



**BlueCross BlueShield  
of Texas**

**Paul Quinn College  
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 Paul Quinn College Student Health Plan covering plans purchased between 08/01/16 - 07/31/17. In accordance with your College/University, coverage may be purchased for varying periods of time. The coverage periods for Paul Quinn College are listed below:

| <b>Coverage Period</b> | <b>Date</b>         |
|------------------------|---------------------|
| Annual                 | 08/01/16 - 07/31/17 |
| Fall                   | 08/01/16 - 12/31/16 |
| Spring/Summer          | 01/01/17 - 07/31/17 |
| Summer                 | 06/01/17 - 07/31/17 |

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-forms](http://www.bcbstx.com/member/policy-forms) or by calling 1-855-267-0214.

| Important Questions  | Answers  | Why this Matters:   |
|--|--|---|
| <b>What is the overall <u>deductible</u>?</b>                    | For In-Network providers<br><b>\$4,500</b> Individual/ <b>\$9,000</b> Family<br>For Out-of-Network providers<br><b>\$12,000</b> Individual/ <b>\$36,000</b> Family<br>Doesn't apply to services that charge a copay, prescription drugs, and In-Network preventive care.<br>Copays do not count toward the deductible. | You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b>deductible</b> 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 <b>deductible</b> .   |
| <b>Are there other <u>deductibles</u> for specific services?</b> | No. There are no other specific deductibles.   | You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.  |
| <b>Is there an <u>out-of-pocket limit</u> on my expenses?</b>    | Yes. For In-Network providers<br><b>\$6,850</b> Individual/ <b>\$12,700</b> Family<br>For Out-of-Network providers<br><b>\$12,800</b> Individual/ <b>\$38,400</b> Family   | The <b>out-of-pocket limit</b> 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.  |
| <b>What is not included in the <u>out-of-pocket limit</u>?</b>   | Premiums, balance-billed charges, preauthorization penalties, and health care this plan doesn't cover  | Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .  |
| <b>Does this plan use a <u>network of providers</u>?</b>         | Yes. See <a href="http://www.bcbstx.com">www.bcbstx.com</a> or call 1-800-810-2583 for a list of In-Network providers.   | If you use an in-network doctor or other health care <b>provider</b> , 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 <b>provider</b> for some services. Plans use the term in-network, <b>preferred</b> , or participating for <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> . |
| <b>Do I need a referral to see a <u>specialist</u>?</b>          | No. You don't need a referral to see a specialist.   | You can see the <b>specialist</b> you choose without permission from this plan.   |
| <b>Are there services this plan doesn't cover?</b>               | 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 <b>excluded services</b> .   |

**Questions:** Call 1-855-267-0214 or visit us at [www.bcbstx.com](http://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](http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf) or call 1-855-756-4448 to request a copy.

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.



- **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 <b>provider's</b> office or clinic | Primary care visit to treat an injury or illness | \$25 copay/visit                            | 30% coinsurance                                 | ---none---   |
|   | Specialist visit                                 | \$40 copay/visit                            | 30% coinsurance                                 |  |
|   | Other practitioner office visit                  | 10% coinsurance                             | 30% coinsurance                                 | Chiropractic services are limited to 35 visits combined for all therapies per plan year. Includes but is not limited to physical or occupational In- and Out-of-Network. |
|   | Preventive care/screening/immunization           | No Charge                                   | 30% coinsurance                                 | No charge for child immunizations Out-of-Network through the 6 <sup>th</sup> birthday.   |
| If you have a test  | Diagnostic test (x-ray, blood work)              | 10% coinsurance                             | 30% coinsurance                                 | ---none---   |
|   | Imaging (CT/PET scans, MRIs)                     | 10% coinsurance                             | 30% 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   |
|--|--|---|--|--|
| <b>If you need drugs to treat your illness or condition</b><br><br>More information about <b>prescription drug coverage</b> is available at <a href="http://www.bcbstx.com">www.bcbstx.com</a> | Generic drugs                                  | \$20 copay (retail) /prescription           | \$20 copay/prescription plus 50% coinsurance           | Retail: Based on a 90 day supply with one copay per 30 days.   |
|  | Preferred brand drugs                          | \$30 copay (retail) /prescription           | \$30 copay/prescription plus 50% coinsurance           | For Non-Participating pharmacy, member must file claim.  |
|  | Non-preferred brand drugs                      | \$45 copay (retail) /prescription           | \$45 copay/prescription plus 50% coinsurance           | Mail orders Not Covered.   |
|  | Specialty drugs                                | \$20/\$30/\$45 copay/prescription           | \$20/\$30/\$45 copay/prescription plus 50% coinsurance | For In-Network benefit, must be obtained from Prime Specialty Pharmacy.  |
| <b>If you have outpatient surgery</b>  | Facility fee (e.g., ambulatory surgery center) | 10% coinsurance                             | 30% coinsurance  | ---none---   |
|  | Physician/surgeon fees                         | 10% coinsurance                             | 30% coinsurance  |  |
| <b>If you need immediate medical attention</b>   | Emergency room services                        | \$300 copay/visit                           | \$300 copay/visit                                      | Emergency room copay waived if admitted. Non-emergency care is covered at 40% coinsurance after deductible for Out-of-Network. |
|  | Emergency medical transportation               | 10% coinsurance                             | 10% coinsurance  | Ground and air transportation covered.   |
|  | Urgent care                                    | \$40 copay/visit                            | 30% coinsurance  | ---none---   |
| <b>If you have a hospital stay</b>   | Facility fee (e.g., hospital room)             | 10% coinsurance                             | 30% coinsurance  | Preauthorization is required; \$250 penalty if services are not preauthorized Out-of-Network.                                  |
|  | Physician/surgeon fee                          | 10% coinsurance                             | 30% 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  |
|---|--|---|---|---|
| <b>If you have mental health, behavioral health, or substance abuse needs</b> | Mental/Behavioral health outpatient services | \$25 copay/visit                            | 30% coinsurance                                 | Certain services must be preauthorized; refer to benefits booklet for details.  |
|   | Mental/Behavioral health inpatient services  | 10% coinsurance                             | 30% coinsurance                                 | All services must be preauthorized. \$250 penalty if services are not preauthorized Out-of-Network.   |
|   | Substance use disorder outpatient services   | \$25 copay/visit                            | 30% coinsurance                                 | Certain services must be preauthorized; refer to benefits booklet for details.  |
|   | Substance use disorder inpatient services    | 10% coinsurance                             | 30% coinsurance                                 | All services must be preauthorized. \$250 penalty if services are not preauthorized Out-of-Network.   |
| <b>If you are pregnant</b>  | Prenatal and postnatal care                  | \$25 copay/visit                            | 30% coinsurance                                 | Copay applies to first prenatal visit (per pregnancy).  |
|   | Delivery and all inpatient services          | 10% coinsurance                             | 30% coinsurance                                 | Preauthorization is required; \$250 penalty if services are not preauthorized Out-of-Network  |
| <b>If you need help recovering or have other special health needs</b>         | Home health care                             | 10% coinsurance                             | 30% coinsurance                                 | Preauthorization is required. Limited to 60 visits per plan year.   |
|   | Rehabilitation services                      | 10% coinsurance                             | 30% coinsurance                                 | Limited to 35 visits combined for all therapies per plan year. Includes, but is not limited to, physical, occupational, and manipulative therapy. |
|   | Habilitation services                        | 10% coinsurance                             | 30% coinsurance                                 |   |
|   | Skilled nursing care                         | 10% coinsurance                             | 30% coinsurance                                 | Preauthorization is required. Limited to 25 days per plan year.   |
|   | Durable medical equipment                    | 10% coinsurance                             | 30% coinsurance                                 | ---none---  |
|   | Hospice service                              | 10% coinsurance                             | 30% coinsurance                                 | Preauthorization is required.   |
| <b>If your child needs dental or eye care</b>                                 | Eye exam                                     | Covered                                     | Covered   | Refer to benefits booklet for details.  |
|   | 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
- 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](http://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](http://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, kwijjigo holne' 1-855-267-0214.

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

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## 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 \$5,520
- Patient pays \$2,020

#### 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           |
| <b>Total</b>               | <b>\$7,540</b> |

#### Patient pays:

|                      |                |
|----------------------|----------------|
| Deductibles          | \$4,500        |
| Copays               | \$20           |
| Coinsurance          | \$300          |
| Limits or exclusions | \$200          |
| <b>Total</b>         | <b>\$5,020</b> |

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

- Amount owed to providers: \$5,400
- Plan pays \$3,550
- Patient pays \$1,850

#### 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          |
| <b>Total</b>                   | <b>\$5,400</b> |

#### Patient pays:

|                      |                |
|----------------------|----------------|
| Deductibles          | \$2,400        |
| Copays               | \$800          |
| Coinsurance          | \$0            |
| Limits or exclusions | \$80           |
| <b>Total</b>         | <b>\$3,280</b> |

Note: These examples are based on individual coverage only.

## 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](http://www.bcbstx.com).

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