City of Edinburg Benefits Guidebook 2026-2027

INSURANCE CARRIERS

Core Benefits

Medical, Dental, Vision, Life Insurance & Long Term Disability

- **Blue Cross Blue Shield (Health)**
  - **Website www.bcbstx.com**
  - **Customer Service: 1-800-521-2227**

- **Delta Dental (Dental)**
  - **Website: www.deltadentalins.com**
  - **Customer Service:800-521-2651**

- **Davis Vision through AFLAC (Vision)**
  - **Website: www.davisvision.com**
  - **Customer Service: 1-800-999-5431**

- **Dearborn of Blue Cross Blue Shield (Group & Voluntary Life)**
  - **Website: www.dearbornnational.com**
  - **Customer Service: 1-800-348-4512**

- **Madison National (Long-Term Disability)**
  - **Website: www.ochsinc.com**
  - **Customer Service: 1-800-392-7295**

Voluntary Products

Cancer, Accident, Hospital Indemnity, Pet Insurance, Short-term Disability, Legal, Emergency Transportation, Critical Illness, Permanent Life, Loan Program, and 457 options

- **Colonial (Cancer)**
  - **Website: coloniallife.com**
  - **Customer Service: 1-800-325-4368**

- **The Hartford (Accident & Hospital Indemnity)**
  - **Website: www.thehartford.com**
  - **Customer Service: 866-547-4205**

- **Pet Partners, Inc. (Pet Insurance)**
  - **Customer Service: 1-844-738-4242**

- **Voya Financial (Short-Term Disability)**
  - **City of Edinburg pg: https://presents.voya.com/EBRC/cityofedinburg**
    Claims submission: https://eb.voyacdn.com/175506/compass.html
  - **Customer Service: 1-800-955-7736**

- **Texas Legal (Legal Services)**
  - **Website: https://texaslegal.org/**
  - **Customer Service: 1-800-252-9346**

- **MASA (Ambulance and Air Services)**
  - **Representative: Brice Calahan 956-252-6818**
  - **Customer Service: 1-800-423-3226**

- **Wellfleet (Critical Illness)**
  - **Website: www.wellfleetworkplace.com**
  - **Customer Service: 1-855-900-4777**

- **Texas Republic Life Insurance Company (Permanent – Universal Life)**
  - **Customer Service: 800-263-7590**
  - **https://texasrepublicife.com/**

- **Community Loan**
  - **Website: www.rgvcommunityloancenter.com**
  - **Customer Service: 956-356-6600**

- **Nationwide (457 Deferred Compensation Plans)**
  - **Representative: Sarita Null**
  - **Customer Service: 1-877-677-3678**

- **Mission Square Retirement – (457 Deferred Compensation Plans)**
  - **Representative: Sandra Aguilar**
  - **Customer Service: 1-800-669-7400**

- **VOYA (457 Deferred Compensation Plans)**
  - **Representative: Rolando Guerra 956-380-6475**
  - **Customer Service: 1-877-884-5050**

- **Employee Assistance Program (Access to Counselors)**
  - **Website: www.niseap.com**
  - **Customer Service: 1-866-451-5465**

EAP for Employees Only

Special Notice: Government Assistance May Be Available to Help Pay Your Health Care Contributions

This notice is required to be distributed to participants in group health plans sponsored by City of Edinburg. Please refer to the information in your Benefits Guide and Summary Plan Descriptions (SPDs) for more details about your benefits, including other required notices.

Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of January 31, 2016. Contact your State for further information on eligibility.

To see if any more states have added a premium assistance program since January 31, 2016, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, ext. 61565

Texas (Medicaid)	http://www.gethipptexas.com/	1-800-440-0493

THE CITY OF Edinburg

Employee Insurance Premium Rate Sheet
Effective October 01, 2026 - September 30, 2027

BlueCross BlueShield
HMO Health Insurance (Low Plan)

	Monthly Premium	City Share Monthly	Employee Share Monthly	Employee Share Per Pay Period
Employee Only	$582.62	$582.62	$0.00	$0.00
Employee & Child(ren)	$906.96	$726.96	$180.00	$90.00
Employee & Spouse	$1,415.58	$1,095.58	$320.00	$160.00
Employee & Family	$1,638.93	$1,113.93	$525.00	$262.50

BlueCross BlueShield
PPO Health Insurance (High Plan)

	Monthly Premium	City Share Monthly	Employee Share Monthly	Employee Share Per Pay Period
Employee Only	$642.62	$582.62	$60.00	$30.00
Employee & Child(ren)	$1,022.50	$780.68	$241.82	$120.91
Employee & Spouse	$1,575.04	$1,176.39	$398.65	$199.33
Employee & Family	$1,826.43	$1,197.34	$629.09	$314.55

Delta Dental
Dental Insurance (Low Plan)

	Monthly Premium	City Share Monthly	Employee Share Monthly	Employee Share Per Pay Period
Employee Only	$6.42	$6.42	$0.00	$0.00
Employee & Child(ren)	$14.63	$6.42	$8.21	$4.11
Employee & Spouse	$15.94	$6.42	$9.52	$4.76
Employee & Family	$20.44	$6.42	$14.02	$7.01

Delta Dental
Dental Insurance (High Plan)

	Monthly Premium	City Share Monthly	Employee Share Monthly	Employee Share Per Pay Period
Employee Only	$27.18	$6.42	$20.76	$10.38
Employee & Child(ren)	$61.61	$6.42	$55.19	$27.60
Employee & Spouse	$63.06	$6.42	$56.64	$28.32
Employee & Family	$83.30	$6.42	$76.88	$38.44

AFLAC (Davis Vision)
Vision Insurance (Low Plan)

	Monthly Premium	City Share Monthly	Employee Share Monthly	Employee Share Per Pay Period
Employee Only	$5.09	$0.00	$5.09	$2.55
Employee & Child(ren)	$9.95	$0.00	$9.95	$4.98
Employee & Spouse	$8.89	$0.00	$8.89	$4.45
Employee & Family	$13.93	$0.00	$13.93	$6.97

AFLAC (Davis Vision)
Vision Insurance (High Plan)

	Monthly Premium	City Share Monthly	Employee Share Monthly	Employee Share Per Pay Period
Employee Only	$8.05	$0.00	$8.05	$4.03
Employee & Child(ren)	$17.20	$0.00	$17.20	$8.60
Employee & Spouse	$14.71	$0.00	$14.71	$7.36
Employee & Family	$21.64	$0.00	$21.64	$10.82

Dearborn National - Life Insurance Note: Rate Coverage is Dependent on Age and Coverage Amount				
	Monthly Premium	**City Share Monthly**	**Employee Share Monthly**	**Employee Share Per Pay Period**
Employee Only (incl. AD&D)	$0.50	$0.50	$0.00	$0.00
Buy-Up Dep. Child(ren) ($10,000)	$1.28	$0.00	$1.28	$0.64
Buy-Up Employee (Max up to $500,000) (Guarantee Issue $100,000- New Hire only)	Starts 0.64 per $1,000	$0.00	Dependent on Employee Election Options	Dependent on Employee Election Options
Buy-Up Spouse (Max up to $200,000) (Guarantee Issue $25,000- New Hire only)	Starts .064 per $1,000	$0.00	Dependent on Employee Election Options	Dependent on Employee Election Options

Madison National - Long Term Disability 100% Employer Paid	
Coverage	**Rate per $100 of covered payroll per month**
Long Term Disability	$0.19

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, call 1-800-521-2227 or at https://policy-srv.box.com/s/g5df1kpa5wktp9ekvm5hjbmdzqhufzam.
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?	For In-Network: $2,000 Individual / $4,000 Family For Out-of-Network: $4,000 Individual / $8,000 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. Services that charge a copayment, prescription drugs, emergency room services, inpatient hospital expenses, certain preventive care, and In-Network diagnostic tests, home health, skilled nursing, and hospice 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?	Yes. Per occurrence: $250 Out-of-Network inpatient admission. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	For In-Network: $6,500 Individual / $13,000 Family For Out-of-Network: $19,500 Individual / $39,000 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 or call 1-800-810-2583 for a list of network 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?	No.	You can see the specialist you choose without a referral.

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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (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	$35/visit; deductible does not apply	30% coinsurance after deductible	Virtual visits are available, please refer to your plan policy for more details.
	Specialist visit	$50/visit; deductible does not apply	30% coinsurance after deductible	None
	Preventive care/screening/ immunization	No Charge; deductible does not apply	30% coinsurance after deductible	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. No Charge for child immunizations Out-of-Network through the 6th birthday.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge; deductible does not apply	30% coinsurance after deductible	Office visit copayment may apply.
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	50% coinsurance after deductible	None

*For more information about limitations and exceptions, see the plan or policy document at https://policy-srv.box.com/s/g5df1kpa5wktp9ekvm5hjbmdzqhufzam.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
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 retail/$37.50 mail order/prescription; deductible does not apply	$15/prescription plus 30% coinsurance; deductible does not apply	Retail covers a 30-day supply. With appropriate prescription, up to a 90-day supply is available. Mail order covers a 90-day supply. Out-of-Network mail order is not covered. Payment of the difference between the cost of a brand name drug and a generic may be required if a generic drug is available. For Out-of-Network pharmacy, member must file claim. Certain drugs require approval before they will be covered. The cost-sharing for insulin included in the drug list will not exceed $25 per prescription for a 30-day supply, regardless of the amount or type of insulin needed to fill the prescription.
	Preferred brand drugs	$35 retail/$87.50 mail order/prescription; deductible does not apply	$35/prescription plus 30% coinsurance; deductible does not apply	
	Non-preferred brand drugs	$55 retail/$137.50 mail order/prescription; deductible does not apply	$55/prescription plus 30% coinsurance; deductible does not apply	
	Specialty drugs	35% coinsurance; deductible does not apply	50% coinsurance; deductible does not apply	For In-Network benefit, specialty drugs must be obtained from In-Network specialty pharmacy provider. Specialty retail limited to a 30-day supply. Mail order is not covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	50% coinsurance after deductible	None
	Physician/surgeon fees	20% coinsurance after deductible	50% coinsurance after deductible	None
If you need immediate medical attention	Emergency room care	$350/visit plus 20% coinsurance; deductible does not apply	$350/visit plus 20% coinsurance; deductible does not apply	Emergency room copayment waived if admitted.
	Emergency medical transportation	20% coinsurance after deductible	20% coinsurance after deductible	Ground and air transportation covered.
	Urgent care	$100/visit; deductible does not apply	30% coinsurance after deductible	You may have to pay for services that are not covered by the visit fee. For an example, see "If you have a test" on page 2.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance; deductible does not apply	50% coinsurance; deductible does not apply	Plan deductible does not apply; a per-admission deductible of $250 does apply Out-of-Network.
	Physician/surgeon fees	20% coinsurance; deductible does not apply	50% coinsurance; deductible does not apply	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35/office visit; deductible does not apply 20% coinsurance after deductible for other outpatient services	30% coinsurance after deductible office visit 50% coinsurance after deductible for other outpatient services	Certain services must be preauthorized; refer to your benefit booklet* for details. Virtual visits are available, please refer to your plan policy for more details.
	Inpatient services	20% coinsurance; deductible does not apply	50% coinsurance; deductible does not apply	Plan deductible does not apply; a per-admission deductible of $250 does apply Out-of-Network.
If you are pregnant	Office visits	$35 PCP/ $50 SPC; deductible does not apply	30% coinsurance after deductible	Copayment applies to first prenatal visit (per pregnancy). Cost sharing does not apply for preventive services. Depending on the type of services, a copayment or coinsurance may apply. Maternity care may include tests and service described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance; deductible does not apply	50% coinsurance; deductible does not apply	
	Childbirth/delivery facility services	20% coinsurance; deductible does not apply	50% coinsurance; deductible does not apply	Plan deductible does not apply; a per-admission deductible of $250 does apply Out-of-Network.

*For more information about limitations and exceptions, see the plan or policy document at https://policy-srv.box.com/s/g5df1kpa5wktp9ekvm5hjbmdzqhufzam.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance; deductible does not apply	50% coinsurance after deductible	Limited to 60 visits per calendar year. Preauthorization is required.
	Rehabilitation services	$35 PCP/ $50 SPC/visit; deductible does not apply 20% coinsurance after deductible for other outpatient services	30% coinsurance after deductible office visit 50% coinsurance after deductible for other outpatient services	Limited to 35 visits combined for all therapies per calendar year. Includes, but is not limited to, occupational, physical, and manipulative therapy.
	Habilitation services	$35 PCP/ $50 SPC/visit; deductible does not apply 20% coinsurance after deductible for other outpatient services	30% coinsurance after deductible office visit 50% coinsurance after deductible for other outpatient services	
	Skilled nursing care	20% coinsurance; deductible does not apply	50% coinsurance after deductible	Limited to 60 visits per calendar year.
	Durable medical equipment	20% coinsurance after deductible	50% coinsurance after deductible	None
	Hospice services	20% coinsurance; deductible does not apply	50% coinsurance after deductible	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	$35 PCP/ $50 SPC; deductible does not apply	30% coinsurance after deductible	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

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.)

- 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
- 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
- Hearing aids (1 per ear per 36-month period)
- Routine eye care (Adult)

*For more information about limitations and exceptions, see the plan or policy document at https://policy-srv.box.com/s/g5df1kpa5wktp9ekvm5hjbmdzqhufzam.

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	**$2,000**
Specialist copayment	**$50**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	
Deductibles	$2,000
Copayments	$50
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,010**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$2,000**
Specialist copayment	**$50**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	
Deductibles	$800
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,620**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$2,000**
Specialist copayment	**$50**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

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	
Deductibles	$1,300
Copayments	$600
Coinsurance	$80
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,980**

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

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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?	$1,250 Individual / $3,750 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. Services that charge a copayment, prescription drugs, and preventive care 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?	$6,500 Individual / $13,000 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 or call 1-800-810-2583 for a list of network 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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (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	$35/visit; deductible does not apply	Not Covered	None
	Specialist visit	$50/visit; deductible does not apply	Not Covered	Referral required.
	Preventive care/screening/ immunization	No Charge; deductible does not apply	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible	Not Covered	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	Not Covered	None

*For more information about limitations and exceptions, see the plan or policy document at https://policy-srv.box.com/s/toazv42sacf45x53kg866nym8if44fwn.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbstx.com	Preferred generic drugs	$15 retail/$37.50 mail order/prescription; deductible does not apply	Not Covered	Retail covers a 30-day supply. With appropriate prescription, up to a 90-day supply is available. Mail order covers a 90-day supply. Payment of the difference between the cost of a brand name drug and a generic may be required if a generic drug is available. Certain drugs require approval before they will be covered. The cost-sharing for insulin included in the drug list will not exceed $25 per prescription for a 30-day supply, regardless of the amount or type of insulin needed to fill the prescription.
	Non-preferred generic drugs	$30 retail/$75 mail order/prescription; deductible does not apply	Not Covered	
	Preferred brand drugs	$45 retail/$112.50 mail order/prescription; deductible does not apply	Not Covered	
	Non-preferred brand drugs	$60 retail/$150 mail order/prescription; deductible does not apply	Not Covered	
	Specialty drugs	$150/prescription; deductible does not apply	Not Covered	Specialty drugs must be obtained from In-Network specialty pharmacy provider. Specialty retail limited to a 30-day supply. Mail order is not covered.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	Not Covered	None
	Physician/surgeon fees	20% coinsurance after deductible	Not Covered	None
If you need immediate medical attention	Emergency room care	$350/visit plus 20% coinsurance; deductible does not apply	$350/visit plus 20% coinsurance; deductible does not apply	Emergency room copayment waived if admitted.
	Emergency medical transportation	20% coinsurance after deductible	20% coinsurance after deductible	Ground and air transportation covered.
	Urgent care	$100/visit; deductible does not apply	Not Covered	You may have to pay for services that are not covered by the visit fee. For an example, see "If you have a test" on page 2.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	Not Covered	None
	Physician/surgeon fees	20% coinsurance after deductible	Not Covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35/office visit; deductible does not apply 20% coinsurance after deductible for other outpatient services	Not Covered	Certain services must be preauthorized; refer to your benefit booklet* for details.
	Inpatient services	20% coinsurance after deductible	Not Covered	None
If you are pregnant	Office visits	$35 PCP/ $50 SPC; deductible does not apply	Not Covered	Copayment applies to first prenatal visit (per pregnancy). Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and service described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance after deductible	Not Covered	
	Childbirth/delivery facility services	20% coinsurance after deductible	Not Covered	None

*For more information about limitations and exceptions, see the plan or policy document at https://policy-srv.box.com/s/toazv42sacf45x53kg866nym8if44fwn.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	Not Covered	None
	Rehabilitation services	$35 PCP/ $50 SPC/visit; deductible does not apply 20% coinsurance after deductible for other outpatient services and inpatient services	Not Covered	None
	Habilitation services	$35 PCP/ $50 SPC/visit; deductible does not apply 20% coinsurance after deductible for other outpatient services and inpatient services	Not Covered	
	Skilled nursing care	20% coinsurance after deductible	Not Covered	Limited to 60 days per calendar year. Preauthorization is required.
	Durable medical equipment	20% coinsurance after deductible	Not Covered	None
	Hospice services	20% coinsurance after deductible	Not Covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	$35 PCP/ $50 SPC; deductible does not apply	Not Covered	None
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

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.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs

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

- Cosmetic surgery (limited coverage services)
- Dental care (Adult and children, limited coverage services)
- Hearing aids (1 per ear per 36-month period)
- Infertility treatment (diagnosis of infertility covered; invitro not covered)
- Routine eye care (Adult)

*For more information about limitations and exceptions, see the plan or policy document at https://policy-srv.box.com/s/toazv42sacf45x53kg866nym8if44fwn.

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	$1,250
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	
Deductibles	$1,250
Copayments	$50
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,660**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,250
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	
Deductibles	$900
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,720**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,250
Specialist copayment	$50
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	
Deductibles	$1,250
Copayments	$300
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,750**

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