775-5642. | Generic drugs                                  | 20% <u>coinsurance</u>                                                                                                                                                | 20% <u>coinsurance</u>                                                                                          | Deductible waived for value/preventive drugs.<br><br>Value (preventive) generic drugs \$5 copay (30-day supply) for In-Network; <u>\$10 copay (90-day supply) for In-Network</u><br><br>Preferred and Non-preferred drugs: If generic isn't chosen, member pays <u>copay</u> plus the difference between the price of generic and brand.<br><br>Anabolic steroids and <u>specialty drugs</u> must be approved prior to dispensing.<br><br><u>Specialty drugs</u> are only covered when acquired through Caremark's mail order program.<br><br>Maintenance Choice: If use maintenance prescription drugs, they must be filled through the mail order drug program or at a CVS pharmacy location only. With each new maintenance prescription, you may fill your prescription 3 times at retail before you must transition to a 90-day supply through mail order. If you wish to opt out of this program, please call CVS. |
|                                                                                                                                                                                                                   | Preferred brand drugs                          | 20% <u>coinsurance</u><br><br>Up to \$75 max per script (30-day supply)<br><br>Up to \$150 max per script (90-day supply)                                             | 30% <u>coinsurance</u>                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|                                                                                                                                                                                                                   | Non-preferred brand drugs                      | 20% coinsurance<br><br>Up to \$120 max per script (30-day supply)<br><br>Up to \$240 max per script (90-day supply)                                                   | 40% <u>coinsurance</u>                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|                                                                                                                                                                                                                   | <u>Specialty drugs</u>                         | 20% coinsurance (generic)<br><br>20% coinsurance up to \$150 max per script (preferred brand)<br><br>20% coinsurance up to \$240 max per script (non-preferred brand) | 20% coinsurance (generic)<br><br>30% coinsurance (preferred brand)<br><br>40% coinsurance (non-preferred brand) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|                                                                                                                                                                                                                   | Facility fee (e.g., ambulatory surgery center) | 20% <u>coinsurance</u>                                                                                                                                                | 40% <u>coinsurance</u>                                                                                          | Acupuncture is covered only when used in lieu of anesthesia for surgery.<br><br>Bariatric (weight loss) surgery is covered with <u>In-Network</u> providers only and for a diagnosis of morbid obesity only.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>If you have outpatient surgery</b>                                                                                                                                                                             | Physician/surgeon fees                         | 20% <u>coinsurance</u>                                                                                                                                                | 40% <u>coinsurance</u>                                                                                          | None                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |

\* For more information about limitations and exceptions, see the plan or policy document at [www.connect2epeople.com](http://www.connect2epeople.com).



| Common Medical Event                    | Services You May Need                   | What You Will Pay                               |                                                    | Limitations, Exceptions, & Other Important Information |
|-----------------------------------------|-----------------------------------------|-------------------------------------------------|----------------------------------------------------|--------------------------------------------------------|
|                                         |                                         | In-Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                        |
| If you need immediate medical attention | <u>Emergency room care</u>              | 20% <u>coinsurance</u>                          | 20% <u>coinsurance</u>                             | None                                                   |
|                                         | <u>Emergency medical transportation</u> | 20% <u>coinsurance</u>                          | 20% <u>coinsurance</u>                             | Ground and air transportation covered.                 |
|                                         | <u>Urgent care</u>                      | 20% <u>coinsurance</u>                          | 40% <u>coinsurance</u>                             | None                                                   |

\* For more information about limitations and exceptions, see the plan or policy document at [www.connect2epeople.com](http://www.connect2epeople.com).

| Common Medical Event                                                      | Services You May Need                     | What You Will Pay                               |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                  |
|---------------------------------------------------------------------------|-------------------------------------------|-------------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                           | In-Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                         |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)        | 20% <u>coinsurance</u>                          | 40% <u>coinsurance</u>                             | <u>Preauthorization</u> is required; \$250 penalty if services are not preauthorized <u>Out-of-Network</u> .                                                                                                                                                            |
|                                                                           | Physician/surgeon fees                    | 20% <u>coinsurance</u>                          | 40% <u>coinsurance</u>                             | None                                                                                                                                                                                                                                                                    |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | 20% <u>coinsurance</u>                          | 40% <u>coinsurance</u>                             | Certain services must be preauthorized; refer to benefits booklet for details.                                                                                                                                                                                          |
|                                                                           | Inpatient services                        | 20% <u>coinsurance</u>                          | 40% <u>coinsurance</u>                             | <u>Preauthorization</u> is required; \$250 penalty if services are not preauthorized <u>Out-of-Network</u> .                                                                                                                                                            |
| If you are pregnant                                                       | Office visits                             | 20% <u>coinsurance</u>                          | 40% <u>coinsurance</u>                             | <u>Cost sharing</u> does not apply for <u>preventive</u> services.<br>Depending on the type of services, a <u>coinsurance</u> or <u>deductible</u> may apply.<br><u>Maternity</u> care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) |
|                                                                           | Childbirth/delivery professional services | 20% <u>coinsurance</u>                          | 40% <u>coinsurance</u>                             |                                                                                                                                                                                                                                                                         |
|                                                                           | Childbirth/delivery facility services     | 20% <u>coinsurance</u>                          | 40% <u>coinsurance</u>                             | <u>Preauthorization</u> is required; \$250 penalty if services are not preauthorized <u>Out-of-Network</u> .                                                                                                                                                            |

\* For more information about limitations and exceptions, see the plan or policy document at [www.connect2epeople.com](http://www.connect2epeople.com).

| Common Medical Event                                           | Services You May Need            | What You Will Pay                               |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                          |
|----------------------------------------------------------------|----------------------------------|-------------------------------------------------|----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                |                                  | In-Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                                 |
| If you need help recovering or have other special health needs | <u>Home health care</u>          | 20% <u>coinsurance</u>                          | 40% <u>coinsurance</u>                             | <u>Preauthorization</u> is required.                                                                                                                                                                                                                                                                                                                                            |
|                                                                | <u>Rehabilitation services</u>   | 20% <u>coinsurance</u>                          | 40% <u>coinsurance</u>                             | Chiropractic care by <u>Airrosti providers</u> is \$25 <u>copay</u> after <u>deductible</u> . Limited to 25 visits per calendar year.<br>Dialysis is covered <u>In-Network only</u>                                                                                                                                                                                             |
|                                                                | <u>Habilitation services</u>     | 20% <u>coinsurance</u>                          | 40% <u>coinsurance</u>                             |                                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                | <u>Skilled nursing care</u>      | 20% <u>coinsurance</u>                          | 40% <u>coinsurance</u>                             | <u>Preauthorization</u> is required.                                                                                                                                                                                                                                                                                                                                            |
|                                                                | <u>Durable medical equipment</u> | 20% <u>coinsurance</u>                          | 40% <u>coinsurance</u>                             | Wigs covered at applicable <u>deductible</u> and <u>coinsurance</u> , up to \$500 calendar year max; combined <u>In-Network</u> and <u>Out-of-Network</u> . Hearing aids are covered 1 pair per 36 months at applicable <u>deductible</u> and <u>coinsurance</u> . Foot orthotics are covered at applicable <u>deductible</u> and <u>coinsurance</u> , regardless of diagnosis. |
|                                                                | <u>Hospice services</u>          | No Charge                                       | 40% <u>coinsurance</u>                             | <u>Preauthorization</u> is required.                                                                                                                                                                                                                                                                                                                                            |
| If your child needs dental or eye care                         | Children's eye exam              | No Charge; <u>deductible</u> does not apply     | No Charge; <u>deductible</u> does not apply        | Limited to 1 exam per calendar year.<br>Does not include vision care benefits/hardware. <u>Out-of-Network</u> can balance bill.                                                                                                                                                                                                                                                 |
|                                                                | Children's glasses               | Not Covered                                     | Not Covered                                        | None                                                                                                                                                                                                                                                                                                                                                                            |
|                                                                | Children's dental check-up       | Not Covered                                     | Not Covered                                        | None                                                                                                                                                                                                                                                                                                                                                                            |

\* For more information about limitations and exceptions, see the plan or policy document at [www.connect2epeople.com](http://www.connect2epeople.com).

## Excluded services & Other Covered Services:

| <b>Services Your <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u>.)</b>                  |                                                                                                                                                                                                                                                                                        |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"><li>• Dental care (Adult)</li><li>• Infertility treatment</li></ul>                                                                                         | <ul style="list-style-type: none"><li>• Long-term care</li><li>• Routine foot care</li><li>• Weight loss programs</li></ul>                                                                                                                                                            |
| <b>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)</b>                                                    |                                                                                                                                                                                                                                                                                        |
| <ul style="list-style-type: none"><li>• Acupuncture (only in lieu of anesthesia)</li><li>• Bariatric surgery (morbid obesity only)</li><li>• Chiropractic care (25 visits per year)</li></ul> | <ul style="list-style-type: none"><li>• Cosmetic surgery (specific medical conditions)</li><li>• Hearing aids (1 per ear per 36-month period)</li><li>• Non-emergency care when traveling outside the U.S.</li><li>• Private-duty nursing</li><li>• Routine eye care (Adult)</li></ul> |

**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](http://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.ccio.cms.gov](http://www.ccio.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](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: Blue Cross and Blue Shield of Texas at 1-800-521-2227 or visit [www.bcbstx.com](http://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](http://www.dol.gov/ebsa/healthreform). 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.texashealthoptions.com](http://www.texashealthoptions.com).

### **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): 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): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-521-2227.

—————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 \$1,800
- Specialist coinsurance 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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,800</b> |
|---------------------------|-----------------|

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

| <u>Cost sharing</u>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$1,800        |
| <u>Copayments</u>                 | \$0            |
| <u>Coinsurance</u>                | \$2,200        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$4,060</b> |

**Managing Joe's type 2 Diabetes**

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

- The plan's overall deductible \$1,800
- Specialist coinsurance 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$7,400</b> |
|---------------------------|----------------|

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

| <u>Cost sharing</u>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$1,800        |
| <u>Copayments</u>                 | \$0            |
| <u>Coinsurance</u>                | \$1,100        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Joe would pay is</b> | <b>\$2,960</b> |

**Mia's Simple Fracture**

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

- The plan's overall deductible \$1,800
- Specialist coinsurance 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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$1,900</b> |
|---------------------------|----------------|

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

| <u>Cost sharing</u>               |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$1,800        |
| <u>Copayments</u>                 | \$0            |
| <u>Coinsurance</u>                | \$30           |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$1,830</b> |

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 speak to an interpreter, call the customer service number on the back of your member card. If you are not a member, or don't have a card, call 855-710-6984.

|                          |                                                                                                                                                                                                                                                                                                                                                                                                  |
|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| العربية<br>Arabic        | اين كان لديك اول لدى شخص تساعد أمثلة، فذلك الحق في الحصول على المساعدة والمعلومات الضرورية بمتك من دون أية تكلفة. للتحدث إلى مترجم فوري، اتصل على رقم خدمة العملاء المذكور على ظهر بطاقة عضويتك. فإن لم تكن عضواً، أو كنت لا تملك بطاقة، فاحصل على 855-710-6984.                                                                                                                                 |
| 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，請致電印在您的會員卡背面的客戶服務電話號碼。如果您不是會員，或沒有會員卡，請致電 855-710-6984。                                                                                                                                                                                                                                                                                            |
| 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, composez le numéro du service client indiqué au verso de votre carte de membre. Si vous n'êtes pas membre ou si vous n'avez pas de carte, veuillez composer le 855-710-6984.                      |
| 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 Kundenservicenummer auf der Rückseite Ihrer Mitgliedskarte an. Falls Sie kein Mitglied sind oder keine Mitgliedskarte besitzen, rufen Sie bitte 855-710-6984 an.                            |
| ગુજરાતી<br>Gujarati      | જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ બી એમ. દલાયિયા સાથે વાત કરવા માટે, તમારા સભ્યપદના કાર્ડની પાછળ આપેલ ગ્રાહક સેવા નંબર પર કોલ કરો કરો જો આપ સભ્યપદ ના ધરાવતા હોવ, અથવા આપની પાસે કાર્ડ નથી તો 855-710-6984 નંબર પર કોલ 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, अपने सदस्य कार्ड के पीछे दिए गए ग्राहक सेवा नंबर पर कॉल करें। यदि आप सदस्य नहीं हैं, या आपके पास कार्ड नहीं है, तो 855-710-6984 पर कॉल करें।                                                                              |
| 日本語<br>Japanese          | ご本人様、またはお客様の方でも、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、メンバーカードの裏のカスタマーサービス番号までお電話ください。メンバーでない場合は 855-710-6984 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. 회원 카드 뒷면에 있는 고객센터 서비스 번호로 전화하십시오. 회원이 아니거나 카드가 없으시면 855-710-6984 으로 전화하십시오.                                                                                                                                                                                                                                            |
| ລາວ<br>Laotian           | ຖ້າທ່ານ ຫຼື ຄົນທີ່ທ່ານກຳລັງໃຫ້ການຊ່ວຍເຫຼືອມີຄຳຖາມ, ທ່ານມີສິດຂໍອີກການຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໄດ້ໃດໆບໍ່ມີຄ່າໃຊ້ຈ່າຍ ເພື່ອນົມັ່ນຄຳຖາມ. ໃຫ້ໃຫ້ທ່ານເບິ່ງ ການລູກຄ້າທີ່ມີຊື່ດ້ານຫຼັງບໍ່ຕ້ອງສະມາຊິກຂອງທ່ານ. ຖ້າທ່ານບໍ່ແມ່ນສະມາຊິກ, ຫຼື ບໍ່ມີບັດ, ໃຫ້ໃຫ້ທ່ານເບິ່ງ 855-710-6984.                                                                                                                |
| Diné<br>Navajo           | T'áá ni, éí doodago ía' da biká anánílwo 'ígíí, na 'ídiłkídag, ts'ídá bee ná ahóótí'í' t'áá níik' e níká a' doolwol. Ána' halne'í bich'í' haadeedzih nínízingo éí kwe' é da' íniishgi áká anídaalwo' ígíí bich'í' hodíłniih, bee nééłhózinii bine' déé' bikaá'. Kojí atah naaltsoos ná hadir' éégoó éí doodago bee nééłhózinigíí ádingo kojí' hodíłniih 855-710-6984.                            |
| فارسی<br>Persian         | اگر شما، یا کسی که شما به او کمک می کنید، سؤالی داشته باشید، حتی این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با خدمات مترجمی به شماره ای که در پشت کارت عضویت شما درج شده است تماس بگیرید. اگر عضو نیستید، یا کارت عضویت ندارید، با شماره 855-710-6984 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 поговорить с переводчиком, позвоните в отдел обслуживания клиентов по телефону, указанному на обратной стороне вашей карточки участника. Если вы не являетесь участником или у вас нет карточки, позвоните по телефону 855-710-6984. |
| 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 comuníquese con el número del Servicio al Cliente que figura en el reverso de su tarjeta de miembro. Si usted no es miembro o no posee una tarjeta, llame al 855-710-6984.                                              |
| 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 wikang nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa numero ng serbisyo para sa kustomer sa likod ng iyong kard ng miyembro. Kung ikaw ay hindi isang miyembro, o kaya ay walang kard, tumawag sa 855-710-6984.                     |
| اردو<br>Urdu             | اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کر رہے ہیں، کوئی سوال درپیش آئے تو، آپ کو اپنی زبان میں مفت اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، کسٹمر سروس نمبر پر کال کریں جو آپ کے کارڈ کی پشت پر درج ہے۔ اگر آپ ممبر نہیں ہیں، یا آپ کے پاس کارڈ نہیں ہے تو، 855-710-6984 پر کال کریں۔                                                                                       |
| Tiếng Việt<br>Vietnamese | Nếu quý vị hoặc người mà quý vị giúp đỡ có bất kỳ câu hỏi nào, quý vị có quyền được hỗ trợ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để hỏi chuyện với thông dịch viên, gọi số dịch vụ khách hàng nằm ở phía sau thẻ hội viên của quý vị. Nếu quý vị không phải là hội viên hoặc không có thẻ, gọi số 855-710-6984.                                                                     |

|                                                                                                                                                                                                                                                                                                                                   |                                                                                                                                                                                                                                                                                                                       |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p style="text-align: center;"><b>Health care coverage is important for everyone.</b></p> <p>We provide free communication aids and services for anyone with a disability or who needs language assistance.<br/>We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.</p> |                                                                                                                                                                                                                                                                                                                       |
| <p>To receive language or communication assistance free of charge, please call us at 855-710-6984.</p>                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                       |
| <p>If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.</p>                                                                                                                                                                                         | <p>Office of Civil Rights Coordinator<br/>300 E. Randolph St.<br/>35th Floor<br/>Chicago, Illinois 60601</p> <p>Phone: 855-664-7270 (voicemail)<br/>TTY/TDD: 855-661-6965<br/>Fax: 855-661-6960<br/>Email: <a href="mailto:CivilRightsCoordinator@hcsc.net">CivilRightsCoordinator@hcsc.net</a></p>                   |
| <p>You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:</p> <p>U.S. Dept. of Health &amp; Human Services<br/>200 Independence Avenue SW<br/>Room 509F, HHH Building 1019<br/>Washington, DC 20201</p>                                                        | <p>Phone: 800-368-1019<br/>TTY/TDD: 800-537-7697<br/>Complaint Portal: <a href="https://ocrportal.hhs.gov/ocr/portal/lobby.jsf">https://ocrportal.hhs.gov/ocr/portal/lobby.jsf</a><br/>Complaint Forms: <a href="http://www.hhs.gov/ocr/office/file/index.html">http://www.hhs.gov/ocr/office/file/index.html</a></p> |



**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 <http://swhp.org/plandocs>, or call 1-800-321-7947. 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 [ccio.cms.gov](http://ccio.cms.gov) or call 1-800-321-7947 to request a copy.

| Important Questions                                                 | Answers                                                                                                                                                                                        | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|---------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <u>deductible</u> ?                             | <u>Participating Provider</u> : \$500 individual / \$1,000 family; Does not apply to services subject to a <u>copay</u> , preventive care and Rx drug expenses.                                | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this plan 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 <u>deductible</u> ? | Yes. <u>Preventive care</u> and primary care services are covered before you meet your <u>deductible</u> .                                                                                     | This <u>plan</u> covers some items and services even if you have not 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 preventive services at <a href="http://healthcare.gov/coverage/preventive-care-benefits/">healthcare.gov/coverage/preventive-care-benefits/</a>                                                                    |
| Are there other <u>deductibles</u> for specific services?           | Yes. Prescription Drugs \$200 Individual / \$400 Family. Does not apply to generic or value generic drugs.                                                                                     | You do not have to meet <u>deductibles</u> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?       | <u>Participating Provider</u> : \$3,000 per individual / \$6,000 per family; Prescriptions: \$2,000 individual / \$4,000 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 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> .                                                                                                                                                                                                              |
| What is not included in the <u>out-of-pocket limit</u> ?            | <u>Premiums</u> , <u>balance-billing</u> charges, Rx deductible and health care this <u>plan</u> does not 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 <a href="http://swhp.org">swhp.org</a> or call 1-800-321-7947, <a href="http://www.caremark.com">www.caremark.com</a> or call 1-877-775-5642 for a list of <u>network providers</u> . | 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 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. |
| Do you need a <u>referral</u> to see a <u>specialist</u> ?          | No                                                                                                                                                                                             | You can see the <u>specialist</u> you choose without a <u>referral</u> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |



 All coinsurance insurance 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<br>(You will pay the least)                                                                                                                    | Out-of-Network Provider<br>(You will pay the most)                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>If you visit a health care provider's office or clinic</b>                                                                                                                                                     | Primary care visit to treat an injury or illness | \$20 <u>copay</u>                                                                                                                                               | 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 <u>plan</u> will pay for.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|                                                                                                                                                                                                                   | <u>Specialist</u> visit                          | \$20 <u>copay</u>                                                                                                                                               | Not Covered                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|                                                                                                                                                                                                                   | <u>Preventive care/screening/immunization</u>    | No Charge                                                                                                                                                       | Not Covered                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>If you have a test</b>                                                                                                                                                                                         | <u>Diagnostic test</u> (x-ray, blood work)       | No Charge                                                                                                                                                       | Not Covered                                                                                             | For prior authorization requirements and penalties see <a href="http://swhp.org/ind-fam/tools-resources">swhp.org/ind-fam/tools-resources</a> . Failure to obtain Prior Authorization will result in the lesser of \$500 or 50% reduction in benefits.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|                                                                                                                                                                                                                   | Imaging (CT/PET scans, MRIs)                     | 10% <u>coinsurance</u>                                                                                                                                          | Not Covered                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <u>prescription drug coverage</u> is available at <a href="http://www.caremark.com">www.caremark.com</a> or 1-877-775-5642. | Generic drugs                                    | \$10 copay / script (30-day supply)<br>\$20 copay / script (90-day supply)                                                                                      | 20% coinsurance                                                                                         | Deductible waived for value/preventive drugs.<br>-Value (preventive) generic drugs \$5 copay per script (30-day supply); \$10 copay per script (90-day supply) for In-Network<br>- Preferred and Non-preferred drugs: If generic isn't chosen, member pays copay plus the difference between the price of generic and brand.<br>-Anabolic steroids and specialty drugs must be approved prior to dispensing.<br>-Specialty drugs are only covered when acquired through Caremark's mail order program.<br>-Maintenance Choice<br>If use maintenance prescription drugs, they must be filled through the mail order drug program or at a CVS pharmacy location only. With each new maintenance prescription, you may fill your prescription 3 times at retail before you must transition to a 90-day supply through mail order. If you wish to opt out of this program, please call CVS. |
|                                                                                                                                                                                                                   | Preferred brand drugs                            | 30% coinsurance and Up to \$100 max per script (30-day supply)<br>Up to \$200 max per script (90-day supply)                                                    | 30% coinsurance                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|                                                                                                                                                                                                                   | Non-preferred Brand drugs                        | 40% coinsurance and Up to \$120 max per script (30-day supply)<br>Up to \$240 max per script (90-day supply)                                                    | 40% coinsurance                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|                                                                                                                                                                                                                   | Specialty drugs                                  | \$20 copay/script (generic)<br>30% coinsurance up to \$200 max per script (preferred brand)<br>40% coinsurance up to \$240 max per script (non-preferred brand) | 20% coinsurance (generic)<br>30% coinsurance (preferred brand)<br>40% coinsurance (non-preferred brand) |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|                                                                                                                                                                                                                   |                                                  |                                                                                                                                                                 |                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |

\* For more information about limitations and exceptions, see the plan or policy document at [swhp.org](http://swhp.org)

| Common Medical Event                                                      | Services You May Need                          | What You Will Pay                            |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                               |
|---------------------------------------------------------------------------|------------------------------------------------|----------------------------------------------|----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                                | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                                                                      |
| If you have outpatient surgery                                            | Facility fee (e.g., ambulatory surgery center) | 10% <u>coinsurance</u>                       | Not Covered                                        | None                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                           | Physician/surgeon fees                         | 10% <u>coinsurance</u>                       | Not Covered                                        |                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                           | Emergency room care                            | 10% <u>coinsurance</u>                       | 10% <u>coinsurance</u>                             |                                                                                                                                                                                                                                                                                                                                                                      |
| If you need immediate medical attention                                   | Emergency medical transportation               | 10% <u>coinsurance</u>                       | 10% <u>coinsurance</u>                             | None                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                           | Urgent care                                    | 10% <u>coinsurance</u>                       | 10% <u>coinsurance</u>                             |                                                                                                                                                                                                                                                                                                                                                                      |
|                                                                           | Facility fee (e.g., hospital room)             | 10% <u>coinsurance</u>                       | Not Covered                                        |                                                                                                                                                                                                                                                                                                                                                                      |
| If you have a hospital stay                                               | Physician/surgeon fees                         | 10% <u>coinsurance</u>                       | Not Covered                                        | For prior authorization requirements and penalties see <a href="http://swhp.org/ind-fam/tools-resources">swhp.org/ind-fam/tools-resources</a> . Failure to obtain Prior Authorization will result in the lesser of \$500 or 50% reduction in benefits, or denial in the case of Health Care Services, other than Emergency Care, provided by an In-Network Provider. |
|                                                                           | Outpatient services                            | \$20 <u>copay</u>                            | Not Covered                                        | Requires referral and preauthorization                                                                                                                                                                                                                                                                                                                               |
| If you need mental health, behavioral health, or substance abuse services | Inpatient services                             | 10% <u>coinsurance</u>                       | Not Covered                                        | Requires referral and preauthorization                                                                                                                                                                                                                                                                                                                               |
|                                                                           | Office visits                                  | \$20 <u>copay</u>                            | Not Covered                                        | No charge for prenatal visits; postnatal visits are covered at the specialist <u>copay</u> .<br>Depending on the type of services, a <u>copayment</u> , <u>coinsurance</u> , or <u>deductible</u> may apply.                                                                                                                                                         |
| If you are pregnant                                                       | Childbirth/delivery professional services      | 10% <u>coinsurance</u>                       | Not Covered                                        | None                                                                                                                                                                                                                                                                                                                                                                 |
|                                                                           | Childbirth/delivery facility services          | 10% <u>coinsurance</u>                       | Not Covered                                        | None                                                                                                                                                                                                                                                                                                                                                                 |
| If you need help                                                          | Home health care                               | \$20 <u>copay</u>                            | Not Covered                                        | None                                                                                                                                                                                                                                                                                                                                                                 |

\* For more information about limitations and exceptions, see the plan or policy document at [swhp.org](http://swhp.org)

| Common Medical Event                          | Services You May Need            | What You Will Pay                            |                                                    | Limitations, Exceptions, & Other Important Information |
|-----------------------------------------------|----------------------------------|----------------------------------------------|----------------------------------------------------|--------------------------------------------------------|
|                                               |                                  | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |                                                        |
| recovering or have other special health needs | <u>Rehabilitation services</u>   | \$20 <u>copay</u>                            | Not Covered                                        | None                                                   |
|                                               | <u>Habilitation services</u>     | \$20 <u>copay</u>                            | Not Covered                                        | None                                                   |
|                                               | <u>Skilled nursing care</u>      | 10% <u>coinsurance</u>                       | Not Covered                                        | Pre-certification required                             |
|                                               | <u>Durable medical equipment</u> | 50% <u>coinsurance</u>                       | Not Covered                                        | None                                                   |
|                                               | <u>Hospice services</u>          | No Charge                                    | Not Covered                                        | None                                                   |
| If your child needs dental or eye care        | Children's eye exam              | \$20 <u>copay</u>                            | Not Covered                                        | One exam limit per year.                               |
|                                               | 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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside U.S.
- Private-duty nursing
- 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.)

- Hearing aids (limited to one per ear every three years for covered members 18 years of age or younger)
- Manipulative therapy (limited to 35 visits per Calendar year)
- Routine eye care (Adult) (limited to annual eye exam conducted by a licensed ophthalmologist or optometrist)

**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: Scott and White Health Plan, visit [swhp.org](http://swhp.org), or call 1-800-321-7947; Department of Labor Employee Benefits Security Administration, visit [dol.gov/ebsa/healthreform](http://dol.gov/ebsa/healthreform), or call 1-866-444-EBSA (3272); Department of Health and Human Services, Center for Consumer Information, visit [ccio.com.gov](http://ccio.com.gov), or call 1-877-267-2323 x61565; Texas Department of Insurance, visit [tdi.texas.gov](http://tdi.texas.gov), or call 1-800-578-4677. 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 [HealthCare.gov](http://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: Scott and White Health Plan, visit [swhp.org](http://swhp.org), or call 1-800-321-7947; Department of Labor Employee Benefits Security Administration, visit [dol.gov/ebsa/healthreform](http://dol.gov/ebsa/healthreform), or call 1-866-444-EBSA (3272); Texas Department of Insurance, visit [tdi.texas.gov](http://tdi.texas.gov), or call 1-800-252-3439.

\* For more information about limitations and exceptions, see the plan or policy document at [swhp.org](http://swhp.org)

**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): Para obtener asistencia en Español, llame al 1-800-321-7947.

\_\_\_\_\_ 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 \$500
- Specialist copayment \$20
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

This **EXAMPLE** event includes services like:

**Sample Care Costs**

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>\$12,731</b> |
|---------------------------|-----------------|

In this example, Peg would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$536          |
| <u>Copayments</u>                 | \$380          |
| <u>Coinsurance</u>                | \$912          |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$60           |
| <b>The total Peg would pay is</b> | <b>\$1,889</b> |

**Managing Joe's type 2 Diabetes**

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

- The plan's overall deductible \$500
- Specialist copayment \$20
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

This **EXAMPLE** event includes services like:

**Sample Care Costs**

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>\$7,389</b> |
|---------------------------|----------------|

In this example, Joe would pay:

| Cost Sharing                      |                |
|-----------------------------------|----------------|
| <u>Deductibles</u>                | \$1,936        |
| <u>Copayments</u>                 | \$160          |
| <u>Coinsurance</u>                | \$363          |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$55           |
| <b>The total Joe would pay is</b> | <b>\$2,514</b> |

**Mia's Simple Fracture**

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

- The plan's overall deductible \$500
- Specialist copayment \$20
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

This **EXAMPLE** event includes services like:

**Sample Care Costs**

Emergency room care (including medical supplies)  
Diagnostic test (x-ray)  
Durable medical equipment (crutches)  
Rehabilitation services (physical therapy)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$1,925</b> |
|---------------------------|----------------|

In this example, Mia would pay:

| Cost Sharing                      |              |
|-----------------------------------|--------------|
| <u>Deductibles</u>                | \$500        |
| <u>Copayments</u>                 | \$140        |
| <u>Coinsurance</u>                | \$156        |
| <i>What isn't covered</i>         |              |
| Limits or exclusions              | \$0          |
| <b>The total Mia would pay is</b> | <b>\$796</b> |

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



# Nondiscrimination Notice

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**ATTENTION:** If you speak English, language assistance services, free of charge, are available to you. Call 1-800-321-7947 (TTY: 711).

Scott and White Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Scott and White Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Scott and White Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print and accessible electronic formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Scott and White Health Plan (SWHP) Compliance Officer at 1-254-820-8888 or send an email to [SWHPComplianceDepartment@BSWHHealth.org](mailto:SWHPComplianceDepartment@BSWHHealth.org).

If you believe that Scott and White Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

SWHP Compliance Officer  
1206 West Campus Drive, Suite 151  
Temple, Texas 76502

Compliance HelpLine; 1-888-484-6977 or <https://app.mycompliancereport.com/report.aspx?cid=swhp>

You can file a grievance in person or by mail, online, or email. If you need help filing a grievance, the SWHP Compliance Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at <https://www.hhs.gov/civil-rights/filing-a-complaint/index.html>.

Non-Discrimination Ntc\_06/2018\_English

# Language Assistance



## English:

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-321-7947 (TTY: 711).

## Spanish:

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-321-7947 (TTY: 711).

## Vietnamese:

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-321-7947 (TTY: 711).

## Chinese:

注意: 如果使用繁體中文, 可以免費獲得語言援助服務。請致電 1-800-321-7947 (TTY: 711)。

## Korean:

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-321-7947 (TTY: 711) 번으로 전화해 주십시오.

## Arabic:

رقم هاتف الصم والبكم: 711 ملحوظة: إذا كنت تتحدث انكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-866-334-3141

## Urdu:

کریں۔ 711 (TTY: 711) خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال

## Tagalog:

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-321-7947 (TTY: 711).

## French:

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-321-7947 (ATS : 711).

## Hindi:

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-321-7947 (TTY: 711) पर कॉल करें।

## Persian:

فراهم می باشد. با 1-800-321-7947 (TTY: 711) تماس بگیرید. توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما

## German:

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-321-7947 (TTY: 711).

## Gujarati:

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિઃશુલ્ક ભાષા સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-321-7947 (TTY: 711).

## Russian:

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-321-7947 (телефайп: 711).

## Japanese:

注意事項: 日本語を話される場合、無料の言語支援をご利用いただけます。1-800-321-7947 (TTY: 711) まで、お電話にてご連絡ください。

## Laotian:

ໃບອຳນວຍ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອຂອງພວກຂ້ານຳພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ຄຸນນະພາບສູງໃຫ້ທ່ານ. ໂທ 1-800-321-7947 (TTY: 711).

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## IMPORTANT LEGALLY REQUIRED BENEFITS INFORMATION: **READ CAREFULLY**

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