

Summary of Coverage: What this Plan Covers & What it Costs

Plan Type: HDHP / PPO



THIS IS NOT A SUMMARY PLAN DESCRIPTION (SPD). You can get the SPD at www.caresbenefits.org or by calling Human Resources at 972-721-5382. A SPD has more detail about how to use the plan and what you and the plan administrator must do. It also has more details about your coverage and costs.

Important Questions	Answers	Why this Matters:						
What is the premium ?	Please refer to the separate rate sheet.	The premium is the amount you pay for coverage by this health plan .						
What is the overall deductible ?	<table border="0"> <tr> <td style="text-align: center;"><u>In-network:</u></td> <td style="text-align: center;"><u>Out-of-network:</u></td> </tr> <tr> <td style="text-align: center;">Individual: \$2,400</td> <td style="text-align: center;">Individual: \$2,400</td> </tr> <tr> <td style="text-align: center;">Family: \$4,800</td> <td style="text-align: center;">Family: \$4,800</td> </tr> </table>	<u>In-network:</u>	<u>Out-of-network:</u>	Individual: \$2,400	Individual: \$2,400	Family: \$4,800	Family: \$4,800	You must pay all the costs up to the deductible amount before this health plan begins to pay for covered services you use. The deductible starts over on January 1st every year. See the chart beginning on page 2 for how much you pay for covered services after you meet the deductible. <i>Note: See the separate document for the HDHP prescription plan.</i>
<u>In-network:</u>	<u>Out-of-network:</u>							
Individual: \$2,400	Individual: \$2,400							
Family: \$4,800	Family: \$4,800							
Are there other deductibles for specific services?	No	The overall deductible applies to all covered services, including prescription drugs . Refer to the separate document for more information about prescription drug coverage.						
Is there an out-of-pocket limit on my expenses?	<table border="0"> <tr> <td style="text-align: center;"><u>In-network:</u></td> <td style="text-align: center;"><u>Out-of-network:</u></td> </tr> <tr> <td style="text-align: center;">Individual: \$5,950</td> <td style="text-align: center;">Individual: \$5,950</td> </tr> <tr> <td style="text-align: center;">Family: \$11,900</td> <td style="text-align: center;">Family: \$11,900</td> </tr> </table>	<u>In-network:</u>	<u>Out-of-network:</u>	Individual: \$5,950	Individual: \$5,950	Family: \$11,900	Family: \$11,900	The out-of-pocket limit is the most you could pay during a plan year for your share of the cost of covered services. This limit helps you plan for health care expenses.
<u>In-network:</u>	<u>Out-of-network:</u>							
Individual: \$5,950	Individual: \$5,950							
Family: \$11,900	Family: \$11,900							
What is not included in the out-of-pocket limit ?	Premium, balance-billed charges, health care this plan doesn't cover and penalties for failure to obtain prior authorization of services do not count toward the limit.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .						
Is there an overall annual limit on what the plan pays?	No. This plan has no overall annual limit on the amount it will pay each year.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services such as office visits.						
Does this plan use a network of providers?	Yes, this plan uses BCBSTX network. You may use out-of-network providers but you may pay more.	For a list of network providers, go to: www.bcbstx.com or call 1-888-762-2190						
Do I need a referral to see a specialist ?	No. this plan does not require you to obtain a referral to see a specialist .	You can see the specialist you choose without permission from this plan.						
Are there any services this plan doesn't cover?	Yes.	Some of the services this plan does not cover are listed on page 3.						

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- **Co-insurance** is *your* share of the cost of a covered service, calculated as a percent of the **allowed amount** for the service. You pay this plus any deductible amounts you owe under this plan. For example, if the health plan's allowed amount for an overnight hospital stay is \$1,000 and you've met your deductible, your co-insurance payment of 20% would be \$200. If you haven't met any of the deductible, you would pay the entire cost of the hospital stay for a total of \$1,000 and you would satisfy \$1,000 toward the deductible.
- The plan's payment 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**).

Common Medical Event	Services You May Need	Your cost if you use		Limitations and Exceptions
		In-network Providers	Out-of-network Providers	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% co-insurance*	40% co-insurance*	* after deductible is satisfied
	Specialty care visit to treat an injury or illness	20% co-insurance*	40% co-insurance*	* after deductible is satisfied
	Physical Therapy or Occupational Therapy	20% co-insurance*	40% co-insurance*	* after deductible is satisfied
	Speech Therapy	20% co-insurance*	40% co-insurance*	* after deductible is satisfied
	Preventive care / screening / immunization	\$0	**	** plan pays 100% of allowed amount
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance*	40% co-insurance*	* after deductible is satisfied
	Imaging (CT, PET scan, MRI, etc.)	20% co-insurance*	40% co-insurance*	* after deductible is satisfied
If you have out-patient surgery	Facility fee (e.g. ambulatory surgery center)	20% co-insurance*	40% co-insurance*	* after deductible is satisfied
	Physician / surgeon fees	20% co-insurance*	40% co-insurance*	* after deductible is satisfied
If you need immediate medical attention	Emergency room services	20% co-insurance*	40% co-insurance*	* after deductible is satisfied
	Emergency medical transportation	20% co-insurance*	40% co-insurance*	* after deductible is satisfied
	Urgent Care	20% co-insurance*	40% co-insurance*	* after deductible is satisfied
If you have a hospital stay	Facility fee (e.g. hospital room)	20% co-insurance*	40% co-insurance*	* after deductible is satisfied
	Physician / surgeon fees	20% co-insurance*	40% co-insurance*	* after deductible is satisfied
If you need mental health, behavioral health or substance abuse treatment	Outpatient Office visits	20% co-insurance*	40% co-insurance*	* after deductible is satisfied
	Inpatient services	20% co-insurance*	40% co-insurance*	* after deductible is satisfied

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Common Medical Event	Services You May Need	Your cost if you use		Limitations and Exceptions
		In-network Providers	Out-of-network Providers	
If you become pregnant	Prenatal and postnatal care	20% co-insurance*	40% co-insurance*	* after deductible is satisfied
	Delivery and all inpatient services	20% co-insurance*	40% co-insurance*	* after deductible is satisfied
If you have a recovery or other special need	Home health care	20% co-insurance*	40% co-insurance*	* after deductible is satisfied
	Rehabilitation services	20% co-insurance*	40% co-insurance*	* after deductible is satisfied
	Skilled nursing care	20% co-insurance*	40% co-insurance*	* after deductible is satisfied
	Durable medical equipment	20% co-insurance*	40% co-insurance*	* after deductible is satisfied
	Hospice care	20% co-insurance*	40% co-insurance*	* after deductible is satisfied

Excluded Services and Other Covered Services

Services Your Plan Does NOT Cover (This isn't a complete list. Check your SPD for others.)

- Bariatric surgery
- Non-emergency Care when traveling outside the United States
- Cosmetic surgery
- Birth control and sterilization
- Dental care
- Long-term care
- Routine foot care
- Weight loss programs
- Charges in excess of the allowed amount
- Experimental and investigational services
- Any services and supplies not medically necessary

Other Covered Services (This isn't a complete list. Check your SPD for other covered services and your costs for these services.)

- Chiropractic Care
- Acupuncture and acupressure
- Hearing Aids
- Prosthetic appliances
- Chemotherapy
- Home infusion therapy
- Radiation therapy
- Organ and tissue transplants
- Serious mental illness

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Your Rights to Continue Coverage:

Under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1983 (COBRA), Participants may have the right to continue coverage after the date coverage ends:

1. for 18-months if coverage terminates as the result of termination of employment (other than for gross misconduct) or reduction of hours, or
2. a covered Dependent may elect to continue coverage for 36 months if coverage terminates as a result of divorce, death of the employee, the Employee becomes eligible for Medicare or the Dependent child no longer meets the Plan's eligibility requirements.

COBRA continuation under the Plan ends at the earliest of the following events:

1. The last day of the eighteen (18) month period for events with a maximum continuation of eighteen (18) months.
2. The last day of the thirty-six (36) month period for events with a maximum continuation of thirty-six (36) months.
3. The first day for which timely payment of contribution is not made to the plan.
4. The Group Health Plan is canceled.
5. The date, after the date of the election upon which the qualified beneficiary first becomes covered under any other group health plan.
6. The date, after the date of election, upon which the qualified beneficiary first becomes entitled to Medicare benefits.

Extension of Coverage Period

The eighteen (18) month coverage period may be extended if an event which could otherwise qualify a Participant for the thirty-six (36) month coverage period occurs during the eighteen (18) month period, but in no event may coverage be longer than thirty-six (36) months from the initial qualifying event. If a Participant is determined to be disabled as defined under the Social Security Act and the Participant notifies the Employer before the end of the initial eighteen (18) month period, coverage may be extended up to an additional eleven (11) months for a total of twenty-nine (29) months. This provision is limited to Participants who are disabled at any time during the first sixty (60) days of COBRA continuation and only if the qualifying event is termination of employment (other than for gross misconduct) or reduction of employment hours.

Your Grievance and Appeals Rights:

- A **grievance** is a complaint you have about your health insurer or plan. You have the right to file a written complaint to express your dissatisfaction with this plan or about a denial of coverage for claims under this plan. Call the Plan's administrator, BlueCross BlueShield of Texas (BCBSTX) at 1-888-762-2190 or visit www.bcbstx.com
- An **appeal** is a request for your plan to review a decision or grievance again. For more information on the appeals process, call the Plan's administrator at 1-888-762-2190 or visit www.caresbenefits.org.

Medical Coverage Examples

Plan Type: HDHP / PPO

About these Coverage Examples:

These examples show how this plan might cover medical care in three situations. Use these examples to see, in general, how much coverage the plan provides.

Having a baby <i>(normal delivery)</i>	Treating Breast Cancer <i>(lumpectomy, chemotherapy, radiation)</i>	Managing diabetes <i>(routine maintenance of condition)</i>
<ul style="list-style-type: none"> Amount owed to providers: \$10,000 Plan pays: \$6,540 You pay: \$3,460 	<ul style="list-style-type: none"> Amount owed to providers: \$96,000 Plan pays: \$90,050 You pay: \$5,950 	<ul style="list-style-type: none"> Amount owed to providers: \$1,300 Plan pays: \$0 You pay: \$1,300
Sample care costs:	Sample care costs:	Sample care costs:
First office visit \$100	Office visits (24) and procedures \$4,000	Office visits and procedures \$960
Radiology \$300	Radiology \$4,000	Laboratory tests \$300
Laboratory tests \$200	Laboratory tests \$2,400	Medical equipment and supplies \$40
Routine obstetric care \$2,000	Hospital charges \$3,300	Pharmacy ----- <i>(see Rx plan options)</i>
Hospital charges (mother) \$4,100	Inpatient medical care \$200	
Hospital charges (baby) \$1,900	Outpatient surgery \$3,400	
Anesthesia \$1,000	Chemotherapy \$64,000	
Circumcision \$200	Radiation therapy \$13,000	
Vaccines, other preventive \$200	Prostheses (wig) \$500	
Total \$10,000	Pharmacy ----- <i>(see Rx plan options)</i>	
You pay:	Mental health (8 visits) \$1,200	
Deductibles: \$2,400	Total \$96,000	Total \$1,300
Co-payments: NA	You pay:	You pay:
Co-insurance: \$1,060	Deductibles: \$2,400	Deductibles: \$1,300
Limits/exclusions: \$0	Co-payments: NA	Co-payments: NA
Total \$3,460	Co-insurance: \$3,550	Co-insurance: NA
	Limits/exclusions: \$0	Limits/exclusions: \$0
	Total \$5,950	Total \$1,300



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.

Note: Please review the separate document for the HDHP prescription plan. The cost of covered prescription drugs applies to the same deductible and out-of-pocket maximum.

Medical Coverage Examples

Plan Type: HDHP / PPO

Questions and answers about Medical 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 to the U.S. Department of Health and Human Services (HHS) and aren't specific to a particular geographic area or health plan.
- Patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same plan year.
- 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, co-payments and co-insurance 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 health care needs?

✗ No. Treatments shown are just examples. The care you would receive for these conditions 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 comparison 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 Summaries of Coverage for other plans, you'll find the same coverage examples. When you compare plans, check the "You Pay" box for each example. The smaller the 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 co-payments, deductibles and co-insurance. 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 costs.

Summary of Coverage: What this Plan Covers & What it Costs

Plan Type: HDHP Rx



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Important Questions	Answers	Why this Matters:
What is the premium ?	\$0	You do not pay any additional premium for the HDHP prescription plan. If you are enrolled in the HDHP medical plan, you are also enrolled in the HDHP prescription plan.
What is the overall deductible ?	Individual: \$2,400 Family: \$4,800	The same deductible applies to all covered medical and prescriptions. You do not have a separate deductible for prescriptions.
Are there other deductibles for specific services?	No	
Is there an out-of-pocket limit on my expenses?	Individual: \$5,950 Family: \$11,900	The out-of-pocket maximum includes all covered medical services and prescriptions.
What is not included in the out-of-pocket limit ?	Not applicable	
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for covered prescriptions.
Does this plan use a network of providers?	Yes, this plan uses Express Scripts, Inc. This plan does <u>not</u> cover prescription drugs purchased at out-of-network pharmacies.	For a list of network pharmacies, go to: www.express-scripts.com or call 1-866-776-0056
Does this plan require prior authorization for any prescription drugs?	Yes. This plan requires prior authorization for certain prescription drugs.	Drugs that can be prescribed for cosmetic uses, injectable medications and medications newly approved by the FDA are examples of prescriptions that may require prior authorization. Contact your human resources office or Express Scripts at 1-866-776-0056 if you have questions about prior authorization.
Are there any prescription drugs this plan doesn't cover?	Yes.	Some of the prescription drugs not covered by this plan are listed on page 3.

Summary of Coverage: What this Plan Covers & What it Costs

Plan Type: HDHP Rx

Type of prescription medication	Days supply and place of purchase	Your cost at		Limitations and exceptions
		In-network pharmacies	Out-of-network pharmacies	
Generics	30-day supply at a retail pharmacy	20% of the cost *	Not covered	* after deductible is satisfied You may purchase a maximum 30-day supply at retail
	90-day supply at Express Scripts Scripts home delivery (mail)	20% of the cost *	Not covered	* after deductible is satisfied You may purchase a maximum 90-day supply at home delivery
Brand	30-day supply at a retail pharmacy	20% of the cost *	Not covered	* after deductible is satisfied You may purchase a maximum 30-day supply at retail
	90-day supply at Express Scripts Scripts home delivery (mail)	20% of the cost *	Not covered	* after deductible is satisfied You may purchase a maximum 90-day supply at home delivery
Non-formulary	30-day supply at a retail pharmacy	20% of the cost *	Not covered	* after deductible is satisfied You may purchase a maximum 30-day supply at retail
	90-day supply at Express Scripts Scripts home delivery (mail)	20% of the cost *	Not covered	* after deductible is satisfied You may purchase a maximum 90-day supply at home delivery
Specialty Products (includes certain complex & costly medications that may require special handling & storage & are not usually available at your local drug store)	30-90 day supply through the Curascript Specialty pharmacy only.	20% of the cost *	Not covered	* after deductible is satisfied You <u>must</u> purchase specialty medications through Curascript. The amount of medication dispensed at one time may be limited for certain drugs. <u>You may contact Curascript at:</u> 1-866-848-9870

Prescriptions Your Plan Does NOT Cover (This isn't a complete list. Check your SPD for others.)

- | | | |
|---|--------------------------------------|---|
| ● Diet pills or appetite suppressants | ● Implantable contraceptive products | ● Drugs for the treatment of sexual dysfunction |
| ● Prescription vitamins (except for prenatal) | ● Drugs to promote hair growth | ● Biological products for allergy immunization |
| ● infertility drugs | ● Drugs to reduce wrinkles | ● Drugs to enhance athletic performance |
| ● Over-the-counter drugs | ● Drugs deemed to be experimental | ● Replacement of lost or stolen drugs |

Your Grievance and Appeals Rights:

- A **grievance** is a complaint you have about your health insurer or plan. You have the right to file a written complaint to express your dissatisfaction with this plan or about a denial of coverage for claims under this plan. Call the plan's prescription benefit administrator, Express Scripts, Inc. at 1-866-776-0056 or visit www.express-scripts.com.
- An **appeal** is a request for your plan to review a decision or grievance again. For more information on the appeals process, call the Plan's administrator at 1-866-776-0056 or visit www.caresbenefits.org.

Prescription Coverage Examples

Plan Type: HDHP Rx

About these Coverage Examples:

These examples show how this plan might cover *prescription medications* in three situations. Use these examples to see, in general, how much coverage the plan provides.

Having a baby * <i>(normal delivery)</i>	Treating Breast Cancer * <i>(lumpectomy, chemotherapy, radiation)</i>	Managing diabetes * <i>(routine maintenance of condition)</i>
<ul style="list-style-type: none"> Amount owed for prescriptions \$200 Plan pays: \$160 You pay: \$40 	<ul style="list-style-type: none"> Amount owed for prescriptions: \$2,000 Plan pays: \$2,000 You pay: \$0 	<ul style="list-style-type: none"> Amount owed for prescriptions \$6,500 Plan pays: \$4,320 You pay: \$2,180
Sample care costs:	Sample care costs:	Sample care costs:
First office visit \$100	Office visits (24) and procedures \$4,000	Office visits (6) and procedures \$960
Radiology \$300	Radiology \$4,000	Laboratory tests \$300
Laboratory tests \$200	Laboratory tests \$2,400	Medical equipment and supplies \$40
Routine obstetric care \$2,000	Hospital charges \$3,300	Pharmacy \$6,500
Hospital charges (mother) \$4,100	Inpatient medical care \$200	
Hospital charges (baby) \$1,900	Outpatient surgery \$3,400	
Anesthesia \$1,000	Chemotherapy \$64,000	
Circumcision \$200	Radiation therapy \$13,000	
Other preventive - Prescriptions prenatal vitamins \$200	Prostheses (wig) \$500	
Total \$10,000	Pharmacy \$2,000	
You pay: deductible met	Mental health (8 visits) \$1,200	
Deductibles: with medical expenses	Total \$2,000	Total \$6,500
Co-payments: NA	You pay: deductible and OOP met with medical expenses	Deductibles: \$1,100
Co-insurance: \$40	Deductible: met with medical expenses	Co-payments: NA
Limits/exclusions: \$0	Co-payments: NA	Co-insurance: \$1,080
Total \$40	Co-insurance: \$0	Limits/exclusions: \$0
	Limits/exclusions: \$0	Total \$2,180



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See the next page for important information about these examples.

** Coverage examples for the medical services associated with the diagnosis examples on this page are illustrated in the separate document for the HDHP medical plan. Please refer to the separate document to determine how you and the plan share in medical costs.*

Prescription Coverage Examples

Plan Type: HDHP Rx

Questions and answers about Medical Coverage Examples:

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- All services and treatments started and ended in the same plan year.
- There are no other prescription drug expenses for any member covered under this plan. Out-of-pocket expenses are based only on treating the condition in the example.
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✓ **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 co-payments, deductibles and co-insurance. 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 costs.