2018 Required Notices

ONCOR LIVE WELL

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,** 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 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 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 to HRA or HSA.
- 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).

Date:	October 1, 2017
Name of Entity/Sender:	Oncor Electric Delivery Company LLC
Contact Position/Office:	ePeople HR Service Center
Address:	P.O. Box 44023 Jacksonville, FL 32231
Telephone:	1.888.812.5465 (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**.

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.KIDS NOW** or **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** 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 August 10, 2017. Contact your State for more information on eligibility.

ALABAMA – Medicaid	**ALASKA – Medicaid**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid	**COLORADO** **Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	**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 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 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/ime/members/medicaid-a-to-z/hipp
Phone: 1-888-346-9562

KANSAS – Medicaid

Website: http://www.kdheks.gov/hcf/
Phone: 1-785-296-3512

KENTUCKY – Medicaid

Website: http://chfs.ky.gov/dms/default.htm
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: 1-800-482-4840

MINNESOTA – Medicaid

Website:
http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.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://dwss.nv.gov/
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 1-603-271-5218

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

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: https://dma.ncdhhs.gov/
Phone: 1-919-855-4100

NORTH DAKOTA – Medicaid

Website:
http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid

Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid

Website:
http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
Phone: 1-800-692-7462

RHODE ISLAND – Medicaid

Website: http://www.eohhs.ri.gov/
Phone: 1-401-462-5300

SOUTH CAROLINA – Medicaid

Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid

Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid

Website: http://gethipptexas.com/
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

Medicaid Website: https://medicaid.utah.gov/

CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT– Medicaid

Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

Medicaid Website:
http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Website:
http://www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 1-855-242-8282

WASHINGTON – Medicaid

Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA – Medicaid

Website: http://mywvhipp.com/
Phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP

Website:
https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002

WYOMING – Medicaid

Website: https://wyequalitycare.acs-inc.com/
Phone: 1-307-777-7531

To see if any other states have added a premium assistance program since August 10, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
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
1.877.267.2323, Menu Option 4, Ext. 61565

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. 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 or call 1-800-521-2227 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For In-Network: $1,250 Individual / $2,500 Family For Out-of-Network: $2,500 Individual / $5,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care, generic prescription drugs, and hospice are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. Prescription drug deductible: $200 Individual / $400 Family. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For In-Network: $3,650 Individual / $7,300 Family For Out-of-Network: $8,000 Individual / $16,000 Family Prescription drug limit: $2,000 Individual / $4,000 Family	The out-of-pocket limit 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 out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, preauthorization penalties, balanced-billed charges, and healthcare this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bcbstx.com or call 1-800-810-2583 for a list of network providers. See www.caremark.com for prescription drug information or call 1-877-775-5642.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

 All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	None
	Specialist visit	20% coinsurance	40% coinsurance	None
	Preventive care/screening/immunization	No Charge; deductible does not apply	No Charge; deductible does not apply	Preventive colonoscopies and sigmoidoscopies- 1 covered every 5 years at 100%. Out-of-Network providers can balance bill. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	None

* For more information about limitations and exceptions, see the plan or policy document at www.connect2epeople.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com or 1-877-775-5642	Generic drugs	$10 copay/script	20% coinsurance	Value (preventive) generic drugs $5 copay for In-Network Preferred and Non-preferred drugs: If generic isn't chosen, member pays copay plus the difference between the price of generic and brand. Anabolic steroids and specialty drugs must be approved prior to dispensing. Specialty drugs are only covered when acquired through Caremark's mail order program.
	Preferred brand drugs	30% coinsurance up to $100 max per script	30% coinsurance	
	Non-preferred brand drugs	40% coinsurance up to $120 max per script	40% coinsurance	
	Specialty drugs	Covered the same as any other drug	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Acupuncture is covered only when used in lieu of anesthesia for surgery. Morbid obesity is covered for In-Network only.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	Ground and air transportation covered.
	Urgent care	20% coinsurance	40% coinsurance	None

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Preauthorization is required.
	Rehabilitation services	20% coinsurance	40% coinsurance	Chiropractic care by Airrosti providers is subject to a $25 copay. Limited to 25 visits per calendar year. Dialysis is covered In-Network only
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	Preauthorization is required.
	Durable medical equipment	20% coinsurance	40% coinsurance	Wigs covered at applicable deductible and coinsurance, up to $500 calendar year max; combined In-Network and Out-of-Network. Hearing aids are covered 1 pair per 36 months at applicable deductible and coinsurance. Foot orthotics are covered at applicable deductible and coinsurance, regardless of diagnosis.
	Hospice services	No Charge; deductible does not apply	40% coinsurance	Preauthorization 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. Out-of-Network 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.

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.)		
• Dental care (Adult)	• Long-term care	• Weight loss programs
• Infertility treatment	• Routine foot care	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture (only in lieu of anesthesia)	• Cosmetic surgery (specific medical conditions)	• Private-duty nursing
• Bariatric surgery (morbid obesity only)	• Hearing aids (1 per ear per 36-month period)	• Routine eye care (Adult)
• Chiropractic care (25 visits per year)	• Non-emergency care when traveling outside the U.S.	

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 1-800-892-2803, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Blue Cross and Blue Shield of Texas at 1-800-521-2227 or visit www.bcbstx.com, or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. 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.

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

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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**	**$1,250**
■ **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)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost sharing	
Deductibles	$1,250
Copayments	$30
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,640**

Managing Joe's type 2 Diabetes

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

■ **The plan's overall deductible**	**$1,250**
■ **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)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost sharing	
Deductibles	$1,450
Copayments	$300
Coinsurance	$1,400
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$3,210**

Mia's Simple Fracture

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

■ **The plan's overall deductible**	**$1,250**
■ **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)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost sharing	
Deductibles	$1,250
Copayments	$0
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,350**

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 Arabic	إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث إلى مترجم فوري، اتصل على رقم خدمة العملاء المذكور على ظهر بطاقة عضويتك. فإن لم تكن عضوًا، أو كنت لا تملك بطاقة، فاتصل على 855-710-6984.
繁體中文 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 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 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 Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ.બી.એમ. દુભાષિયા સાથે વાત કરવા માટે, તમારા સભ્યપદના કાર્ડની પાછળ આપેલ ગ્રાહક સેવા નંબર પર કૉલ કરો. જો આપ સભ્યપદ ના ધરાવતા હોવ, અથવા આપની પાસે કાર્ડ નથી તો 855-710-6984 નંબર પર કૉલ કરો.
हिंदी 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 Japanese	ご本人様、またはお客様の身の回りの方でも、ご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、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またはカードをお持ちでない場合は 855-710-6984 までお電話ください。
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 회원 카드 뒷면에 있는고객 서비스 번호로 전화하십시오. 회원이 아니시거나 카드가 없으시면 855-710-6984 으로 전화주십시오.
ພາສາລາວ Laotian	ຖ້າທ່ານ ຫຼື ຄົນທີ່ທ່ານກໍາລັງໃຫ້ການຊ່ວຍເຫຼືອມີຄໍາຖາມ, ທ່ານມີສິດຂໍເອົາການຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໄດ້ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອລົມກັບນາຍແປພາສາ, ໃຫ້ໂທຫາເບີຝ່າຍບໍລິການລູກຄ້າທີ່ມີຢູ່ດ້ານຫຼັງບັດສະມາຊິກຂອງທ່ານ. ຖ້າທ່ານບໍ່ແມ່ນສະມາຊິກ, ຫຼື ບໍ່ມີບັດ, ໃຫ້ໂທຫາເບີ 855-710-6984.
Diné Navajo	T'áá ni, éí doodago ła'da bíká anánílwo'ígíí, na'ídílkidgo, ts'ídá bee ná ahóóti'i' t'áá níík'e níká a'doolwoł. Ata' halne'í bich'į' hadeesdzih nínízingo éí kwe'é da'íníishgi áká anídaalwo'ígíí bich'į' hodíílnih, bee nééhózinii bine'dęę' bikáá'. Koji atah naaltsoos ná hadít'éégóó éí doodago bee nééhózinígíí ádingo koji' hodíílnih 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سؤالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با خدمات مشتری 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 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 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 Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 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 Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کررہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 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 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 nói 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.

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance.
We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.

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

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator	Phone:	855-664-7270 (voicemail)
300 E. Randolph St.	TTY/TDD:	855-661-6965
35th Floor	Fax:	855-661-6960
Chicago, Illinois 60601	Email:	CivilRightsCoordinator@hcsc.net

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services	Phone:	800-368-1019
200 Independence Avenue SW	TTY/TDD:	800-537-7697
Room 509F, HHH Building 1019	Complaint Portal:	https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Washington, DC 20201	Complaint Forms:	http://www.hhs.gov/ocr/office/file/index.html

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. 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 or call 1-800-521-2227 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For In-Network: $1,800 Individual / $3,600 Family For Out-of-Network: $3,600 Individual / $7,200 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care and preventive prescription drugs are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For In-Network: $4,800 Individual / $9,600 Family For Out-of-Network: $9,600 Individual / $19,200 Family	The out-of-pocket limit 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 out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, preauthorization penalties, balanced-billed charges, and healthcare this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bcbstx.com or call 1-800-810-2583 for a list of network providers. See www.caremark.com for prescription drug information or call 1-877-775-5642.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

 All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	None
	Specialist visit	20% coinsurance	40% coinsurance	None
	Preventive care/screening/immunization	No Charge; deductible does not apply	No Charge; deductible does not apply	Preventive colonoscopies and sigmoidoscopies- 1 covered every 5 years at 100%. Out-of-Network providers can balance bill. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	None

* For more information about limitations and exceptions, see the plan or policy document at www.connect2epeople.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com or 1-877-775-5642	Generic drugs	20% coinsurance	40% coinsurance	Value (preventive) generic drugs $5 copay for In-Network Preferred and Non-preferred drugs: If generic isn't chosen, member pays copay plus the difference between the price of generic and brand. Anabolic steroids and specialty drugs must be approved prior to dispensing. Specialty drugs are only covered when acquired through Caremark's mail order program.
	Preferred brand drugs	20% coinsurance $25 min to $75 max/ prescription retail	40% coinsurance	
	Non-preferred brand drugs	20% coinsurance $50 min to $120 max/ prescription retail	40% coinsurance	
	Specialty drugs	20% coinsurance	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Acupuncture is covered only when used in lieu of anesthesia for surgery. Morbid obesity is covered for In-Network only.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	Ground and air transportation covered.
	Urgent care	20% coinsurance	40% coinsurance	None

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Preauthorization is required.
	Rehabilitation services	20% coinsurance	40% coinsurance	Chiropractic care by Airrosti providers is $25 copay after deductible. Limited to 25 visits per calendar year. Dialysis is covered In-Network only
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	Preauthorization is required.
	Durable medical equipment	20% coinsurance	40% coinsurance	Wigs covered at applicable deductible and coinsurance, up to $500 calendar year max; combined In-Network and Out-of-Network. Hearing aids are covered 1 pair per 36 months at applicable deductible and coinsurance. Foot orthotics are covered at applicable deductible and coinsurance, regardless of diagnosis.
	Hospice services	No Charge	40% coinsurance	Preauthorization 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. Out-of-Network 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.

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.)		
• Dental care (Adult)	• Long-term care	• Weight loss programs
• Infertility treatment	• Routine foot care	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture (only in lieu of anesthesia)	• Cosmetic surgery (specific medical conditions)	• Private-duty nursing
• Bariatric surgery (morbid obesity only)	• Hearing aids (1 per ear per 36-month period)	• Routine eye care (Adult)
• Chiropractic care (25 visits per year)	• Non-emergency care when traveling outside the U.S.	

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 1-800-892-2803, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Blue Cross and Blue Shield of Texas at 1-800-521-2227 or visit www.bcbstx.com, or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. 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.

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

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost sharing	
Deductibles	$1,800
Copayments	$0
Coinsurance	$2,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,060**

Managing Joe's type 2 Diabetes

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

■ **The plan's overall deductible**	**$1,800**
■ **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)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost sharing	
Deductibles	$1,800
Copayments	$0
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,960**

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)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost sharing	
Deductibles	$1,800
Copayments	$0
Coinsurance	$20
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,820**

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 Arabic	إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث إلى مترجم فوري، اتصل على رقم خدمة العملاء المذكور على ظهر بطاقة عضويتك. فإن لم تكن عضوًا، أو كنت لا تملك بطاقة، فاتصل على 855-710-6984.
繁體中文 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 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 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 Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ.બી.એમ. દુભાષિયા સાથે વાત કરવા માટે, તમારા સભ્યપદના કાર્ડની પાછળ આપેલ ગ્રાહક સેવા નંબર પર કૉલ કરો. જો આપ સભ્યપદ ના ધરાવતા હોવ, અથવા આપની પાસે કાર્ડ નથી તો 855-710-6984 નંબર પર કૉલ કરો.
हिंदी 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 Japanese	ご本人様、またはお客様の身の回りの方でも、ご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、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またはカードをお持ちでない場合は 855-710-6984 までお電話ください。
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 회원 카드 뒷면에 있는고객 서비스 번호로 전화하십시오. 회원이 아니시거나 카드가 없으시면 855-710-6984 으로 전화주십시오.
ພາສາລາວ Laotian	ຖ້າທ່ານ ຫຼື ຄົນທີ່ທ່ານກໍາລັງໃຫ້ການຊ່ວຍເຫຼືອມີຄໍາຖາມ, ທ່ານມີສິດຂໍເອົາການຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໄດ້ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອລົມກັບນາຍແປພາສາ, ໃຫ້ໂທຫາເບີຝ່າຍບໍລິການລູກຄ້າທີ່ມີຢູ່ດ້ານຫຼັງບັດສະມາຊິກຂອງທ່ານ. ຖ້າທ່ານບໍ່ແມ່ນສະມາຊິກ, ຫຼື ບໍ່ມີບັດ, ໃຫ້ໂທຫາເບີ 855-710-6984.
Diné Navajo	T'áá ni, éí doodago ła'da bíká anánílwo'ígíí, na'ídílkidgo, ts'ídá bee ná ahóóti'i' t'áá níík'e níká a'doolwoł. Ata' halne'í bich'į' hadeesdzih nínízingo éí kwe'é da'íníishgi áká anídaalwo'ígíí bich'į' hodíílnih, bee nééhózinii bine'dęę' bikáá'. Koji atah naaltsoos ná hadít'éégóó éí doodago bee nééhózinígíí ádingo koji' hodíílnih 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سؤالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با خدمات مشتری 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 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 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 Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 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 Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کررہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 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 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 nói 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.

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance.
We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.

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

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator	Phone:	855-664-7270 (voicemail)
300 E. Randolph St.	TTY/TDD:	855-661-6965
35th Floor	Fax:	855-661-6960
Chicago, Illinois 60601	Email:	CivilRightsCoordinator@hcsc.net

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services	Phone:	800-368-1019
200 Independence Avenue SW	TTY/TDD:	800-537-7697
Room 509F, HHH Building 1019	Complaint Portal:	https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Washington, DC 20201	Complaint Forms:	http://www.hhs.gov/ocr/office/file/index.html

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

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/en-us/employers/services/large-groups, 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 at www.cciio.cms.gov.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**Network Provider:** $500 individual / $1,000 family; Does not apply to services subject to a **copay**, preventive care and Rx drug expenses	Generally, you must pay all of the costs from **providers** up to the **deductible** amount before this **plan** begins to pay. If you have other family members on the **plan**, each family member must meet their own individual **deductible** until the total amount of **deductible** expenses paid by all family members meets the overall family **deductible**.
Are there services covered before you meet your deductible?	Yes. **Preventive care** and primary care services are covered before you meet your **deductible**.	This **plan** covers some items and services even if you have not yet met the **deductible** amount. But a **copayment** or **coinsurance** may apply. For example, this **plan** covers certain **preventive services** without **cost-sharing** and before you meet your **deductible**. See a list of covered **preventive services** at https://www.healthcare.gov/coverage/preventive-care-benefits/
Are there other deductibles for specific services?	Yes. Prescription Drugs $200 Individual / $400 Family. Does not apply to generic or value generic drugs.	You do not have to meet **deductibles** for specific services.
What is the out-of-pocket limit for this plan?	**Network Provider**: $3,000 per individual / $6,000 per family; Prescriptions: $2,000 individual / $4,000 family	The **out-of-pocket limit** is the most you could pay in a year for covered services. If you have other family members in this **plan**, the overall family **out-of-pocket limit** must be met.
What is not included in the out-of-pocket limit?	**Copayments** on certain services, **premiums, balance-billing** charges, Rx deductible and health care this **plan** does not cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Will you pay less if you use a network provider?	Yes. See www.swhp.org or call 1-800-321-7947, www.caremark.com or call 1-877-775-5642. www.magellanhealth.com/member 1-800-327-7850 for a list of **In-network providers**.	This **plan** uses a **provider network**. You will pay less if you use a **provider** in the **plan's network**. You will pay the most if you use an **out-of-network provider**, and you might receive a bill from a **provider** for the difference between the **provider's** charge and what your **plan** pays (**balance billing**). Be aware your **network provider** might use an **out-of-network provider** for some services (such as lab work). Check with your **provider** before you get services.
Do you need a referral to see a specialist?	No	You can see the **specialist** you choose without a **referral**.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's **office or clinic**	Primary care visit to treat an injury or illness	$20 copay	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 plan will pay for.
	Specialist visit	$20 copay	Not Covered	
	Preventive care/screening/ immunization	No Charge	Not Covered	
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	Not Covered	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com or 1-877-775-5642.	Generic drugs	$10 copay / script	20% coinsurance	-Value (preventive) generic drugs $5 copay for In-Network - Preferred and Non-preferred drugs: If generic isn't chosen, member pays copay plus the difference between the price of generic and brand. –Anabolic steroids and specialty drugs must be approved prior to dispensing. –Specialty drugs are only covered when acquired through Caremark's mail order program. –***NEW OPTION***: *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.
	Preferred brand drugs	30% coinsurance up to $100 max per script	30% coinsurance	
	Non-preferred Brand drugs	40% coinsurance up to $120 max per script	40% coinsurance	
	Specialty drugs	Covered the same as any other drug	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Not Covered	None
	Physician/surgeon fees	10% coinsurance	Not Covered	

* For more information about limitations and exceptions, see the plan or policy document at http://www.swhp.org

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	None
	Emergency medical transportation	10% coinsurance	10% coinsurance	
	Urgent care	10% coinsurance	10% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	Not Covered	For prior authorization requirements and penalties see http://www.swhp.org/ind-fam/tools-resources. 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.
	Physician/surgeon fees	10% coinsurance	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$20 copay	Not Covered	Requires referral and preauthorization
	Inpatient services	10% coinsurance	Not Covered	Requires referral and preauthorization
If you are pregnant	Office visits	$20 copay	Not Covered	No charge for prenatal visits; postnatal visits are covered at the specialist copay. Depending on the type of services, a **copayment**, **coinsurance**, or **deductible** may apply.
	Childbirth/delivery professional services	10% coinsurance	Not Covered	None
	Childbirth/delivery facility services	10% coinsurance	Not Covered	None
If you need help recovering or have other special health needs	Home health care	$20 copay	Not Covered	None
	Rehabilitation services	$20 copay	Not Covered	None
	Habilitation services	$20 copay	Not Covered	None
	Skilled nursing care	10% coinsurance	Not Covered	Pre-certification required
	Durable medical equipment	50% coinsurance	Not Covered	None
	Hospice services	No Charge	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	$20 copay	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)
- Hearing aids
- 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.)

- Manipulative therapy (35 visit limit per calendar year, 5 per month)
- Routine eye care (limited to one refraction annually)

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 http://www.swhp.org , or call 1-800-321-7947; Department of Labor Employee Benefits Security Administration, visit http://www.dol.gov/ebsa/healthreform , or call1-866-444-EBSA (3272); Department of Health and Human Services, Center for Consumer Information, visit http://www.cciio.com.gov, or call 1-877-267-2323 x61565; Texas Department of Insurance, visit http://www.tdi.texas.gov, or call1-800-578-4677. 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 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: Scott and White Health Plan, visit http://www.swhp.org , or call 1-800-321-7947; Department of Labor Employee Benefits Security Administration, visit http://www.dol.gov/ebsa/healthreform , or call 1-866-444-EBSA (3272); Texas Department of Insurance, visit http://www.tdi.texas.gov , or call 1-800-252-3439.

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.

* For more information about limitations and exceptions, see the plan or policy document at http://www.swhp.org

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)		**Managing Joe's type 2 Diabetes** (a year of routine in-network care of a well-controlled condition)		**Mia's Simple Fracture** (in-network emergency room visit and follow up care)	
• The plan's overall deductible	$500	• The plan's overall deductible	$500	• The plan's overall deductible	$500
• Specialist copayment	$20	• Specialist copayment	$20	• Specialist copayment	$20
• Hospital (facility) coinsurance	10%	• Hospital (facility) coinsurance	10%	• Hospital (facility) coinsurance	10%
• Other coinsurance	10%	• Other coinsurance	10%	• Other coinsurance	10%
This EXAMPLE event includes services like: Sample Care Costs		**This EXAMPLE event includes services like: Sample Care Costs**		**This EXAMPLE event includes services like: Sample Care Costs**	
Specialist office visits (prenatal care)		Primary care physician office visits (including disease education)		Emergency room care (including medical supplies)	
Childbirth/Delivery Professional Services		Diagnostic tests (blood work)		Diagnostic test (x-ray)	
Childbirth/Delivery Facility Services		Prescription drugs		Durable medical equipment (crutches)	
Diagnostic tests (ultrasounds and blood work)		Durable medical equipment (glucose meter)		Rehabilitation services (physical therapy)	
Specialist visit (anesthesia)					
Total Example Cost	**$12,731**	**Total Example Cost**	**$7,389**	**Total Example Cost**	**$1,925**
In this example, Peg would pay:		**In this example, Joe would pay:**		**In this example, Mia would pay:**	
Cost Sharing		*Cost Sharing*		*Cost Sharing*	
Deductibles	$536	Deductibles	$1,936	Deductibles	$500
Copayments	$380	Copayments	$160	Copayments	$140
Coinsurance	$912	Coinsurance	$363	Coinsurance	$156
What isn't covered		*What isn't covered*		*What isn't covered*	
Limits or exclusions	$60	Limits or exclusions	$55	Limits or exclusions	$0
The total Peg would pay is	**$1,889**	**The total Joe would pay is**	**$2,514**	**The total Mia would pay is**	**$796**

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

English:
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-321-7947 (TTY: 1-800-735-2989). Scott & 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.

Spanish:
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-321-7947 (TTY: 1-800-735-2989). Scott & White Health Plan cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.

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: 1-800-735-2989). Scott & White Health Plan tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.

Chinese:

注意：如果您說英語，您可以免費使用語言援助服務。致電 1-800-321-7947（TTY：1-800-735-2989）。斯科特和白人健康計劃符合適用的聯邦民權法律，不會根據種族，膚色，國籍，年齡，殘疾或性別進行歧視。

Korean:
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-321-7947 (TTY: 1-800-735-2989) 번으로 전화해 주십시오. Scott & White Health Plan 은(는) 관련 연방 공민권법을 준수하며 인종, 피부색, 출신 국가, 연령, 장애 또는 성별을 이유로 차별하지 않습니다.

Arabic:

اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بلامجان. اتصل برقم 1-7947-321-800 (رقم
على أساس العرق أو اللون أو هاتف الصم والبكم: 1-2989-735-800). ملحوظة: إذا كنت تتحدث
الجنس. يلتزم Scott & White Health Plan بقوانين الحقوق المدنية الفدرالية المعمول بها ولا يميز
الأصل الوطني أو السن وأ الإعاقة أو

Urdu:

رگا پ آ اردو ےتلوبہیں، وت پ آ وک نباز یک دمد یک تخدما تفم یم بستیاد ں یہ ۔ لکا
ں یرک .(TTY: 1-800-735-2989) 1-800-321-7947
Scott & White Health Plan باق ل ق لاطا یقافو یشہر ق حقو ےک نیناقو یک لیمعت اترک ےہ
اور ہیہ ک نسل، گ نر ، قومیت، عمر، ی ورمعذ ایس نج یک دبنیا ر پ زمتیاا ں یہن ک رتا

Tagalog:
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-3217947 (TTY: 1-800-735-2989). Sumusunod ang Scott & White Health Plan sa mga naaangkop na Pederal na batas sa karapatang sibil at hindi nandidiskrimina batay sa lahi, kulay, bansang pinagmulan, edad, kapansanan o kasarian.

French:
ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-321-7947 (ATS: 1-800-7352989). Scott & White Health Plan respecte les lois fédérales en vigueur relatives aux droits civiques et ne pratique aucune discrimination basée sur la race, la couleur de peau, l'origine nationale, l'âge, le sexe ou un handicap.

Hindi:
ध्यान दें: यदद आप य हंदी बोलते हैं तो आपके य लए मुफ्त में भाषा सहायता सेवाएंउपलब्ध हैं। 1-800-321-7947 (TTY: 1-800-735-2989) पर कॉल करें। Scott & White Health Plan
लागू होनेयोग्य संघीय नागरक यिधकार क़ानून का पालन करता हैऔर जाय त, रंग, राष्ट्रीय मूल, आयु, य वकलांगता, या य लंग के आधार पर भेदभाव नहीं करता है।

Persian:
ہوطبرم تتبعی یم دکن و مهارف ی مدباشم ابTTY: 1-800-735-2989) 1-800-321-7947 س تمادیربگیر. ہجوت: رگا ہبنباز ی سرفاوگفتگ ی مکنید، تتسهیلا ی نابزتوربصنیگارا ی ارب امشم
لقایی منودشم. ہنویچگهی ضیعبتر ب سااندازه، گ نوپرست، تصلیایتیلم، سن، ی نوانات ایتجنسیرادفا Scott & White Health Plan نازنیواقق وحق ی ندم الدرف

German:
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-321-7947 (TTY: 1800-735-2989). Scott & White Health Plan erfüllt geltenden bundesstaatliche Menschenrechtsgesetze und lehnt jegliche Diskriminierung aufgrund von Rasse, Hautfarbe, Herkunft, Alter, Behinderung oder Geschlecht ab.

Gujarati:

~ુ ચના: જો તમે ~ુ જરાતી બોલતા હો, તો િુન:~ુ લ્ક ભાષા સહાય સેવાઓ તમારા માટ~ ઉપલબ્ધ છે. ફોન કરો **1-800-321-7947 (TTY: 1-800-735-2989). Scott & White Health Plan** પડOા સમવાયી નાગr~રક િિધકાર કાયદા સાથે ~ુ સંગત િ4. **રગ,રાષ્ટ્ર~ય ~ુ ળ, ~મર, િશક્તતા િથવા ~લ~ગના આધાર~ ભેદભાવઆવતો નથી.**

Russian:

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1**-800-321-**7947 (телетайп: 1**-800-735-2989).** Scott & White Health Plan соблюдает применимое федеральное законодательство в области гражданских прав и не допускает дискриминации по признакам расы, цвета кожи, национальной принадлежности, возраста, инвалидности или пола.

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:1-800-735-2989)**まで、お電話にてご連絡ください。**Scott & White Health Plan** は適用される連邦公民権法を遵守し、人種、肌の色、出身国、年齢、障害または性別に基づく差別をいたしません。

Laotian:

ໂປດຊາບ**:** ຖ້າວ່ າ ທ່ ານເວ ້າພາສາ ລາວ, ການບໍ ລິ ການຊ່ ວຍເຫ ຼື ອດ້ ານພາສາ, ໂດຍບໍ່ ເສັ ຽຄ່ າ, ແມ່ ນມີ ພ້ ອມໃຫ້ ທ່ ານ. ໂທຣ **1-800-321-7947 (TTY: 1-800735-2989). Scott & White Health Plan** ປະຕິ ບັ ດຕາມກ ດໝາຍວ່ າດ້ ວຍສິ ດທິ ພ ນລະເມືອງຂອງຣັ ຖບານກາງທີ່ ແລະບໍ່ ຈຳແນກໂດຍອີ ງໃສ່ ບຖານການຊ ປັ້ຈຸບັນໃຊ້ ເຊື້ອຊາດ, ສີຜິ ວ, ຊາດກຳ ເນີ ດ, ອາຍຸ , ຄວາມພິ ການ, ຫ ຼື ເພດ.

ePeople Service Center
P.O. Box 44023
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IMPORTANT LEGALLY REQUIRED BENEFITS INFORMATION: **READ CAREFULLY**

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