

Summary of Benefits and Coverage (SBC) Plan Year 2024-2025

Benefit Coverage Period: 10/01/2024 - 09/30/2025

When does my Deductible and Out-of-Pocket start over: 01/01



BAY CITY

Coverage Tiers: 4 Tier

Network: Choice Plus

Plan Type: HMO | Plan Description: HMO-3K-6K

Prescription Plan: Mandatory Generic Program

All Covered Services (except in emergencies) must be provided by or through Your Participating Primary Care Physician/Practitioner, who may refer You for further treatment by Providers in the applicable network of Participating Specialists and Hospitals. Female Participants may visit a Participating OB/GYN Physician in their PCP's Provider network for diagnosis and treatment without a Referral from their PCP. Urgent Care, Virtual Visits and Retail Health Clinics do not require Primary Care Physician/Practitioner Referral.

Out-of-Network Emergency care will be covered at the In-Network Benefit, subject to the Out-of-Network allowable amount. **In accordance with the Consolidated Appropriations Act you may not be responsible for Out-of-Network charges in excess of the allowable amount when services are received as a result of an emergency.**

Important Questions	In-Network Benefit	Why This Matters
What is the overall deductible?	Individual: \$3000 Family: \$6000	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. For any services that are subject to benefit maximum, only the amount up to the benefit maximum will apply toward your deductible/out-of-pocket if not already satisfied.
Are there services covered before you meet your deductible?	Yes	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. Refer to your Medical Plan Booklet for a list of covered preventive services.
Are there other deductibles for specific services?	Facility Inpatient: None	
Is there a maximum out-of-pocket limit on my expenses?	Individual: \$6000 Family: \$12000	The maximum out-of-pocket limit is the most you could pay in a year for covered services and includes in-network deductibles and coinsurance and medical and prescription copayments. If you have other family members in this Plan, they have to meet their own maximum out-of-pocket limits until the overall family maximum out-of-pocket limit has been met.
What is not included in the maximum out-of-pocket limit?		Premiums, penalties and non-covered services will not accumulate to your maximum out-of-pocket amount.
Is there an overall annual	No	

Important Questions	<i>In-Network</i> Benefit	Why This Matters
limit on what the <i>Plan</i> pays?		
Does this Plan use a <i>network of providers</i> ?	Yes	This <i>Plan</i> uses a <i>provider</i> network. Out-of-Network services are only covered for emergency care. You will pay the most if you use an <i>out-of-network provider</i> , and you might receive a bill from a provider for the difference between the provider's charge and what your Plan pays (<i>balance billing</i>). See www.BCBSTX.com or call (855) 762-6084 for a list of participating providers.
Do I need a <i>referral</i> to see a <i>Specialist</i> ?	Yes	All Covered Services (except in emergencies) must be provided by or through Your Participating Primary Care Physician/Practitioner, who may refer You for further treatment by Providers in the applicable network of Participating Specialists and Hospitals. Female Participants may visit a Participating OB/GYN Physician in their PCP's Provider network for diagnosis and treatment without a Referral from their PCP. Urgent Care, Virtual Visits and Retail Health Clinics do not require Primary Care Physician/Practitioner Referral.
Are there any services the Plan does not cover?	Yes	Refer to the " <i>Excluded Services</i> " benefit information. A full list of Exclusions and Limitations can be found within the Medical Plan Booklet.
What is my <i>copayment</i> ?	See below	This <i>Plan</i> does require medical copayments; unless otherwise specified.

Common Medical Event	Services You May Need	<i>In-Network</i> Benefit (You will pay the least)	Limitations, Exceptions and Other Important Information
If you visit a health care provider's office or clinic	<i>Primary care</i> visit to treat an injury or illness	\$30 copay	Includes Internist, Family Practitioner, Pediatrician, Behavioral Health Practitioner, Gynecologist, Physician Assistant or Advanced Practice Nurse who works under the supervision of one of these listed physicians. Plan pays 100% after copayment.
	<i>Specialist</i> visit	\$60 copay	All other specialties. Plan pays 100% after copayment.
	MDLIVE Medical Consult	No Charge	
	MDLIVE Initial and Follow-Up Visit for Behavioral Health	No Charge	
	MDLIVE Psychotherapy Visit for Behavioral Health	No Charge	
	<i>Preventive care/screening/immunization</i>	No charge	See the Medical Plan Booklet for a list of covered preventive services, including those mandated by the US Preventive Task Force (USPSTF) at no charge. Colorectal DNA screening, (i.e., Cologuard), limited to one test every three years.
If you visit an <i>urgent care</i> clinic	Urgent care visit to treat an injury or illness	\$75 copay	Plan pays 100% after copayment.

Common Medical Event	Services You May Need	<i>In-Network</i> Benefit (You will pay the least)	Limitations, Exceptions and Other Important Information
If you have a test	Lab and X-ray in an office, outpatient facility, lab drawing site or free-standing radiology center	No Charge	
	Lab and X-ray in conjunction with outpatient surgery in a facility treatment room or emergency room, or in an inpatient setting	20%	
	Other <i>Diagnostic Tests</i>	20%	Subject to the office visit copay in an office setting.
	Major Imaging (CT/PET scans, MRIs)	20%	See the " <i>Pre-Authorization</i> Requirements" section in the Medical Plan Booklet. Call (855) 762-6084 for information on how to control your out-of-pocket costs for these services. Subject to the office visit copay in an office setting
Specialty and other Non-Oncology Infused Drugs	Specialty non-infused drugs administered in a medical setting	20%	See the " <i>Pre-Authorization</i> Requirements" section in the Medical Plan Booklet Subject to the office visit copay in an office setting
	Non-Oncology Infused Drugs in an Office, Home or Freestanding Infusion Center	\$30 copay	
	Non-oncology infused drugs in a Facility setting	\$500 copay	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center or outpatient hospital)	20%	Many surgery services can be accessed through the Surgery Plus program at little to no out-of-pocket cost. Call (855) 715-1684 for more information.
	Physician/surgeon fees	20%	See the " <i>Pre-Authorization</i> Requirements" section in the Medical Plan Booklet.

Common Medical Event	Services You May Need	<i>In-Network</i> Benefit (You will pay the least)	Limitations, Exceptions and Other Important Information
If you need immediate medical attention Emergency room (ER)	<i>Emergency room facility services</i> for medical emergencies	20%	\$500 Emergency Room Fee (waived if admitted) <i>Coinsurance</i> will apply after the <i>deductible</i> is met.
	<i>Emergency room facility services</i> for non-medical emergencies	20%	
	<i>Emergency room physician services</i> for medical emergencies	20%	
	<i>Emergency Ambulance services</i>	20%	<ul style="list-style-type: none"> • \$2,500 maximum allowed per trip for Ground Ambulance. • \$12,000 maximum allowed per trip for Air Ambulance.
If you have a hospital stay	<i>Inpatient</i> Hospital	20%	
	<i>Outpatient</i> Hospital	20%	
	Physician/surgeon fees	20%	
If you need mental health, behavioral health, or substance abuse services	Mental/Behavioral health outpatient services	20%	See the " <i>Pre-Authorization</i> Requirements" section in the Medical
	Mental/Behavioral health inpatient services	20%	
	Chemical Dependency/Substance use disorder outpatient services	20%	
	Chemical Dependency/Substance use disorder inpatient services	20%	
If you are pregnant	Prenatal and postnatal care	20%	<i>Coinsurance</i> does not apply to certain services from <i>in-network providers</i> . Newborns must be enrolled within 31 days for coverage.
	Delivery and all inpatient services	20%	
If you need help recovering or have other special health needs	<i>Home health care</i>	20%	60 Home Health Care visits per year
	<i>Rehabilitation/Habilitation</i> services	20%	<p>The following frequency limits apply for office/outpatient services. Subject to the office visit copay in an office setting.</p> <ul style="list-style-type: none"> • 30 Speech Therapy visits per year • 48 Physical, Occupational, and Aquatic visits combined per year • 10 Chiropractic Care visits per year

Common Medical Event	Services You May Need	<i>In-Network</i> Benefit (You will pay the least)	Limitations, Exceptions and Other Important Information
If you need help recovering or have other special health needs	<i>Skilled nursing care</i>	20%	See the " <i>Pre-Authorization</i> Requirements" section in the Medical Inpatient private duty nursing is subject to medical necessity.
	<i>Durable medical equipment</i>	20%	Subject to the office visit copay in an office setting. A prescription order from your Health Care practitioner is required. Reimbursement for rented equipment will not exceed purchase price.
	<i>Hospice services</i>	20%	See the " <i>Pre-Authorization</i> Requirements" section in the Medical
	Other Eligible Medical Expenses	20%	Subject to the office visit copay in an office setting.
If your child needs dental or eye care	Children's eye exam	N/A	Vision Acuity Screenings are paid as <i>Preventive</i> under the Medical Plan at 100% for in-network providers.
	Children's glasses	N/A	Not covered under the Medical Plan. Glasses may be covered under a separate vision plan.
	Children's dental checkup	N/A	Pediatric oral fluoride varnish paid as <i>Preventive</i> under Medical Plan at 100% for in-network providers.

Excluded Services & Other Covered Services:

Services Your <i>Plan</i> Generally Does NOT Cover (Check your Medical Plan Booklet for more information and a list of any other excluded services.)		
<ul style="list-style-type: none"> • Acupuncture • Cosmetic surgery • Custodial care 	<ul style="list-style-type: none"> • Dental care (excluding dental injuries) • Non-Emergency care when traveling outside the U.S. • Personal comfort and convenience items 	<ul style="list-style-type: none"> • Routine eye care • Routine foot care • Sterilization Reversal • Weight loss surgery

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your Medical Plan Booklet.)	
<ul style="list-style-type: none"> • Custom-molded foot <i>orthotics</i>: 1 pair/36 months • Hearing aids: One standard model pair every 3 years 	<ul style="list-style-type: none"> • Removeable contacts or glasses following cataract surgery \$200 allowed • Wig for cancer related hair loss: \$400 allowed benefit/year

TX Health Benefits Pool is a non-profit trust organization created by political subdivisions to provide group benefits services to participating political subdivisions and is not an insurance company.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions and Other Important Information
		<i>In-Network</i> Benefit (You will pay the least)	<i>Out-of-Network</i> Benefit (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at TXHB.gov .	For prescriptions purchased from a retail, mail order, or specialty pharmacy. This is a Mandatory Generic Prescription Plan. This means if a brand name drug is dispensed and a generic alternate drug exists, you will pay the difference between the brand name and generic price in addition to the appropriate Copayment for the brand name. The cost difference between the brand name and generic price does not apply to any individual Deductibles or out of pocket amounts.			
	Disease Management Maintenance (certain generic drugs to treat diabetes, high blood pressure, and high cholesterol)	\$0	Not covered	All Copays listed are per 30 days for retail and mail order. Copays 2x's for 31 – 60 days' supply and 3x's for 61 - 90 days' supply. This benefit includes contraceptive drugs and devices obtainable from a pharmacy. No charge for generic FDA-approved women's contraceptives in-network and other drugs mandated by the US Preventive Task Force (USPSTF). Pre-Authorization and Step therapy are required for some drugs. *Could be less if coupon available.
	Tier 1 drug – most generics and some lower cost brand products	\$10 copay	Not covered	
	Tier 2 drug – preferred brand products and certain higher cost generics	\$45 copay	Not covered	
	Tier 2 - Insulins	\$25 copay	Not covered	
	Tier 3 drug – non-preferred products	\$90 copay	Not covered	
	Tier 4 drug – Specialty	\$150 copay*	Not covered	
Tier 5 drug - Cost Share	\$175 copay	Not covered		

Your Rights to Continue Coverage

An Employee's eligibility for continuation of benefits under the Consolidated Omnibus Budget Reconciliation Act ("COBRA") is subject to Federal law. Employers who do not employ 20 or more employees in the prior calendar year are not subject to COBRA and their employees will not receive COBRA benefits under the Plan. Federal and State laws may provide protections that allow you to continue [health coverage](#) after it would otherwise end. For more information about your rights and obligations under the [Plan](#) and under federal law, you should review the Medical Plan Booklet or contact TX Health Benefits Pool, PO Box 140526, Austin, Texas 78714-0526 or by telephone (800) 282-5385. You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance [Marketplace](#). For more information about the Marketplace, visit www.healthcare.gov or call (800) 318-2596.

Your [Grievance](#) and [Appeals](#) Rights

If you have a complaint or are dissatisfied with a denial of coverage for [claims](#) under your [Plan](#), you may be able to appeal or file a grievance. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your Medical Plan Booklet also provides complete information to submit a claim appeal or a grievance for any reason. For assistance, contact Blue Cross and Blue Shield of Texas Claims Division, P.O. Box 660044, Dallas, Texas, 75266-0044 or by telephone (855) 762 6084. You may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at (877) 267-2323 x61565 or www.cciio.cms.gov.

Does this Plan provide *Minimum Essential Coverage*? Yes.

The Affordable Care Act requires most people to have *health coverage* that qualifies as “minimum essential coverage”. This *Plan* does provide minimum essential coverage.

Does this Plan Meet *Minimum Value Standard*?

The Affordable Care Act establishes a minimum-value standard of benefits of a health *plan*. The minimum value standard is 60% (actuarial value). This *health coverage* does meet the minimum-value standard for the benefits it provides.

About these Coverage Examples

These examples show how this *Plan* might cover medical care in a few situations and how *deductibles*, *copayments*, and *coinsurance* can add up. Use these examples to see, in general, how much financial protection a sample patient might get from *coverage* under this Plan compared to other plans by comparing the "Covered Individual Pays" section for the same example under each plan's Summary of Benefits and Coverage. **This is not a cost estimator.** Do not use these examples to estimate your actual costs under this Plan. Treatments shown are just examples and your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Also, costs do not include *premiums* you pay to buy coverage under a plan.

Having a Baby <i>(normal delivery)</i>		Managing Type 2 Diabetes <i>(routine maintenance of a well-controlled condition)</i>		Simple Fracture <i>(with emergency room visit)</i>	
• Amount owed to Providers:	\$13,772.46	• Amount owed to Providers:	\$8,673.52	• Amount owed to Providers:	\$3,383.56
• Plan pays:	\$11,247.46	• Plan pays:	\$7,441.18	• Plan pays:	\$2,252.62
• Covered Individual/Patient pays:	\$2,500.00	• Covered Individual/Patient pays:	\$1,232.34	• Covered Individual/Patient pays:	\$1,130.94
Sample Care Costs		Sample Care Costs		Sample Care Costs	
Hospital charges (mother)	\$5,829.57	Prescriptions:	\$7,138.32	Emergency Services:	\$2,319.54
Hospital charges (baby):	\$1,505.65	Medical Equip. & Supplies:	\$208.32	Medical Equip. & Supplies:	\$128.10
Routine obstetric care:	\$3,313.16	Office Visits and Procedures:	\$858.20	Office Visits and Procedures:	\$598.13
Anesthesia:	\$2,200.00	Education:	\$204.50	Physical Therapy:	\$307.74
Laboratory tests:	\$325.96	Laboratory tests:	\$116.54	Laboratory tests:	\$0.00
Prescriptions:	\$45.00	Vaccines, other preventive:	\$147.64	Prescriptions:	\$30.05
Radiology:	\$553.12	Total:	\$8,673.52	Total:	\$3,383.56
Total:	\$13,722.46	Covered Individual/Patient Pays		Covered Individual/Patient Pays	
Deductible:	\$500.00	Deductible:	\$170.34	Deductible:	\$500.00
Copayments: Medical/Rx:	\$25.00/\$0.00	Copayments: Medical/Rx:	\$150.00/\$912.00	Copayments: Medical/Rx:	\$75.00/\$0.00
Coinsurance:	\$1,975.00	Coinsurance:	\$0.00	Coinsurance:	\$455.94
Plan/Max Plan OOP:	\$2,500.00	Plan/Max Plan OOP:	\$1,232.34	Plan/Max Plan OOP:	\$1,030.94
Limits or Exclusions:	\$0.00	Limits or Exclusions:	\$0.00	Limits or Exclusions:	\$100.00
Total:	\$2,500.00	Total:	\$1,232.34	Total:	\$1,130.94

Guidance document appears at 77 Fed Reg. 8668 and 8706 respectively (2-14-12). To request a translated document, call (800) 282-5385.

For general definitions of common terms, such as *allowed amount*, *balance billing*, *coinsurance*, *copayment*, *deductible*, *provider*, or other hyperlinked terms, see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call (800) 282-5385 to request a copy.

Non-Discrimination

TX Health Benefits Pool complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. TX Health Benefits Pool does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

TX Health Benefits Pool:

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

If you need these services, contact our Civil Rights Coordinator. If you believe that TX Health Benefits Pool has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, TX Health Benefits Pool, PO Box 140526, Austin, Texas 78714-0526 (800) 282-5385, TTY 711, Fax (512) 719-6539, CRCordinator@txhb.gov. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, (800) 368-1019, (800) 537-7697 (TDD). Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

TTY: 711

Language Assistance

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call (855) 762 6084.

Spanish ----- ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (855) 762 6084.

Vietnamese ----- CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (855) 762 6084.

Chinese ----- 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (855) 762 6084.

Korean ----- 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (855) 762 6084번으로 전화해 주십시오. ◦

Arabic ----- واليكم الصم هاتف - . برقم اتصل .بالمجان لك تتوافر اللغوية المساعدة خدمات فإن اللغة، اذكر تتحدث كنت إذا :ملحوظة - (855) 762 6084 (رقم

Urdu ----- کریں 762 6084 (855) کال - بین دستیاب میں مفت خدمات کی مدد کی زبان کو آپ تو ہیں، بولتے اردو آپ اگر :خبردار

Tagalog ----- PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (855) 762 6084.

French ----- ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (855) 762 6084.

Hindi ----- ध्यान दः यद आप हदी बोलते ह तो आपके िलए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह । (855) 762 6084पर कॉल कर।

Persian (Farsi) -- بگیرید تماس با .باشد می فراهم (855) 762 6084 شما برای رایگان بصورت زبانی تسهیلات کنید، می گفتگو فارسی زبان به اگر :توجه --

German ----- ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (855) 762 6084.

Gujarati ----- યુના: જો તમે જરાતી બોલતા હો, તો િન:લુ ભાષા સહાય સેવાઓ તમારા માટ ઉપલબ્ધ છ. ફોન કરો (855) 762 6084.

Russian ----- ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (855) 762 6084.

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。(855) 762 6084まで、お電話にてご連絡ください。

Laotian ----- ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຍຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ (855) 762 6084.