BlueCross BlueShield of Texas

Lone Star College System
Student Health Insurance Plan

Dear Student:

Under the Affordable Care Act, all health insurers and group health plans are required to provide consumers with a Summary of Benefits and Coverage (SBC). The SBC is a summary of the benefits and health coverage offered by a particular plan.

Attached is the SBC for the Lone Star College System Student Health Plan covering plans purchased between 08/10/16 - 08/09/17. In accordance with your College/University, coverage may be purchased for varying periods of time. The coverage periods for Lone Star College System are listed below:

Coverage Period	**Date**
Fall:	08/10/16 - 12/31/16
Spring/Summer:	01/01/17 - 08/09/17
Summer:	06/01/16 - 08/09/17

If you have any questions regarding your coverage or the length of time you purchased, please contact customer service at 855-267-0214.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bcbstx.com/member/policy-formsor by calling 1-855-267-0214.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For In-Network providers **$350** Individual/**$1,050** Family For Out-of-Network providers **$700** Individual/**$2,100** Family Doesn't apply to services that charge a copay, prescription drugs, and In-Network diagnostic tests and preventive care. Copays do not count toward the deductible.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No. There are no other specific deductibles.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. For In-Network providers **$6,850** Individual/**$13,700** Family For Out-of-Network providers **$13,700** Individual/**$27,400** Family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, preauthorization penalties, balance-billed 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**.
Does this plan use a network of providers?	Yes. See www.bcbstx.com or call 1-855-267-0214 for a list of In-Network providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-855-267-0214 or visit us at www.bcbstx.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-855-756-4448 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an Out-of-Network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an Out-of-Network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use In-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copay/visit	40% coinsurance	---none---
	Specialist visit	$35 copay/visit	40% coinsurance	
	Other practitioner office visit	20% coinsurance	40% coinsurance	Chiropractic services are limited to 35 visits combined for all therapies per benefit period. Includes, but is not limited to, physical and occupational therapy.
	Preventive care/screening/immunization	No Charge	40% coinsurance	No charge for child immunizations Out-of-Network through the 6th birthday.
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	

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbstx.com	Generic drugs	$15 copay/ prescription	$15 copay/ prescription plus 50% coinsurance	Mail order is not covered. Retail copay covers a 30 day supply. With appropriate prescription, up to a 90 day supply is available.
	Preferred brand drugs	$30 copay/ prescription	$30 copay/ prescription plus 50% coinsurance	
	Non-preferred brand drugs	$40 copay/ prescription	$40 copay/ prescription plus 50% coinsurance	
	Specialty drugs	$15/$30/$40 copay/prescription	$15/$30/$40 copay/prescription plus 50% coinsurance	For In-Network benefit, must be obtained from Prime Specialty Pharmacy. Mail order is not covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	---none---
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room services	$150 copay/visit plus 20% coinsurance	$150 copay/visit plus 20% coinsurance	Emergency room copay waived if admitted. Non-emergency use of the emergency room 40% coinsurance after deductible Out-of-Network.
	Emergency medical transportation	20% coinsurance	20% coinsurance	---none---
	Urgent care	$35 copay/visit	40% coinsurance	
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 fee	20% coinsurance	40% coinsurance	---none---

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$35 copay/visit	40% coinsurance	Certain services must be preauthorized; refer to benefits booklet for details.
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	All services must be preauthorized; $250 penalty if services are not preauthorized Out-of-Network.
	Substance use disorder outpatient services	$35 copay/visit	40% coinsurance	Certain services must be preauthorized; refer to benefits booklet for details.
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	All services must be preauthorized; $250 penalty if services are not preauthorized Out-of-Network.
If you are pregnant	Prenatal and postnatal care	$35 copay/visit	40% coinsurance	Copay applies to first prenatal visit (per pregnancy).
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	---none---
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Limited to 60 visits per benefit period. Preauthorization is required.
	Rehabilitation services	20% coinsurance	40% coinsurance	Limited to 35 visits combined for all therapies per benefit period. Includes, but is not limited to, physical, occupational, and manipulative therapy.
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	Limited to 25 days per benefit period. Preauthorization is required.
	Durable medical equipment	20% coinsurance	40% coinsurance	---none---
	Hospice service	20% coinsurance	40% coinsurance	Preauthorization is required.
If your child needs dental or eye care	Eye exam	Covered	Covered	Refer to Benefit Booklet for detailsx
	Glasses	Covered	Covered	
	Dental check-up	Covered	Covered	

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Acupuncture
- Bariatric surgery
- Cosmetic surgery (limited covered services)
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care (with the exception of person with diagnosis of diabetes)
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Chiropractic care
- Hearing aids (limited to 1 new aid per ear per 36-month period)
- Routine eye care (Adult)

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-888-697-0683. You may also contact your state insurance department at www.tdi.texas.gov.

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 questions about your rights, this notice, or assistance, you can contact: Texas Department of Insurance at (800) 578-4677 or visit www.tdi.texas.gov.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the 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.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-267-0214.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-267-0214.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-855-267-0214.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-267-0214.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,640
- **Patient pays** $1,900

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$350
Copays	$20
Coinsurance	$1,380
Limits or exclusions	$150
Total	**$1,900**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,800
- **Patient pays** $1,600

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$350
Copays	$950
Coinsurance	$220
Limits or exclusions	$80
Total	**$1,600**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from Out-of-Network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-855-267-0214 or visit us at www.bcbstx.com.
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