



BlueCross BlueShield of Texas



Personalized just for you

See inside for information about your 2024 health plan

Your 2024 Health Plan

October 16, 2023

Prepared for:

Member ID number:

For questions, contact a BCBSTX Health Plan Specialist at 855-813-1465.



Your current health plan will be renewed for 2024, with some changes.

Your Estimated Monthly Payment Amount

Thank you for being a member of Blue Cross and Blue Shield of Texas (BCBSTX). Your current health plan, Blue Advantage Gold HMO 603, will be renewed for 2024.

	2023	2024
Premium	\$2,070.10	\$2,196.70 6.12% change from 2023

You may be able to lower your monthly payment amount. Please use our Premium Tax Credit Estimator at [StayBlueTX.com](https://www.staybluetx.com) to see if you qualify for a 2024 subsidy (also called "premium tax credit").

If you or someone you know is ready to begin planning for Medicare, we are here to help. To learn more, visit [StayWithBlueTX.com](https://www.staywithbluetx.com). You can also call 855-745-5152, or contact your independent, authorized Blue Cross and Blue Shield of Texas agent.



Key Dates

- **November 1:** Open enrollment begins.
- **January 1:** The 2024 plan year begins. First payment is due.
- **January 15:** Open enrollment ends.

Questions? See "Help is Available" on the inside back cover.

Get Ready for 2024



If you do nothing, your health plan will renew on January 1.

1. You Can Renew or Shop

Renew Your Plan

- Just keep making your monthly payments and you'll be re-enrolled in your current health plan.
- If you have Auto Bill Pay, your payments will continue.
- Some plan benefits, like copays and coinsurance amounts, may change in 2024. See **Benefit Changes** on the next page.

Shop for a Different Plan

- Contact a licensed BCBSTX Health Plan Specialist at 855-813-1465.
- Visit [StayBlueTX.com](https://www.staybluetx.com) during open enrollment.
- If you were enrolled in a dental plan or Auto Bill Pay, **you will need to re-enroll.**



Please note: The doctors and hospitals in a plan's network may change.

Visit [StayBlueTX.com](https://www.staybluetx.com) to confirm your providers are in your plan's network.

2. Make Your Payment by January 1, 2024

You can pay or enroll in Auto Bill Pay, if you have not already done so, at [PayBlueTX.com](https://www.paybluetx.com). If payment is not made, you may see service disruptions when you seek care or fill prescriptions.

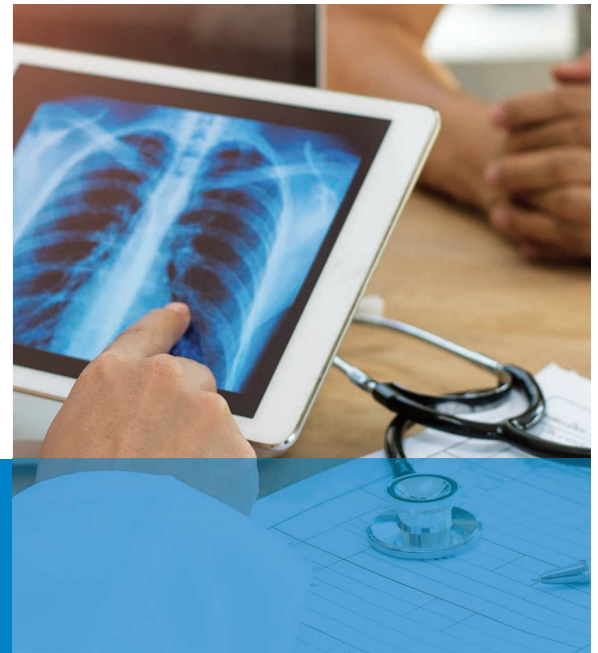
3. Look for Your Member ID Card and Benefit Information

 BlueCross BlueShield of Texas	Sample Network Name
Member Name SAMPLE CARD	
Member ID ABC123456789	
Group No. 123456	BIN 123456
Effective Date MM/DD/YY	Rx PCN STDR
Primary Care Physician	Rx Generic Co-Ins 10%/20%
	Rx Brand Co-Ins 30%/40%
	Rx Specialty Co-Ins 50%/60%
	Emergency Room \$400
	PCP Visit Copay \$30
	Specialist Copay \$50
	

You will receive your 2024 member ID card(s) before the end of the year.

You will also receive a welcome kit with helpful information about your plan. Sign up at [StayBlueTX.com](https://www.staybluetx.com) to receive your welcome kit electronically instead of by mail.

Benefit Changes



Review some benefit changes starting January 1, 2024.

Your Out-of-Pocket Costs

The terms below help explain your out-of-pocket costs.

Deductible	<ul style="list-style-type: none">• The amount you pay for most covered services before your health plan starts to pay.• When you go to a provider that is in the plan's network, before you meet the deductible you pay a discounted amount that has been negotiated with the provider.• The deductible resets at the beginning of the calendar year or when you enroll in a new plan.
Copay	<ul style="list-style-type: none">• The set dollar amount you pay for a covered health care service at the time you receive care or when you pick up a prescription drug.
Coinsurance	<ul style="list-style-type: none">• The percentage of the costs of a covered health care service or prescription drug you pay after you've paid your deductible.• You pay 100 percent of the full allowed amount until you meet your deductible.
Out of Network	<ul style="list-style-type: none">• Services are considered out of network when you use a doctor or other provider that does not have a contract with your health plan.• Out-of-network services may not be covered or may be covered at a lower level.• You may be responsible for all or part of an out-of-network provider's bill.
Individual and Family Out-of-Pocket Maximums	<ul style="list-style-type: none">• The highest allowed amount that you may have to pay for covered services in a plan year.• After you spend this amount on deductibles, copays and coinsurance, your health plan pays 100 percent of the costs of covered benefits.• For plans that cover more than one person, individual out-of-pocket maximums count toward the family out-of-pocket maximum. Once the family out-of-pocket maximum is reached, the plan pays 100 percent of the cost of covered benefits for everyone on your plan.• The out-of-pocket maximum doesn't include your monthly premium payments or anything you spend for services your plan doesn't cover.

For the full list of terms, please visit [BlueGlossaryTX.com](https://www.BlueGlossaryTX.com).

Benefit Changes *continued*

Here Are Key Plan Changes

Your Benefits	2023	2024
In-network family deductible	\$4,500	\$3,000

- In 2024, the number of services that need prior authorization may change. Visit [KnowYourPlanTX.com](https://www.knowyourplantx.com) for a list of services and categories that need prior authorization. This list is updated when services are added or removed. You can also call BCBSTX customer service at the toll-free number on the back of your member ID card.
- Please review the 2024 drug list at [BlueRxTX.com](https://www.blue-rx-tx.com) to see if the drugs that you take or are prescribed are affected by any changes. For example, a drug may have moved to a lower or higher drug tier.
- A new drug discount program, MedsYourWay®, has been established with your plan. This program will automatically apply the lower available price for your eligible prescription at the point of sale with your local pharmacy. See “Pharmacy Information and Prescription Drug Changes” section for more details.

This is not a complete list of benefit changes.

For a more complete summary of your benefits, see the enclosed **Summary of Benefits and Coverage** for 2024, also available online at [BlueBenefitsSummaryTX.com/22/](https://www.bluebenefitssummarytx.com/22/).

About Dental Coverage

If you don't have a separate BCBSTX dental plan: When you bought your health plan from BCBSTX, you told us you have what is known as an “exchange-certified stand-alone dental plan,” which provides coverage for the “Pediatric Dental Essential Health Benefit (EHB).” Please contact us if you no longer have this required coverage. If we don't hear from you, our records will show that you have the Pediatric Dental EHB from another insurance company.

Pharmacy Information and Prescription Drug Changes

Your BCBSTX prescription drug coverage has a network of pharmacies, online tools and more.



Changes to your pharmacy benefit program will start on January 1, 2024.

Visit [BlueRxTX.com](https://www.BlueRxTX.com) to see if any of these changes may affect your drugs, coverage or for more information. If you are affected by these changes, talk to your doctor about your treatment options.

Coverage and Cost of Drugs

Check the drug list to see if a drug you take is covered. Your health plan uses drug tiers to price drugs. In general, the lower the tier, the lower your out-of-pocket costs.

Some drugs on your prescription drug list may be newly covered, move to a lower or higher tier, may no longer be covered or have additional requirements, such as prior authorization.

View your 2024 drug list at [BlueRxTX.com](https://www.BlueRxTX.com). You can also see complete lists of drugs that are newly covered, moving tiers, no longer covered or have additional requirements as of January 1, 2024.



Things to Do

Talk to your doctor about next steps. Your doctor or pharmacist can answer questions or concerns you may have about your prescribed medicines. Pharmacy selections and your care are always between you and your doctor.

- **Ask about lower-cost alternatives** if your drug moves to a higher tier.
- **Review drug options** if your drug is no longer covered (often a covered generic or brand alternative may be available).
- Have an **authorization request** sent to us, or ask to change your prescription, if your drug has an additional requirement.
- Order your prescriptions to be filled at **in-network pharmacies**.

Pharmacy Information and Prescription Drug Changes *continued*

Changes in Coverage for Commonly Used Drugs

Commonly Used Drugs That Will No Longer Be Covered as of January 1, 2024				
Generic		Brand		Specialty
cholestyram powder 4 gm lite packet	isradipine cap 2.5 mg, 5 mg	COMBIGAN SOL 0.2/0.5%	SUMATRIPTAN SUCCINATE SOLUTION CARTRIDGE 4 MG/0.5 ML, 6 MG/0.5 ML	ESBRIET TAB 267 MG, 801 MG
cholestyram powder 4 gm packet	leucovor ca tab 10 mg	DALIRESP TAB 250 MCG, 500 MCG	VANDAZOLE GEL 0.75%	GILENYA CAP 0.5 MG
ciclopirox sus 0.77%	nicardipine cap 20 mg, 30 mg	DEXILANT CAP 30 MG DR, 60 MG DR	VIIBRYD TAB 10 MG, 20 MG, 40 MG	NEXAVAR TAB 200 MG
diltiazem cap 60 mg er, 90 mg er, 120 mg er	verapamil cap 360 mg sr	MIRVASO GEL 0.33%	ZORTRESS TAB 1 MG	
diltiazem er/matzim la tab 240 mg/24	vimpat sol 10 mg/ml	PRADAXA CAP 150 MG		
diltiazem er/matzim tab 180 mg	zolmitriptan orally disintegrating tab 2.5 mg, 5 mg			
dutast/tamsu cap 0.5-0.4				

Pharmacies and Ways to Save

Be sure to use your BCBSTX member ID card when you fill prescriptions at any in-network pharmacy. Some medicines may be eligible for the **MedsYourWay®** drug discount card program. This program works with your pharmacy benefit to automatically search for and find lower available costs, comparing drug discount card prices to your plan cost share amount. You'll pay the lower available price, and what you pay counts toward your plan deductible or out-of-pocket maximum.

You can save money by using an **in-network pharmacy**. Your out-of-pocket costs are often lower at an in-network pharmacy.

At a **preferred pharmacy**, you may pay the lowest out-of-pocket cost. You can also fill up to a 90-day supply of most covered drugs in store at these pharmacies or through home delivery.

Your costs will be highest at an **out-of-network pharmacy**, up to the full cost of the drug. If you have an out-of-network benefit, you can submit a claim to have BCBSTX apply to your out-of-network benefits.

Pharmacy Information and Prescription Drug Changes *continued*

Mail order and specialty pharmacies offer home delivery choices for members with maintenance and specialty pharmacy needs. BCBSTX offers mail order services through Express Scripts® Pharmacy (express-scripts.com/rx or 833-715-0942) and specialty pharmacy services through Accredo (accredo.com or 833-721-1619). Other in-network specialty pharmacies are available for select specialty drugs.

To find an in-network pharmacy or make sure that your pharmacy is still in your network, visit **myprime.com**.

Commonly used drugs that are no longer covered may not apply to all strengths/formulations. Third-party brand names are the property of their respective owners.

Coverage is based on the limits and terms noted in your plan materials. For some medicines, members must meet certain criteria before prescription drug coverage may be approved. See your plan materials for details. **As always, treatment decisions are between you and your doctor.**

Some benefit plans may have preventive drug benefits. This means you may pay a lower cost, as low as \$0, for preventive care drugs. If your plan has these preventive drug benefits, and coverage for your prescription changes, the amount you pay under the preventive drug benefit may also change.

Drugs that have not received U.S. Food and Drug Administration (FDA) approval are not covered. Some drugs may be covered under your medical plan instead of your pharmacy benefits.

MedsYourWay® is not insurance. It is a drug discount card program that compares the drug discount card price for an eligible medication at participating in-network retail pharmacies to the member's benefit plan cost share amount and then applies the lower available price. MedsYourWay® is administered by Prime Therapeutics, LLC. Not all retail pharmacies may participate with MedsYourWay® pricing.

A preferred or "participating" pharmacy has a contract with BCBSTX or BCBSTX's pharmacy benefit manager (Prime Therapeutics) to provide pharmacy services at a negotiated rate. The terms preferred and "participating" should not be construed as a recommendation, referral or any other statement as to the ability or quality of such pharmacy.

Prime Therapeutics LLC is a separate pharmacy benefit management company contracted by Blue Cross and Blue Shield of Texas (BCBSTX) to provide pharmacy benefit management and related other services. In addition, contracting pharmacies are contracted through Prime Therapeutics. The relationship between BCBSTX and contracting pharmacies is that of independent contractors. BCBSTX, as well as several independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime Therapeutics. Myprime.com is an online resource offered by Prime Therapeutics LLC.

Express Scripts® Pharmacy is a pharmacy that is contracted to provide mail pharmacy services to members of BCBSTX. The relationship between Express Scripts® Pharmacy and BCBSTX is that of independent contractors. Express Scripts® Pharmacy is a trademark of Express Scripts Strategic Development, Inc.

Accredo is a specialty pharmacy that is contracted to provide services to members of BCBSTX. The relationship between Accredo and BCBSTX is that of independent contractors. Accredo is a trademark of Express Scripts Strategic Development, Inc.

Government-Required Notice

Member Name
Address 1
Address 2
City, State, Zip Code

October 16, 2023

Important: It's time to review your health coverage. **Take action by December 15, 2023**, or we'll automatically re-enroll you in the same or similar coverage. This may change some of your costs and coverage, so review your options carefully.

Thank you for choosing Blue Cross and Blue Shield of Texas (BCBSTX) for your health care needs. We're here to help you prepare for Open Enrollment.

Why am I getting this letter?

Your health coverage is still being offered in 2024, but some details may have changed. Read this letter carefully and decide if you want to keep this plan or choose another one. Unless you take action by December 15, we'll automatically keep you in this plan for 2024.

Blue Advantage Gold HMO 603 isn't a Health Insurance Marketplace® plan. You won't get any financial help lowering your monthly premium or out-of-pocket costs (like deductibles, copayments, and coinsurance) if you stay in this plan.

- To find out if you qualify for these savings and to enroll in a plan through the Marketplace, visit healthcare.gov by January 15.
- If you don't enroll in a plan through the Marketplace by January 15, you may not be able to do so for 2024, even if your finances change.

What's changing in 2024

Your new premium

- **Starting in January, your estimated monthly premium in Blue Advantage Gold HMO 603 will be \$2,196.70.**
Important: This is only an estimate based on current information we have. It doesn't reflect any changes to your enrollment, such as adding additional members to your coverage. You'll see your new monthly premium amount when you get your January bill.
- Your 2023 monthly premium is \$2,070.10.

Other changes

- Please see the enclosed **Benefit Changes** section.
- You can review more details about your plan at StayBlueTX.com and in your 2024 **Summary of Benefits and Coverage** at BlueBenefitsSummaryTX.com/22/.

Government-Required Notice *continued*

What you need to do

Decide if you want to enroll in Blue Advantage Gold HMO 603 or choose another one.

I want to enroll in this plan.

Pay the new monthly premium by January 1, 2024, and you'll be automatically enrolled.

I want to pick a different plan.

You can choose a different plan between November 1, 2023, and January 15, 2024. Enroll by December 15, for coverage to start January 1.

Here are some ways to find other plans and enroll:

- Check with BCBSTX to see what other plans may be available. Remember, you won't get financial help unless you qualify and enroll through the Marketplace.
- Visit healthcare.gov to see Marketplace plans. Compare plans to save money and find a plan that best meets your needs and budget. Select the Plan name and ID of the plan you want to enroll in.

We're here to help

- Call BCBSTX at 1-888-697-0683 or visit bcbstx.com.
- Visit healthcare.gov, or call 1-800-318-2596 (TTY: 1-855-889-4325) to learn more about the Marketplace and to see if you qualify for lower costs.
- Find in-person help from an assister, agent, or broker in your community at localhelp.healthcare.gov.
- Call 1-888-697-0683 to get this information in an accessible format, like large print, Braille, or audio, at no cost to you.



**BlueCross BlueShield
of Texas**

Consumer Choice Plan Disclosure Statement

This health plan does not include the same level of benefits required in other plans.

This HMO plan is a consumer choice plan. This plan doesn't include the same level of benefits that are in Texas health plans known as state-mandated plans. This plan does include all health benefits required by the Affordable Care Act.

[The benefits or coverages you are agreeing to on this renewal are different from your current plan.]

[The benefits required by state law have changed since you first received this disclosure.]

To see all benefits offered by this plan, go to the plan's "Summary of Benefits and Coverage."

Benefit/coverage:	This plan:	A health plan with required benefits (state-mandated plan):
Deductible The amount you pay for care before the plan begins to share the cost.	Has a deductible.	Has no deductibles for participating provider care.
Out-of-Pocket Costs The amount you pay when you receive covered services, up to a calendar year maximum.	Includes out-of-pocket costs that meet federal requirements but may sometimes be more than in a state-mandated plan.	A copay must be less than 50% of the total cost of the service. Annual out-of-pocket costs must be capped at 200% of your annual premium cost if you alert the plan.
[Habilitative and Rehabilitative Care Care that helps you improve skills for daily living.	Includes a limit on the number of visits per year for speech therapy, occupational therapy, physical therapy and chiropractic care. Limits do not apply for the treatment of acquired brain injury and autism spectrum disorder.	Has no limits on the amount of care if it is needed for medical reasons.]
Home Health Services	Includes a limit for home health services.	Has no limits on home health services.
[Therapies for Children with Developmental Delays	Does not cover therapies for treatment of developmental delay in children	Covers certain development delay therapies for children with developmental delay, up to age three.]



BlueCross BlueShield of Texas

If you want a plan with all required benefits:

We also offer a state-mandated plan that includes all required benefits. This plan is not on Healthcare.gov and does not allow you to get help with premiums and out-of-pocket costs. To learn more about this plan, call 1-877-299-2377 or visit <https://www.bcbstx.com/shop-plans-and-products>.

When you first bought this consumer choice plan, you agreed to the following statements:

- I understand the consumer choice plan I am applying for does not provide the same level of coverage required in other Texas health plans (state-mandated plans).
- I understand I can get more information about consumer choice plans from the Texas Department of Insurance's website, <https://www.tdi.texas.gov/consumer/consumerchoice.html>, or by calling the Consumer Help Line at 1-800-252-3439.

HMO must give you a copy of this statement upon request.

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period: 01/01/2024 – 12/31/2024



Coverage for: Individual/Family | Plan Type: HMO



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. **NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.bcbstx.com/bb/ind/fbb_ghsa27bavitxo_tx_2024.pdf or by calling 1-888-697-0683. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary/ or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	\$1,500 Individual/\$3,000 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. In-Network Preventive Health Care services, services with a copayment, and some 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?	\$5,000 Individual/\$10,000 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, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bcbstx.com/go/bahmo or call 1-888-697-0683 for a list of Participating 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?	Yes.	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.



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
		Participating Providers (You will pay the least)	Non-Participating Providers (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	\$45/visit; <u>deductible</u> does not apply	Not Covered	Virtual Visits are available. See your benefit booklet* (Your PCP) for details.
	Specialist visit	40% <u>coinsurance</u>	Not Covered	<u>Referral</u> required.
	Preventive care/screening/immunization	No Charge; <u>deductible</u> does not apply	Not Covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	Freestanding Facility: 20% <u>coinsurance</u> Hospital: 40% <u>coinsurance</u>	Not Covered	<u>Referral</u> may be required. <u>Preauthorization</u> may also be required; see your benefit booklet* (Outpatient Lab and X-Ray services) for details.
	Imaging (CT/PET scans, MRIs)	Freestanding Facility: 20% <u>coinsurance</u> Hospital: 40% <u>coinsurance</u>	Not Covered	<u>Referral</u> may be required. <u>Preauthorization</u> may also be required; see your benefit booklet* (Outpatient Lab and X-Ray services) for details.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.bcbstx.com/rx24/6I	Generic drugs (Preferred)	Retail - Preferred Participating - No Charge Participating - \$10/prescription Mail - No Charge; <u>deductible</u> does not apply	Not Covered	Limited to a 30-day supply at retail (or a 90-day supply at a network of select retail pharmacies). Up to a 90-day supply at mail order. <u>Specialty drugs</u> limited to a 30-day supply except for certain FDA-designated dosing regimens. Payment of the difference between the cost of a brand name drug and a generic may also be required if a generic drug is available. Certain drugs require approval before they will be covered. <u>Cost sharing</u> for insulin included in the drug list will not exceed \$25 per prescription for a 30-day
	Generic drugs (Non-preferred)	Retail - Preferred Participating - \$10/prescription Participating - \$20/prescription Mail - \$30/prescription; <u>deductible</u> does not apply	Not Covered	
	Brand drugs (Preferred)	Retail - Preferred Participating - \$50/prescription Participating - \$60/prescription Mail - \$150/prescription; <u>deductible</u> does not apply	Not Covered	

*For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com/bb/ind/bb_ghsa27bavitxo_tx_2024.pdf.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Providers (You will pay the least)	Non-Participating Providers (You will pay the most)	
	Brand drugs (Non-preferred)	Retail - Preferred Participating - 35% coinsurance Participating - 40% <u>coinsurance</u> Mail - 35% <u>coinsurance</u>	Not Covered	supply, regardless of the amount or type of insulin needed to fill the prescription.
	Specialty drugs (Preferred)	45% <u>coinsurance</u>	Not Covered	
	Specialty drugs (Non-preferred)	50% <u>coinsurance</u>	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Freestanding Facility: \$600/visit plus 20% coinsurance Hospital: \$600/visit plus 40% <u>coinsurance</u>	Not Covered	Referral required. <u>Preauthorization</u> may also be required. For Outpatient Infusion Therapy, see your benefit booklet* (Outpatient Facility Services) for details.
	Physician/surgeon fees	40% <u>coinsurance</u>	Not Covered	
If you need immediate medical attention	Emergency room care	\$950/visit plus 40% <u>coinsurance</u>	\$950/visit plus 40% <u>coinsurance</u>	<u>Copayment</u> waived if admitted.
	Emergency medical transportation	40% <u>coinsurance</u>	40% <u>coinsurance</u>	
	Urgent care	\$60/visit; <u>deductible</u> does not apply	Not Covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$850/visit plus 40% <u>coinsurance</u>	Not Covered	Referral required. <u>Preauthorization</u> may also be required; see your benefit booklet* (Inpatient Hospital Services) for details.
	Physician/surgeon fees	40% <u>coinsurance</u>	Not Covered	
	Outpatient services	40% coinsurance for office visits; 20% <u>coinsurance</u> for other outpatient services	Not Covered	
If you need mental health, behavioral health, or substance abuse services	Inpatient services	\$850/visit plus 40% <u>coinsurance</u>	Not Covered	Referral required. <u>Preauthorization</u> may also be required; see your benefit booklet* (Behavioral Health Services) for details.

*For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com/bb/find/bb_ghsa27bavitxo_tx_2024.pdf.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Providers (You will pay the least)	Non-Participating Providers (You will pay the most)	
If you are pregnant	Office visits	Primary Care: \$45/initial visit; <u>deductible</u> does not apply Specialist: 40% <u>coinsurance</u>	Not Covered	<u>Copayment</u> applies to first prenatal visit (per pregnancy). <u>Cost sharing</u> does not apply for preventive services. Depending on the type of services, <u>copayment</u> , <u>coinsurance</u> or <u>deductible</u> may apply. <u>Maternity care</u> may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	40% <u>coinsurance</u>	Not Covered	
	Childbirth/delivery facility services	\$850/visit plus 40% <u>coinsurance</u>	Not Covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	40% <u>coinsurance</u>	Not Covered	60 visits/year. <u>Referral</u> required. <u>Preauthorization</u> may also be required; see your benefit booklet* (Extended Care Services) for details.
	<u>Rehabilitation services</u>	40% <u>coinsurance</u>	Not Covered	Separate 35-visit maximum per benefit period for <u>Habilitation</u> and <u>Rehabilitation services</u> , including <u>chiropractic care</u> . <u>Referral</u> required. <u>Preauthorization</u> may also be required; see your benefit booklet* (<u>Rehabilitation Services</u> and <u>Habilitation Services</u>) for details.
	<u>Habilitation services</u>	40% <u>coinsurance</u>	Not Covered	
	<u>Skilled nursing care</u>	40% <u>coinsurance</u>	Not Covered	25 days/year. <u>Referral</u> required. <u>Preauthorization</u> may also be required; see your benefit booklet* (Extended Care Services) for details.
	<u>Durable medical equipment</u>	40% <u>coinsurance</u>	Not Covered	<u>Referral</u> required. <u>Preauthorization</u> may also be required; see your benefit booklet* (<u>Durable Medical Equipment</u>) for details.
	<u>Hospice services</u>	40% <u>coinsurance</u>	Not Covered	<u>Referral</u> required. <u>Preauthorization</u> may also be required; see your benefit booklet* (Extended Care Services) for details.
If your child needs dental or eye care	Children's eye exam	No Charge; <u>deductible</u> does not apply	Up to a \$30 reimbursement is available; <u>deductible</u> does not apply	One visit per year. Out-of-Network reimbursement will not exceed the retail cost. See your benefit booklet* (Pediatric Vision Care Benefits) for details.

*For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com/bb/ind/bb_qhsa27bavixo_tx_2024.pdf.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Providers (You will pay the least)	Non-Participating Providers (You will pay the most)	
	Children's glasses	No Charge; <u>deductible</u> does not apply	Up to a \$75 reimbursement is available; <u>deductible</u> does not apply	One pair of glasses per year. Reimbursement for frames, lenses, and lens options purchased Out-of-Network is available (not to exceed the retail cost). See your benefit booklet* (Pediatric Vision Care Benefits) for details.
	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.bcbstx.com/bb/ind/bb_ghsa27bavitxo_tx_2024.pdf.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Abortion (Except for a pregnancy that, as certified by a physician, places the woman in danger of death or a serious risk of substantial impairment of a major bodily function unless an abortion is performed)
- Acupuncture
- Bariatric surgery
- Cosmetic surgery (Except for the correction of congenital deformities or for conditions resulting from accidental injuries, scars, tumors, or diseases when medically necessary)
- Dental care (Adult and child)
- Infertility treatment (Diagnosis and treatment covered; in vitro not covered)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (Unless medically necessary)
- Routine eye care (Adult)
- Routine foot care (Except when medically necessary)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care (35 visits/year combined with habilitation and rehabilitation services)
- Hearing aids (Limited to one hearing aid per ear every 36 months)

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 Blue Cross and Blue Shield of Texas at 1-888-697-0683 or visit www.bcbs.tx.com. You may also contact your state insurance department at 1-800-252-3439 or Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 OR state Health Insurance Marketplace or SHOP.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Texas Department of Insurance at 1-800-578-4677 or visit <https://fdi.texas.gov>.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Not Applicable

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 1-888-697-0683.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-697-0683.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-888-697-0683.

Navajo (Dine): Dineke'gho shika at'ohwol ninisingo, kwijigo holne' 1-888-697-0683.

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 40%
- Hospital (facility) copayment/coinsurance \$850+40%
- Other coinsurance 40%

This EXAMPLE event includes services like:
Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

Total Example Cost \$12,700

In this example, Peg would pay:

Cost sharing	
<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$900
<u>Coinsurance</u>	\$2,600
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$5,060

Managing Joe's Type 2 Diabetes

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

- The plan's overall deductible \$1,500
- Specialist coinsurance 40%
- Hospital (facility) copayment/coinsurance \$850+40%
- Other coinsurance 40%

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 \$5,600

In this example, Joe would pay:

Cost sharing	
<u>Deductibles</u>	\$1,200
<u>Copayments</u>	\$700
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,920

Mia's Simple Fracture

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

- The plan's overall deductible \$1,500
- Specialist coinsurance 40%
- Hospital (facility) copayment/coinsurance \$850+40%
- Other coinsurance 40%

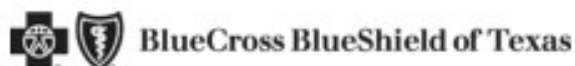
This EXAMPLE event includes services like:
Emergency room care (including medical supplies)
Diagnostic test (X-ray)
Durable medical equipment (crutches)
Rehabilitation services (physical therapy)

Total Example Cost \$2,800

In this example, Mia would pay:

Cost sharing	
<u>Deductibles</u>	\$1,500
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,300

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



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, sexual orientation, health status or disability.

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

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

Office of Civil Rights Coordinator
300 E. Randolph St.
35th Floor
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960

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

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>
Complaint Forms: <http://www.hhs.gov/ocr/office/file/index.html>



BlueCross BlueShield of Texas

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost.
To talk to an interpreter, call 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, llame al 855-710-6984.
العربية Arabic	إن كان لديك أو لدى شخص تساعد أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم فوري، اتصل بلع الرقم 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，請撥電話 號碼 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, appelez 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 Nummer 855-710-6984 an.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ.બી.એમ. કાયદેમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કોલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपके अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनवादक से बात करने के लिए 855-710-6984 पर कॉल करें।
Italiano Italian	Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
Diné Navajo	T'áá ni, éí doodago la'da biká anánílwo'ígíí, na'ídiilkidgo, ts'ídá bee ná ahóótí'i' t'áá níik'e níká a'doolwoł dóó bína'ídiilkidígíí bee níh h odoonih. Ata'dahalne'ígíí bich'í' hodíilnih kwe'é 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک می کنید، سوالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاف، با شماره 855-710-6984 تماس حاصل نمایید.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiegokolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984.
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 связаться с переводчиком, позвоните по телефону 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 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کو آپ مدد کر رہے 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، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984.

Help is Available



Visit StayBlueTX.com to:

- Find in-network doctors and hospitals.
- Sign up to get your health plan information electronically instead of by mail.
- Review other health plan options and connect to our online shopping experience.
- Download the mobile app to access all these features and more.



Still have questions?

To talk with a licensed BCBSTX Health Plan Specialist about your 2024 health plan options, please call 855-813-1465. We are available:

- Monday through Friday: 8 a.m. to 8 p.m. CT
- Saturday: 8 a.m. to 6 p.m. CT
- Sunday: 10 a.m. to 2 p.m. CT

Expect longer wait times closer to January 15, when open enrollment ends.

To obtain a copy of BCBSTX's Notice of Privacy Practice (NOPP), please visit bcbstx.com/privacy.htm, email NOPP@bcbstx.com or call the number on the back of your member ID card.

Should you have a complaint or dispute concerning your rates, you should contact Blue Cross and Blue Shield of Texas first. If the dispute is not resolved, or to find additional information and assistance, you may contact the following agencies:

- Texas Department of Insurance (TDI) at 800-252-3439; online at tdi.texas.gov. Or you may write TDI at: PO Box 12030, Austin, TX 78711-2030. – For information on how to file a complaint with TDI, please go to <https://www.tdi.texas.gov/consumer/get-help-with-an-insurance-complaint.html>
- Texas Consumer Health Assistance Program at 800-252-3439; or visit the website: <http://tdi.texas.gov>
- United States Department of Health and Human Services website: <http://cms.gov/ccio/index.html>



**BlueCross BlueShield
of Texas**

P.O. Box 660819 • Dallas, TX 75266-0819



Member Name
Address 1
Address 2
City, State, Zip Code

