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

TX Health BENEFITS POOL

BAY CITY

Coverage Tiers: 4 Tier **Network:** Choice Plus **Plan Type:** PPO | **Plan Description:** Copay-3K-7K ER

Prescription Plan: Mandatory Generic Program

Important Questions	*In-Network* Benefit	*Out-of-Network* Benefit	Why This Matters
What is the overall *deductible*?	Individual: $3000 Family: $6000	Individual: $6000 Family: $12000	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. Charges applied to the out-of-network deductible do accumulate to the in-network 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	No	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	Facility Inpatient: None	
Is there a *maximum out-of-pocket limit* on my expenses?	Individual: $7000 Family: $14000	Individual: $0 Family: $0 Never pays at 100%	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, non-covered services, and out-of-network expenses will not accumulate to your *maximum out-of-pocket* amount.
Is there an overall annual limit on what the *Plan* pays?	No	No	
Does this Plan use a *network of providers*?	Yes	N/A	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)*. See *www.BCBSTX.com* or call (855) 762-6084 for a list of participating providers.
Do I need a *referral* to see a *Specialist*?	No	No	
Are there any services the Plan does not cover?	Yes	Yes	Refer to the "*Excluded Services*" benefit information. A full list of Exclusions and Limitations can be found within the Medical Plan Booklet.

Important Questions	*In-Network* Benefit	*Out-of-Network* Benefit	Why This Matters
What is my *copayment*?	See below	N/A	This *Plan* does require medical copayments, unless otherwise specified

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions and Other Important Information
		In-Network Benefit (You will pay the least)	*Out-of-Network* Benefit (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	$30 copay*	50%	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 exams, consultations, and psychotherapy at 100% after $30 *copayment*.** All other services, excluding lab and x-ray subject to *deductible* and *coinsurance*.
	Specialist visit	$60 copay*	50%	***Plan pays exams & consultations at 100% after *copayment*.** All other services, excluding lab and x-ray subject to *deductible* and *coinsurance*.
	Other practitioner office visit	20%*	50%	*Office visit copayment will be determined based upon specialty.
	MDLIVE Medical Consult	No Charge	N/A	
	MDLIVE Initial and Follow-Up Visit for Behavioral Health	No Charge	N/A	
	MDLIVE Psychotherapy Visit for Behavioral Health	No Charge	N/A	
	Preventive care/*screening*/ immunization	No charge	50%	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 *urgent care* clinic	Urgent care visit to treat an injury or illness	$75 copay*	50%	***Plan pays exams & consultations at 100% after *copayment*.** All other services, excluding lab and x-ray to *deductible* and *coinsurance*.
If you have a test	Lab and X-ray in an office, outpatient facility, lab drawing site or free- standing radiology center	No Charge	50%	

	Lab and X-ray in conjunction with outpatient surgery, in a facility treatment room or emergency room, or in an inpatient setting	20%	50%	
If you have a test Cont.	Other *Diagnostic Tests*	20%	50%	
	Major Imaging (CT/PET scans, MRIs)	20%	50%	See the "*Pre-Authorization* 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.
Specialty and other Non-Oncology Infused Drugs	Specialty non-infused drugs administered in a medical setting	20%	50%	See the "Pre-Authorization Requirements" section in the Medical Plan Booklet.
	Non-Oncology Infused Drugs	$30 copay	$500 copay	
	in an Office, Home or Freestanding Infusion Center			
	Non-oncology infused drugs in a Facility setting	$500 copay	$1,000 copay	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center or outpatient hospital)	20%	50%	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%	50%	See the "*Pre-Authorization* Requirements" section in the Medical Plan Booklet. ‡ Out-of-Network *Specialist* services received at an in-network hospital will be paid as in-network and patients may be responsible for charges in excess of the allowable amount.
If you need immediate medical attention Emergency room (ER)	*Emergency room facility services* for medical emergencies	20%	20%	$500 Emergency Room Fee (waived if admitted) *Coinsurance* will apply after the *deductible* is met. ‡ Out-of-Network charges will be paid as in-network for medical emergencies and patients may be responsible for charges more than the allowable amount.
	Emergency room facility services for non-emergency treatment	20%	50%	
	Emergency room physician services for medical emergencies	20%	20%	

If you need immediate medical attention Emergency room (ER) Cont.	*Emergency Ambulance services*	20%	20%	• $2,500 maximum allowed per trip for Ground Ambulance. • $12,000 maximum allowed per trip for Air Ambulance. • ‡ For Out-of-Network services, patients may be responsible for charges more than the allowable amount.
If you have a hospital stay	*Inpatient* Hospital	20%	50%	See the "*Pre-Authorization* Requirements" section in the Medical Plan Booklet. ‡ Out-of-Network *Specialist* services received at an in-network hospital will be paid as in-network and patient may be responsible for charges in excess of the allowable amount.
	Outpatient Hospital	20%	50%	
	Physician/surgeon fees	20%	50%	
If you need mental health, behavioral health, or substance abuse services	Mental/Behavioral health outpatient services	20%	50%	See the Medical Plan Booklet for Pre-Authorization requirements and additional coverage information.
If you need mental health, behavioral health, or substance abuse services, continued	Chemical dependency/Substance use disorder outpatient services	20%	50%	See the Medical Plan Booklet for *Pre-Authorization* requirements and additional coverage information.
	Chemical dependency/Substance use disorder inpatient services	20%	50%	
If you are pregnant	Prenatal and postnatal care	20%	50%	See the "*Pre-Authorization* Requirements" section in the Medical Plan Booklet. *Coinsurance* does not apply to certain services from *in-network providers*. Newborns must be enrolled within 31days for coverage.
	Delivery and all inpatient services	20%	50%	
If you need help recovering or have other special health needs	*Home health care*	20%	50%	60 Home Health Care visits per year See the Medical Plan Booklet for *Pre-Authorization* requirements and additional coverage information.
	Rehabilitation/*Habilitation* services	20%	50%	The following frequency limits apply for office/outpatient services: • 30 Speech Therapy visits per year • 48 Physical, Occupational, and Aquatic visits combined per year • 10 Chiropractic Care visits per year
If you need help recovering or have other special	*Skilled nursing care*	20%	50%	See the Medical Plan Booklet for *Pre-Authorization* requirements and additional coverage information. Inpatient private duty nursing is subject to medical necessity.

health needs Cont.	*Durable medical equipment*	20%	50%	A prescription order from your Health Care practitioner is required. Reimbursement for rented equipment will not exceed purchase price.
	Hospice services	20%	50%	See the Medical Plan Booklet for *Pre-Authorization* requirements and additional coverage information.
	Other Eligible Medical Expenses	20%	50%	
If your child needs dental or eye care	Children's eye exam	N/A	N/A	Vision Acuity Screenings are paid as *Preventive* under the Medical Plan at 100% for in-network providers.
	Children's glasses	N/A	N/A	Not covered under the Medical Plan. Glasses may be covered under a separate vision plan.
	Children's dental checkup	N/A	N/A	Pediatric oral fluoride varnish paid as *Preventive* under Medical Plan at 100% for in-network providers.

‡ 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 at an in- network facility or as a result of an emergency.***

Excluded Services **& Other Covered Services:**

Services Your *Plan* Generally Does NOT Cover (Check your Medical Plan Booklet for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic surgery
- Custodial care
- Dental care (excluding dental injuries)
- Non-Emergency care when traveling outside the U.S.
- Personal comfort and convenience items
- Routine eye care
- Routine foot care
- Sterilization Reversal
- Weight loss surgery

Other Limited Benefits (The maximum benefits shown below will apply toward your deductible/out-of-pocket if not already satisfied). (This isn't a complete list. Please see your Medical Plan Booklet.)		
• Custom-molded foot *orthotics*: 1 pair/36 months • Hearing aids: One standard model pair every 3 years	• Wig for cancer related hair loss: $400 allowed benefit/year	• Removeable contacts or glasses following cataract surgery $200 allowed ***Refer to the Medical Plan Booklet for a full list of services that require Pre-Authorization and additional coverage requirements.***

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.

Extenuating Circumstances

If a Covered Person requires care from a *specialist* care provider but there is not an in-network specialist care provider within a seventy-five (75) mile radius from the employee's home, the provider will be paid at in-network benefits subject to the out-of-network allowable amount..

Common Medical Event	**Services You May Need**	**What You Will Pay**		**Limitations, Exceptions and Other Important Information**
		***In-Network* Benefit (You will pay the least)**	***Out-of-Network* 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 to 60 days' supply and 3x's for 61 to 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** (excludes insulins)	$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, 75266-0044or 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 *(normal delivery)*	
• Amount owed to Providers:	$13,772.46
• Plan pays:	$11,247.46
• Covered Individual/Patient pays:	$2,500.00
Sample Care Costs	
Hospital charges (mother)	$5,829.57
Hospital charges (baby):	$1,505.65
Routine obstetric care:	$3,313.16
Anesthesia:	$2,200.00
Laboratory tests:	$325.96
Prescriptions:	$45.00
Radiology:	$553.12
Total:	**$13,722.46**
Covered Individual/Patient Pays	

Managing Type 2 Diabetes *(routine maintenance of a well-controlled condition)*	
• Amount owed to Providers:	$8,673.52
• Plan pays:	$7,441.18
• Covered Individual/Patient pays:	$1,232.34
Sample Care Costs	
Prescriptions:	$7,138.32
Medical Equip. & Supplies:	$208.32
Office Visits and Procedures:	$858.20
Education:	$204.50
Laboratory tests:	$116.54
Vaccines, other preventive:	$147.64
Total:	**$8,673.52**
Covered Individual/Patient Pays	

Simple Fracture *(with emergency room visit)*	
• Amount owed to Providers:	$3,383.56
• Plan pays:	$2,252.62
• Covered Individual/Patient pays:	$1,130.94
Sample Care Costs	
Emergency Services:	$2,319.54
Medical Equip. & Supplies:	$128.10
Office Visits and Procedures:	$598.13
Physical Therapy:	$307.74
Laboratory tests:	$0.00
Prescriptions:	$30.05
Total:	**$3,383.56**
Covered Individual/Patient Pays	

Deductible:	$500.00
Copayments: Medical/Rx:	$25.00/$0.00
Coinsurance:	$1,975.00
Plan/Max Plan OOP:	$2,500.00
Limits or Exclusions:	$0.00
Total:	**$2,500.00**

Deductible:	$170.34
Copayments: Medical/Rx:	$150.00/$912.00
Coinsurance:	$0.00
Plan/Max Plan OOP:	$1,232.34
Limits or Exclusions:	$0.00
Total:	**$1,232.34**

Deductible:	$500.00
Copayments: Medical/Rx:	$75.00/$0.00
Coinsurance:	$455.94
Plan/Max Plan OOP:	$1,030.94
Limits or Exclusions:	$100.00
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, *CRCoordinator@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. (800) 282-5385 번으로 전화해 주십시오.◦

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

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

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 द: यद आप हदी बोलते ह तो आपके लए मुफ्त म भाषा सहायता सेवाएं उपलब्ध ह। (855) 762 6084पर कॉल कर।

Persian (Farsi) -- **توجه**: اگر بهزبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. (800) 282-5385 تماس بگیرید.

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

Gujarati ---------- **ચુના: જો તમે જરાતી બોલતા હો, તો ન:લ્કુ 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, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ ((855) 762 6084.