COGENT Energy Services

2017 Benefits Guide

Your wellness is our focus

What's Inside

Welcome to your 2017-2018 Employee Benefits Guide

We recognize the important role employee benefits plays as a critical component of your overall compensation. As such, Cogent Energy Services continues to make every effort to target the best quality benefit plans for our employees and their families. Our program offers a range of plan options to meet the needs of our diverse workforce. We know that your benefits are important to you and your family, and this program is designed to assist you in providing for the health, well being and financial security of you and your covered dependents.

Benefits Guide Overview

This Guide, along with your Summary of Benefits and Coverage, provides a full explanation of the benefits available to you and your family. At this time, you may elect to enroll in the benefit programs offered. Options selected during this enrollment period will remain in place until August 1, 2018 unless you or your dependents experience a qualified life event.

For the Health of You and Your Family

As an employee the health benefits available to you represent a significant component of your compensation package and they provide important protection to keep you and your family in good health.

Employees

Full time employees who work 30 hours per week are eligible for benefits on the first of the month following 60 days of employment. Eligibility is determined based on your date of hire .

Dependents

In addition to enrolling yourself, you may also enroll any eligible dependents in the medical, dental, vision. Eligible dependents include:

- Spouse (including same sex spouse): a person to whom you are legally married. Such a person remains a spouse until a decree of divorce is issued.

Child:

- a child who is yours by birth or legal adoption;
- your spouse's child by birth or legal adoption;
- one whose medical care is the legal obligation of you or your spouse as per a court order or court approved requirement;
- the subject of a child support order that recognizes the right of that person to receive benefits under your medical coverage, issued by a court or administrative agency of any US State or US Territory;
- your grandchild in the court-ordered custody of you or your spouse;
- a child who is your dependent and who is in the guardianship of you or your spouse;
- a legal dependent child under the age of 26. Coverage will cease at the end of the month in which the dependent reaches age 26.

Disabled Dependent:

- a child who is dependent on you or your spouse as a result of mental or physical incapacity;
- a child who is disabled prior to reaching the maximum age allowed under the plan.

Eligibility

As you make your benefit elections, please keep in mind that these elections and the related payroll deductions generally cannot be canceled or changed until your next open enrollment period. However, you may request to make a change in your coverage if (1) you, your spouse, or your dependent experience a Change-in-Status Event and (2) the Change-in-Status Event affects you, your spouse's or your dependent's eligibility for coverage under this plan or another employer's plan.

Change -in- Event Status

Allowable events are changes in:

- legal marital status, including marriage, divorce, annulment; or death of spouse;
- number of dependents due to birth, adoption, placement for adoption, or death;
- employment for you, your spouse, or your dependent, including commencement or termination;
- hours of employment, including a switch between full-time and part-time status or the commencement or return from a leave of absence;
- eligibility status of your dependent due to attainment of age, change in student status, or any similar circumstance;
- residence or worksite.

Other situations that allow you to make a change in your benefit elections include:

- entitlement to a special enrollment right;
- taking a leave under the Family Medical Leave Act;
- complying with a judgment, decree or order that requires you, a former spouse or another living individual to obtain health or accident coverage for a child who is your dependent;
- entitlement to coverage or loss of eligibility for coverage under Medicare or Medicaid for you, your spouse, or your dependent;
- an election or change under your spouse or dependent's employer's plan during an open enrollment period that does not correspond with this plan's open enrollment period;
- change of dependent care provider or imposition of a cost change for the dependent care provider.

A request for a benefit election change cannot be processed unless:

- the Division of Human Resources is notified within 30 days of the Change-in-Status Event; and
- documentation is provided to support the change requested; and
- the change is permitted under the terms of the plan document or insurance contract.

Coverage will begin on the first of the month following the Change-in-Status, unless the change is due to the birth, adoption, or placement of a child in which case coverage is effective on the date of birth, adoption or placement.

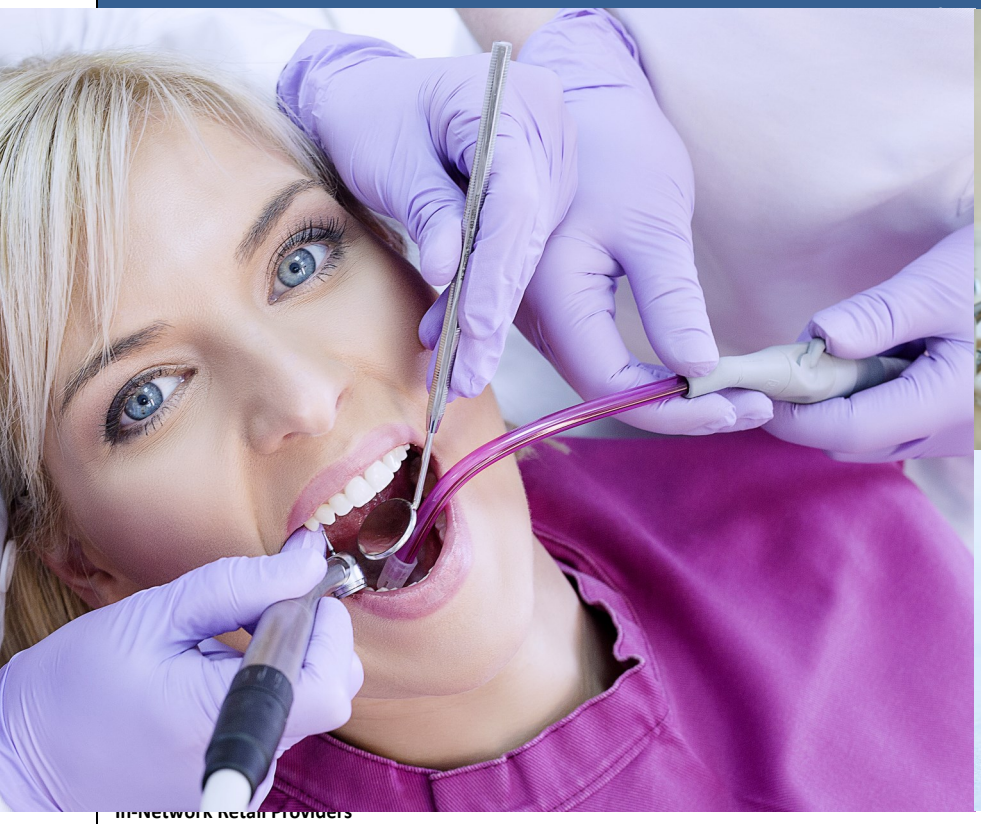
Resource Directory

Carrier/ Coverage	Phone Number	Website
Blue Cross Blue Shield of Texas Medical & Dental	**Member Services:** 800-521-2227	www.bcbstx.com/member
EyeMed Vision	**Member Services:** 866-723-0513	www.eyemed.com
Employee Benefits Corporation Flexible Spending Account	**Member Services:** 800-346-2126	www.ebcflex.com

Medical Coverage - BCBS TX		
Type of Plan	**Best Choice PPO RS30**	
Deductible (Calendar Year)	**In-Network**	**Out-of-Network**
Individual	$5,000	$10,000
Family	$15,000	$30,000
Out-of-Pocket-Maximum (Calendar Year)	**Includes Coinsurance (Medical & Rx)**	
Individual	$0	$10,000
Family	$0	$30,000
Coinsurance	Plan pays 100% after the deductible	Plan pays 70% after deductible
Physician's Office Visits		
Primary Care	$30 Copay, deductible waived	Plan pays 70% after deductible
Specialist	$55 Copay, deductible waived	Plan pays 70% after deductible
Preventive Care Services	Plan pays 100%	Plan pays 70% after deductible
Maternity	Plan pays 100% after the deductible	Plan pays 70% after deductible
Hospital Inpatient Expenses *(Facility Charges)*	Plan pays 100% after the deductible	Plan pays 70% after deductible
Hospital Outpatient Expenses *(Facility Charges)*	Plan pays 100% after the deductible	Plan pays 70% after deductible
Emergency Room *(Facility Charges)*	$100 Copay per visit	$100 Copay per visit
Urgent Care	$55 Copay / visit	Plan pays 70% after deductible
Mental Health/Behavioral Treatment Services		
Inpatient	Plan pays 100% after the deductible	Plan pays 70% after deductible
Outpatient	Plan pays 100% after $30 Copay	Plan pays 70% after deductible
Alcohol/Drug Abuse Treatment Services		
Inpatient	Plan pays 100% after the deductible	Plan pays 70% after deductible
Outpatient	Plan pays 100% after the deductible	Plan pays 70% after deductible
Prescription Drugs		
Retail Pharmacy	*$10 for Tier 1 drugs* *$40 for Tier 2 drugs* *$60 for Tier 3 drugs*	20% coinsurance plus copy
Mail Order Maintenance Drug	*$10 for Tier 1 drugs* *$40 for Tier 2 drugs* *$60 for Tier 3 drugs*	
Contact Information	www.bcbstx.com	1.800.521.2227

Medical Coverage - BCBS TX		
Type of Plan	**Best Choice PPO RS41**	
Deductible (Calendar Year)	**In-Network**	**Out-of-Network**
Individual	$10,000	$10,000
Family	$30,000	$30,000
Out-of-Pocket-Maximum (Calendar Year)	**Includes Coinsurance (Medical & Rx)**	
Individual	$0	$10,000
Family	$0	$30,000
Coinsurance	Plan pays 100% after the deductible	Plan pays 70% after deductible
Physician's Office Visits		
Primary Care	$25 Copay, deductible waived	Plan pays 70% after deductible
Specialist	$25 Copay, deductible waived	Plan pays 70% after deductible
Preventive Care Services	Plan pays 100%	Plan pays 70% after deductible
Maternity	Prenatal and postnatal care: $25 copay / visit Delivery and all inpatient services: Plan pays 100% after the deductible	Plan pays 70% after deductible
Hospital Inpatient Expenses *(Facility Charges)*	Plan pays 100% after the deductible	Plan pays 70% after deductible
Hospital Outpatient Expenses *(Facility Charges)*	Plan pays 100% after the deductible	Plan pays 70% after deductible
Emergency Room	$100 Copay per visit	$100 Copay per visit
Urgent Care	$50 Copay / visit	Plan pays 70% after deductible
Mental Health/Behavioral Treatment Services		
Inpatient	Plan pays 100% after the deductible	Plan pays 70% after deductible
Outpatient	Plan pays 100% after the deductible	Plan pays 70% after deductible
Alcohol/Drug Abuse Treatment Services		
Inpatient	Plan pays 100% after the deductible	Plan pays 70% after deductible
Outpatient	Plan pays 100% after the deductible	Plan pays 70% after deductible
Prescription Drugs		
Retail Pharmacy	$15 for Tier 1 drugs $40 for Tier 2 drugs $60 for Tier 3 drugs $15/$40/$60 copay/prescription for Specialty drugs	20% coinsurance plus copy
Mail Order Maintenance Drug	$15 for Tier 1 drugs $40 for Tier 2 drugs $60 for Tier 3 drugs No mail order for Specialty drugs	20% coinsurance plus copy
Contact Information	www.bcbstx.com	1.800.521.2227

Dental Coverage - BCBSTX		
Type of Plan	**PPO Plan DTXLRO5**	
	In-Network	**Out-of-Network** *Reasonable and Customary Apply*
Deductible - Applies to Basic and Major Services only (Calendar Year)		
Individual	$50	$50
Family	$150	$150
Annual Maximum	$1500	$1500
Preventive	100% Oral Exams, X-rays, Cleanings	100% Oral Exams, X-rays, Cleanings
Basic	80% Fillings, Periodontics, Simple Extractions	80% Fillings, Periodontics, Simple Extractions
Major	50% Crowns, Dentures, Bridges, Root Canals, Surgical Extractions	50% Crowns, Dentures, Bridges, Root Canals, Surgical Extractions
Orthodontia	Not Covered	Not Covered
Contact Information	www.bcbstx.com	1.800.521.2227



In-Network Retail Providers **Private Practitioners**

Dental

Dental Benefits

BlueCross BlueShield of Texas

BlueCare Dental℠

Plan ID: DTXLR05

This information only provides a summary of the benefits for this Dental Plan. Please refer to your Dental Benefit Booklet for additional benefit information. The Deductibles, Coinsurance and Benefit Period Maximum shown below are subject to change as permitted by applicable law.

Summary of Dental Benefits

Program Basics

Benefit Period Maximum	$1,500
Deductible	$50 Individual/$150 Family

Covered Services

Diagnostic Evaluations Periodic oral evaluations Problem focused oral evaluations Comprehensive oral evaluations	100% (Deductible waived)
Preventive Services Prophylaxis (cleanings) Topical fluoride applications	100% (Deductible waived)
Diagnostic Radiographs Full-mouth and panoramic films Bitewing films Periapical films	100% (Deductible waived)
Miscellaneous Preventive Services Sealants Space maintainers	80%
Basic Restorative Dental Services Amalgams Resin-based composite restorations	80%
Non-Surgical Extractions Removal of retained coronal remnants Removal of erupted tooth or exposed root	80%
Non-Surgical Periodontal Services Periodontal scaling and root planing Full-mouth debridement Periodontal maintenance procedures	80%
Adjunctive Services Palliative treatment (emergency) Deep sedation / general anesthesia	80%
Endodontic Services Therapeutic pulpotomy and pulpal debridement Root canal therapy Apexification/recalcification	50%

Dental Benefits

Covered Services (continued)

Oral Surgery Services Surgical tooth extractions Alveoloplasty and vestibuloplasty Excision of benign odontogenic tumor/cyst Excision of bone tissue Incision and drainage of an intraoral abscess	50%
Surgical Periodontal Services Gingivectomy or gingivoplasty and gingival flap procedures Clinical crown lengthening Osseous surgery Osseous grafts Soft tissue grafts/allografts Distal or proximal wedge procedure Anatomical crown exposures	50%
Major Restorative Services Single crown restorations Gold foil and inlay/onlay restorations Labial veneer restorations Crowns placed over implants	50%
Prosthodontic Services Complete and removable partial dentures Denture reline/rebase procedures Fixed bridgework Prosthetics placed over implants	50%
Miscellaneous Restorative and Prosthodontic Services Prefabricated crowns Recementations Post and core, pin retention and crown/bridge repairs Adjustments	50%

Orthodontic Services

Orthodontic Services Orthodontic Diagnostic Procedures and Treatment Lifetime Maximum per Participant	Not Covered

Dental implants are not covered.

The above is a listing of common services available through your network of Participating Dentists.
The Member's share of the cost is determined by whether care is received from a Participating or Non-Participating Dentist.

Services from non-participating providers will be subject to reasonable and customary allowances, as determined by the Company. Amounts in excess of these allowances will be the full responsibility of the insured.

Orthodontia	Not Covered	Not Covered
Contact Information	www.bcbstx.com	1.800.521.2227
Vision Coverage - Eyemed		
Eye Exam	**Every 12 Months**	
	$10 Copay	Reimbursed up to $40
Prescription Lenses	**Every 12 Months**	
Single	$15 Copay	Reimbursed up to $30
Bifocal	$15 Copay	Reimbursed up to $50
Trifocal	$15 Copay	Reimbursed up to $70
Progressive	Standard - $80 Copay Premium - Copay varies	Reimbursed up to $50
Frames	**Every 24 Months**	
	$130 Allowance +20 % off balance over $130	Reimbursed up to $91
Contact Lens Benefit	**Every 12 Months**	
Conventional	$130 Allowance + 15% off balance over $130	Reimbursed up to $130
Contact Information	www.eyemed.com	1.866.800.5457
In-Network Retail Providers	* LensCrafters * Pearle Vision * Sears Optical * Target Optical * JC Penney Optical * Private Practitioners	

Vision

Vision Benefits

Animas Well Services

Proposed Benefits

EyeMed Vision Care in conjunction with Fidelity Security Life Insurance Company

Option 1

Exam and Materials

Insight Network

Fully Insured

Employee Paid

Funded Benefits

Frequency

Examination
Once every 12 months

Lenses or Contact Lenses
Once every 12 months

Frame
Once every 24 months

Vision Care Services	Member Cost In-Network	Out of Network Member Reimbursement up to:
Exam *With Dilation as Necessary*	$10 copay	$40
Frames *Any available frame at provider location*	$0 copay; $130 allowance, 20% off balance over $130	$91
Contact Lenses *(Contact Lens allowance includes materials only)*		
Conventional	$0 copay, $130 allowance, 15% off balance over $130	$130
Disposable	$0 copay, $130 allowance, plus balance over $130	$130
Medically Necessary	$0 copay, Paid-In-Full	$210
Standard Plastic Lenses		
Single Vision	$15 copay	$30
Bifocal	$15 copay	$50
Trifocal	$15 copay	$70
Lenticular	$15 copay	$70
Standard Progressive	$80 copay	$50
Premium Progressive Tier 1	$100 Copay	$50
Premium Progressive Tier 2	$110 Copay	$50
Premium Progressive Tier 3	$125 Copay	$50
Premium Progressive Tier 4	$80 Copay, 20% off charge less $120 Allowance	$50

Monthly Rate	
Subscriber	$7.44
Subscriber + Spouse	$14.13
Subscriber + Child(ren)	$14.87
Subscriber + Family	$21.87

All plans are based on a 48-month contract term and 48-month rate guarantee
Monthly Rate is subject to adjustment even during a rate guarantee period in the event of any of the following events: changes in benefits, employee contributions, the number of eligible employees, or the imposition of any new taxes, fees or assessments by Federal or State regulatory agencies

EyeMed Vision Care reserves the right to make changes to the products available on each tier. All providers are not required to carry all brands on all tiers. For current listing of brands by tier, visit http://www.discovereyemed.com

Plan Details
Quote for group situsedin the State of TX and will be valid until the 9/1/2016 implementation date. Date Quoted 9/8/2016. Benefit allowances provide no remaining balance for future use within the same benefit frequency. Rates are valid only when the quoted plan is the sole stand-alone vision plan offered by the group. Insured Plans are underwritten by Fidelity Security Life Insurance Company. Policy Number VC-19; Policy Form No. M-9083

Plan Exclusions
No benefits will be paid for services or materials connected with or changes arising from:
-orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses;
-medical and/or surgical treatment of the eye, eyes or supporting structures;
-any Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; safety eyewear;
-services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;
-plano (non-prescription) lenses;
-non-prescription sunglasses;
-two pair of glasses in lieu of bifocals;
-services or materials provided by any other group benefit plan providing vision care;
-services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and services rendered to the Insured Person are within 31 days from the date of such order; or
-lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.

Vision Benefits

Cogent Energy Services

Saving our members some extra green

We're committed to keeping money in our members' pockets

That's why we offer our members additional discounts above the proposed plan benefits.

$avings for Members

40% off
additional pairs of glasses and a 15% discount on conventional lenses once funded benefit is used – an industry exclusive

20% off
any item not covered by the plan, including non-prescription sunglasses

Lasik
Lasik or PRK
15% off retail price or 5% off promotional price

Hearing Care

40% off hearing exams and a low price guarantee on discounted hearing aids

Additional Discounts

Vision Care Services	Member Cost In-Network
Discounted Exam Services	
Retinal Imaging Benefit	Up to $39
Contact Lens Fit and Follow-up	
(Contact lens fit and two follow-up visits are available once a comprehensive eye exam has been completed.)	
Standard Contact Lens Fit & Follow-Up:	Up to $55
Premium Contact Lens Fit & Follow-Up:	10% off retail price
Discounted Lens Options	
Photochromic (Plastic)	$75
Tint (Solid & Gradient)	$15
UV Treatment	$15
Standard Plastic Scratch Coating	$15
Standard Polycarbonate – 19 and over	$40
Standard Polycarbonate - under age 19	$40
Premium Anti-Reflective Coating	
Standard	$45
Tier 1	$57
Tier 2	$68
Tier 3	20% off Retail Price
Other Add-on Services and Materials	20% off Retail Price

Discount Details
Member receives a 20% discount on items not covered by the plan at EyeMed In-Network locations. Discount does not apply to EyeMed Provider's professional services, or contact lenses.
Plan discounts cannot be combined with any other discounts or promotional offers.
In certain states members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see EyeMed's online provider locator to determine which participating providers have agreed to the discounted rate.
Discounts on vision materials may not be applicable to certain manufacturers' products
EyeMed Vision Care reserves the right to make changes to the products on each tier and the member out-of-pocket costs. Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels.
Service and amounts listed above are subject to change at any time

Vision Benefits

The secret is out

5 ways we challenge the status quo

EyeMed

We want every person to see life to the fullest. That's why we're doing things differently and providing you with more of what's best, not more of the same. And that includes the network employees want with vision benefits that redefine expectations, all while making the experience easy. After all, it takes vision to see beyond the status quo.

1 Network

We offer so many options for care

Your employees can choose a provider on their terms, not ours. That's because we have the right mix of independent, national retail and regional retail providers.

2 Network

In-network means online, too

Now our members canuse Glasses.com andContactsDirect as in-network providers.

3 Benefits

Members love even more perks

With us, members receive an industry-leading 40% off additional pairs of glasses* and special offers for additional savings can always be found on our website.

4 Easy

We're all about providing user friendly tools

We have the resources to help your employees when they need it: open enrollment support, our enhanced provider search tool and the industry's first mobile vision app for members.

5 Easy

Service that barely sleeps

We offer award-winning service,[1] even on Sundays! Our live agentsare available to assist you untilthe wee hours of the night – an average of 15 hours per day.

[1] Purdue University Benchmark Portal Independent assessment of call centers nationwide, 2015.

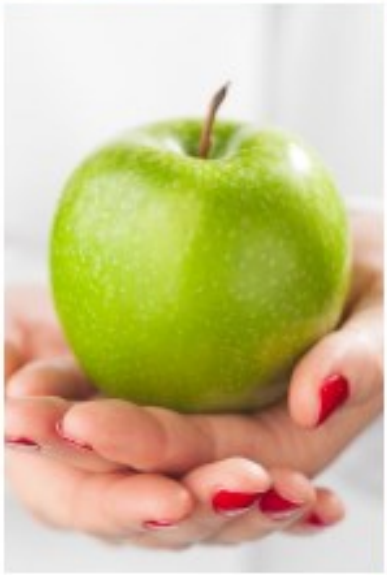
Tangible results you see. Performance we're proud to guarantee.

97% member satisfaction
97% client satisfaction
99% client retention

* Results are based upon EyeMed's internal satisfaction surveys conducted by Convergys and Walker 2014

S-1601-C-24

Flexible Spending Account (FSA) - EBC	
Overview	Allows participants to pay for eligible healthcare (Medical, Dental and Vision) and/or dependent daycare expenses with pre-tax dollars. May not change election during the calendar year, except due to change in family status.
Deferral Limits	Health Care: $2,550 per calendar year Dependent Care: $5000 per calendar year, if filing single or separate income tax returns. $2,500 per calendar year, if you are married and file a joint income tax return.
If you are opening a Health Savings Account (HSA), you can only participate in a limited purpose health care FSA for Dental and Vision Expenses Only	
Employee Benefits Corporation	
Benefit Questions & Claim Resolutions	A medical benefits or claims expert can help you with complex conditions, find specialist, address eldercare issues, clarify insurance coverage, work on claims denials and help negotiate medical bills and more.
Contact Information	www.ebcflex.com 1.800.346.2126



FSA Benefits

The BESTflex℠ Plan

Enrollment Guide

Enroll in the BESTflex℠ Plan and you'll pay less for eligible health care and daycare expenses.

Use **tax-free dollars** to pay for eligible health care and daycare expenses.

Tax-Free Dollars

The BESTflex Plan is an easy way for you to set aside a portion of your earnings, and use it to pay for insurance, health care and daycare expenses. The money you set aside in the BESTflex Plan is free from payroll taxes, so you save approximately 30 percent* in taxes for each dollar you contribute.

A Prescription for Savings

Whether your prescription medicine helps calm your allergies after snuggling with your cat, suppress heartburn after your favorite meal, breathe through your asthma – or something else entirely – the BESTflex Plan lets you pay less for it.

The plan saves you approximately 30 percent* in taxes on your eligible prescriptions and prescription co-payments, meaning a $20 prescription expense amounts to about $14.

Smile!

When you go out to socialize with your friends and meet new people, you trust in your bright smile to lend yourself confidence. It's no surprise, then, that you like to keep your smile in tip-top shape, despite how expensive it can be.

The BESTflex Plan helps you save approximately 30 percent* on your dental expenses, and keep your smile healthy and bright. A dental exam and cleaning might cost you $100 – or more, depending on your provider. Using funds in the BESTflex Plan, you essentially pay around $70. That's a savings that's likely to bring a smile to your face.

Daycare Relief

You know how the hundreds of dollars you spend on daycare each month can pinch your finances. The BESTflex Plan dulls the pinch. By saving you around 30 percent* on your daycare expenses, a week of care at $150 is, in essence, closer to $105.

*These tax examples are broad approximations of tax liability. You should consult a tax advisor for help with your own situation. Current IRS tax laws control all BESTflex Plan matters.

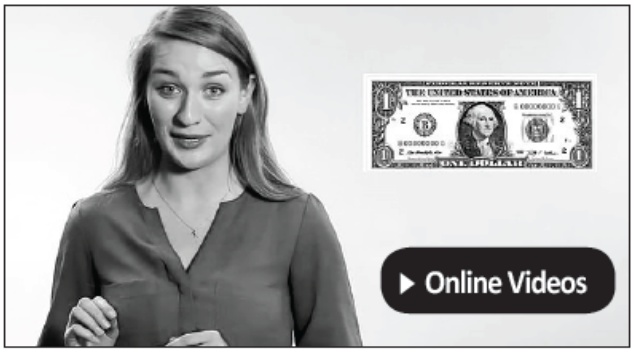
8037-6 06/15 Standard

FSA Benefits

Why pay more than you have to?

The BESTflex Plan makes it easy for you to set aside a portion of your earnings and use it to pay for certain insurance, medical and dependent care expenses. Because dollars you place in the BESTflex Plan are exempt from Federal, State and FICA taxes, you'll save approximately 30 percent* in taxes for each dollar you contribute.

Direct those tax savings toward your eligible BESTflex Plan expenses and a **$20 prescription could cost $14.** A week of daycare could cost $70 instead of $100 and your $30 health insurance premium could cost you $21.



Our online videos explain where extra FSA dollars come from, the difference between FSA account types, and how to submit claims. ***Watch them now!*** *Visit our website at www.ebcflex.com.*

My **Mobile** Account Assistant

Smart, Simple,
Secure and Mobile!

- File a claim
- Attach receipts
- Check balances
- View payment history

Visit www.ebcflex.com to learn more.

Available on the App Store Google play

How the BESTflex Plan Works

When you enroll in the BESTflex Plan, you set aside the portion of your pay you'll spend annually on eligible health and dependent care expenses. Throughout the year, these elections are deducted bit by bit from your paychecks and placed in flexible spending accounts (FSAs). The usual payroll taxes do not apply to your BESTflex Plan contributions, saving you from paying approximately 30 percent* in taxes on each dollar you contribute to the BESTflex Plan.

Just a Fraction of the Eligible Expenses

These savings can be applied to a variety of expenses. Prescription medicines, dental expenses, vision expenses – including contact lens solution, contact lenses and prescription eyeglasses – day care expenses and co-payments are just a few of the common expenses on which the BESTflex Plan helps you save money.

Enrollment in the BESTflex Plan

We help you set aside the right amount of money for eligible health care and dependent care expenses. Referencing your *Eligible Expenses List* and using the worksheets we've created, you'll arrive at a solid estimate of how much money you should contribute to the plan and help alleviate concerns about forfeiting any contributions.

Reimbursement From the BESTflex Plan

To get back the pre-tax money that's deducted from your pay and deposited in your FSA(s), simply submit a *Claim Form*, along with documentation, such as an itemized receipt, for the eligible expense. We quickly process your form and mail you a reimbursement check or deposit the payment into your bank account.

Filing Claims

We make filing claims easy and we offer three options:
Mobile, Online or via a paper **Claim Form**

My Mobile Account Assistant lets you file a claim and scan and submit a receipt – at the pharmacy, your provider or anywhere you have access to a 3G or wireless internet connection. Filing a claim for any eligible health care or dependent care expense doesn't get any easier than this. Complete a few lines on a simple form, upload your receipt using your phone's camera and tap "Submit." My Mobile Account Assistant makes filing claims smart, simple, secure and mobile!

Participant Support

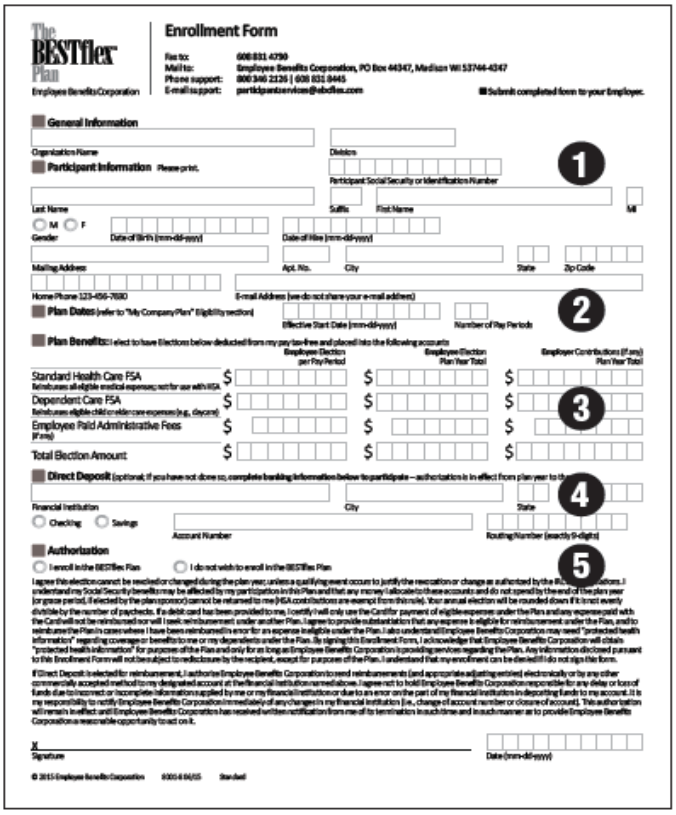
If you have questions or need information regarding your account, you can call our in-house Participant Services team at **800 346 2126** for one-on-one support, or access our convenient Telephone Account Assistant, which provides you with basic account details. We are also available via email at **participantservices@ebcflex.com.**

Download information regarding The BESTflex Plan and your FSAs by activating then logging in to My Account Assistant at www.ebcflex.com.

*These tax examples are broad approximations of tax liability. You should consult a tax advisor for help with your own situation. Current IRS tax laws control all BESTflex Plan matters.

FSA Benefits

How to enroll in the BESTflex Plan:



Enrollment Form

The BESTflex Plan — Employee Benefits Corporation

Fax to: 608 831 4290
Mail to: Employee Benefits Corporation, PO Box 44347, Madison WI 53744-4347
Phone support: 800 340 2235 | 608 831 8445
E-mail support: partidpantservices@ebcflex.com

■ Submit completed form to your employer.

■ General Information

Organization Name | Division

■ Participant Information Please print.

Participant Social Security or Identification Number | Last Name | Suffix | First Name | MI | Gender | Date of Birth (mm-dd-yyyy) | Date of Hire (mm-dd-yyyy) | Mailing Address | Apt. No. | City | State | Zip Code | Home Phone 123-456-7890 | E-mail Address (we do not share your e-mail address)

■ Plan Dates (refer to "My Company Plan" Eligibility section) | Effective Start Date (mm-dd-yyyy) | Number of Pay Periods

■ Plan Benefits: I elect to have Elections below deducted from my pay tax-free and placed into the following accounts

	Employee Election per Pay Period	Employee Election Plan Year Total	Employer Contributions (if any) Plan Year Total
Standard Health Care FSA (reimburses all eligible medical expenses; not for use with HSA)	$	$	$
Dependent Care FSA (reimburses eligible child or elder care expenses (e.g., daycare))	$	$	$
Employee Paid Administrative Fees (if any)	$	$	$
Total Election Amount	$	$	$

■ Direct Deposit (optional; if you have not done so, complete banking information below to participate – authorization is in effect from plan year to the

Financial Institution | City | State | ○ Checking ○ Savings | Account Number | Routing Number (exactly 9 digits)

■ Authorization

○ I enroll in the BESTflex Plan ○ I do not wish to enroll in the BESTflex Plan

I agree this election cannot be revoked or changed during the plan year, unless a qualifying event occurs to justify the revocation or change as authorized by the IRS Code and Regulations. I understand my Social Security benefits may be affected by my participation in this Plan and that any money I allocate to these accounts and do not spend by the end of the plan year (or grace period, if elected by the plan sponsor) cannot be returned to me (HSA contributions are exempt from this rule). Your annual election will be rounded down if it is not evenly divisible by the number of paychecks. If a debit card has been provided to me, I certify I will only use the Card for payment of eligible expenses under the Plan and any expenses paid with the Card will not be reimbursed nor will I seek reimbursement under another Plan. I agree to provide substantiation that any expense is eligible for reimbursement under the Plan, and to reimburse the Plan in cases where I have been reimbursed in error for an expense ineligible under the Plan. I also understand Employee Benefits Corporation may need "protected health information" regarding coverage or benefits for me or my dependents under the Plan. By signing this Enrollment Form, I acknowledge that Employee Benefits Corporation will obtain "protected health information" for purposes of the Plan and only for as long as Employee Benefits Corporation is providing services regarding the Plan. Any information disclosed pursuant to this Enrollment Form will not be subject to redisclosure by the recipient, except for purposes of the Plan. I understand that my enrollment can be denied if I do not sign this form.

If Direct Deposit is elected for reimbursement, I authorize Employee Benefits Corporation to send reimbursements (and appropriate adjustments) electronically or by any other commercially accepted method to my designated account at the financial institution named above. I agree not to hold Employee Benefits Corporation responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or my financial institution or due to an error on the part of my financial institution in depositing funds to my account. It is my responsibility to notify Employee Benefits Corporation immediately of any changes in my financial institution (i.e., change of account number or closure of account). This authorization will remain in effect until Employee Benefits Corporation has received written notification from me of its termination in such time and in such manner as to provide Employee Benefits Corporation a reasonable opportunity to act on it.

X Signature | Date (mm-dd-yyyy)

© 2015 Employee Benefits Corporation 8000-0-04/15 Standard

(Sample Enrollment Form shown; your form may differ slightly)

1: Enter General and Personal Information. All of it, including your email address, if you have one. Email is how we prefer to contact you.

2: Enter Plan Dates. Enter the date you start the plan (the Effective Start Date) and the number of paychecks per year from which your elections are deducted (Number of Pay Periods). Enrollment is for one plan year, usually consisting of 12 calendar months or less.

3: Enter BESTflex Plan Benefits. Use the mini-worksheet on the *Enrollment Form* to enter your annual election. Choose the amount you'd like deducted from each paycheck (Employee Deduction per Pay Period) and multiply that amount by the Number of Pay Periods to determine your Plan Year Total. Do this for each of the FSAs in which you wish to enroll and total the form.

If you receive contributions from your employer, add the Employer Contribution Plan Year Total.

4: Complete Direct Deposit Information. You have the option of having your reimbursement check mailed to you or deposited directly at your bank, credit union or other financial institution. To authorize the direct deposit feature of the BESTflex Plan, provide the financial account information requested on the enrollment form. If you already have direct deposit information on file with us, it is not necessary to provide it again. The direct deposit feature will carry over to your new plan year.

5: Authorize Enrollment and Direct Deposit. First, indicate whether you want to participate in the BESTflex Plan. Then sign and date the form and return it to your employer.

If you choose to not enroll in the BESTflex Plan FSAs, you must sign and date the form anyway. Your eligible employer-provided insurance premiums will still be deducted from your pay on a pre-tax basis.

What Happens After I Enroll?
Your employer transfers the amounts you elected on the *Enrollment Form* to your Health and/or Dependent Care FSA. Check your pay stub to ensure these amounts are correct.

Once your plan year starts, visit our website at **www.ebcflex.com.** You can activate your online account and obtain your secure PIN via email. Log in and you'll be taken to My Account Assistant, where you'll see your account information and be able to download useful materials to help you make the most of your plan.

Review My Company Plan

My Company Plan, the appendix to your *Summary Plan Description (SPD),* describes the specific details and features of your company's BESTflex Plan. Use the information in *My Company Plan* to aid in completing your enrollment (additional appendices may be provided to explain special features of your BESTflex Plan).

My Company Plan Contains:

A. BESTflex Plan Dates, including the date your employer started its BESTflex Plan (Original Plan Date) and the start and end dates of your employer's current BESTflex Plan (My Company's Plan Year)

B. Eligibility definitions

C. Group Insurance Premiums, the types of premiums deducted from your paycheck on a pre-tax basis

D. The Health Care and Dependent Care FSA contribution limits, the maximum amount you can contribute to each account

E. Plan Amendments, if any

F. Company Information regarding who to contact within your Company

G. Legal Information defining the relationship between your employer and Employee Benefits Corporation

My Company Plan

The BESTflex Plan

Employee Benefits Corporation

My Company Plan is available online at www.ebcflex.com by logging in to My Account Assistant.

FSA Benefits

Employee Benefits Corporation's Website

Once you enroll in the BESTflex Plan, our website makes it easy to view your claims and reimbursements. Get started at www.ebcflex.com.

My Account Assistant

As a BESTflex Plan participant, it's important to monitor the status of the claims you've submitted, stay aware of your FSA balances, be mindful of the deadlines for submitting claims, and have a place to find the latest BESTflex Plan forms and materials.

Once you enroll in the BESTflex Plan, our website makes all of this easy with **My Account Assistant,** your online account management portal.

Using My Account Assistant, you can:

- File claims
- Review account balance(s)
- Review when a claim was processed and when the reimbursement was mailed or direct deposited
- Download BESTflex Plan forms and information regarding the operation of your plan
- Update personal information
- View a detailed account history

In order for you to view your account, you activate it by entering a valid email address and receiving a password. You can then log-in and view your account using your Social Security Number and your password.

Employee Benefits Corporation
We make it easy.

P: 800 346 2126 | 608 831 8445
F: 608 831 4790
P.O. Box 44347
Madison, WI 53744-4347
An employee-owned company
www.ebcflex.com

Special Enrollment Rights

If you are declining enrollment for yourself, or your dependents (including your spouse) in the medical plan because of other medical coverage, you may be able to enroll yourself and/or your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' coverage). However, you must request enrollment within 30 days after your previous coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result

of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents in the medical plan, provided that you request enrollment within 30 days of the marriage, birth, adoption, or placement for adoption.

If you or your dependent lose eligibility for coverage under Medicaid or a State child health plan or if you or your dependent become eligible for State-sponsored premium assistance for the

medical plan, you may be able to enroll yourself and/or your dependents in this plan if you request enrollment within 60 days of the date of termination of Medicaid or State child health plan coverage or your eligibility for premium assistance.

Newborns'andMothers'HealthProtectionAct

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours if applicable).

Women'sHealthandCancerRightsActof1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCA). The Women's Health and Cancer Rights Act requires group health plans and their insurance companies and HMOs to provide certain benefits for mastectomy patients who elect breast reconstruction. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

Breast reconstruction benefits are subject to deductibles and co-insurance limitations that are consistentwiththoseestablishedforotherbenefitsundertheplan.

HealthInsurancePortabilityandAccountabilityAct(HIPAA)

This group health plan complies with the privacy requirement for Protected Health Information (PHI) under HIPAA. You may obtain a copy of the plan's Notice of Privacy Practices by contacting the Division of Human Resources.

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 one of the states listed in this notice, 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, 2017. Contact your state for more information on eligibility.

To see if any more States have added a premium assistance program since January 31, 2017, or for more information on special enrollment rights, you can 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

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Health First Colorado Website: https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711
CHP+: Colorado.gov/HCPF/Child-Health-Plan-Plus
CHP+ Customer Service: 1-800-359-1991/State Relay 711

FLORIDA – Medicaid
Website: http://flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64
Website: http://www.hip.in.gov
Phone: 1-877-438-4479
All other Medicaid Website: http://www.indianamedicaid.com
Phone 1-800-403-0864

IOWA – Medicaid
Website: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp
Phone: 1-888-346-9562

MAINE – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-462-1120

MINNESOTA – Medicaid
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp
Phone: 1-800-657-3739

NEBRASKA – Medicaid
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx
Phone: 1-855-632-7633

NEW HAMPSHIRE – Medicaid
Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 603-271-5218

NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

PENNSYLVANIA – Medicaid
Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm
Phone: 1-800-692-74622

TEXAS – Medicaid
Website: http://gethipptexas.com/
Phone: 1-800-440-0493

VERMONT - Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 1-855-242-8282

BlueCross BlueShield of Texas

: BestChoice PPO RS30MAT

Coverage for: All | Plan Type: PPO

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, visit www.bcbstx.com/member/policy-forms/2017 or by calling 1-800-521-2227. 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 https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For Network and Out-of-Network $5,000 Individual/$15,000 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?	Preventive Care, copays, and Prescription Drugs do not apply to the Network 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 https://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?	Yes. For Network $5,000 Individual/$15,000 Family. For Out-of-Network $15,000 Individual/$45,000 Family.	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, pharmacy/drugs, 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 don't need a Referral to see a Specialist.	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
		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	$30 copay/visit	30% coinsurance	none
	Specialist visit	$30 copay/visit	30% coinsurance	
	Preventive care/screening/ immunization	No Charge	30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	30% coinsurance	none
	Imaging (CT/PET scans, MRIs)	No charge after Deductible	30% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbstx.com/member/rx_drugs.html	Generic drugs	$10 copay/prescription	20% coinsurance plus copay	Copay amounts are per 30-day supply for retail and mail order.
	Preferred brand drugs	$40 copay/prescription	20% coinsurance plus copay	
	Non-preferred brand drugs	$60 copay/prescription	20% coinsurance plus copay	
	Specialty drugs	$10/$40/$60 copay/prescription	20% coinsurance plus copay	Copay amounts are per 30-day supply for retail only, no mail order.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge after Deductible	30% coinsurance	none
	Physician/surgeon fees	No charge after Deductible	30% coinsurance	
If you need immediate medical attention	Emergency room care	$100 copay/visit	$100 copay/visit	Copay amount waived if admitted.
	Emergency medical transportation	No charge after Deductible	No charge after Deductible	none
	Urgent care	$55 copay/visit	30% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after Deductible	30% coinsurance	Preauthorization is required and there is a $250 penalty if Out-of-Network is not preauthorized.

* For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com/member/policy-forms/2017.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	No charge after Deductible	30% coinsurance	none
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge after Deductible	30% coinsurance	$30 copay per office visit in lieu of coinsurance for Network. Coverage is limited to 25 visits per calendar year. Certain services must be preauthorized; refer to benefit booklet for details.
	Inpatient services	No charge after Deductible	30% coinsurance	Preauthorization is required. Coverage is limited to 10 days per calendar year.
If you are pregnant	Office visits	$30 copay/visit	30% coinsurance	Copay applies to first prenatal visit (per pregnancy).Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge after Deductible	30% coinsurance	Preauthorization is only required if extension of minimum length of stay is requested.
	Childbirth/delivery facility services	No charge after Deductible	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge after Deductible	30% coinsurance	Preauthorization is required. Limited to 60 visits per calendar year.
	Rehabilitation services	No charge after Deductible	30% coinsurance	Limited to combined 35 visits per year, including Chiropractic.
	Habilitation services	No charge after Deductible	30% coinsurance	
	Skilled nursing care	No charge after Deductible	30% coinsurance	Preauthorization is required. Limited to 25 days per calendar year.
	Durable medical equipment	No charge after Deductible	30% coinsurance	none
	Hospice services	No charge after Deductible	30% coinsurance	Preauthorization is required.

For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com/member/policy-forms/2017.

*

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		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	$30 copay/visit	30% coinsurance	none
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

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.)

- Abortions
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental Care(Adult)
- Long-term care
- Private-duty nursing
- 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
- Infertility treatment (Invitro and artificial insemination are not covered unless shown in your Plan document)
- Non-emergency care when traveling outside the U.S.
- Routine eye care(Adult)
- Routine foot care (Only covered in connection with diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the plan at 1-800-521-2227, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or **www.cciio.cms.gov**.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Blue Cross and Blue Shield of Texas at 1-800-521-2227 or visit **www.bcbstx.com**, or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit **www.dol.gov/ebsa/healthreform.**

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

* For more information about limitations and exceptions, see the plan or policy document at **www.bcbstx.com/member/policy-forms/2017**.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Spanish (Español): Para obtener asistencia en Español, llame al 1-800-521-2227.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-521-2227.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-521-2227.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-521-2227.

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

For more information about limitations and exceptions, see the plan or policy document at **www.bcbstx.com/member/policy-forms/2017**.

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	$5,000
Specialist copayment	$30
Hospital (facility)	$0
Other	$0

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	$5,000
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,160**

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

The plan's overall deductible	$5,000
Specialist copayment	$30
Hospital (facility)	$0
Other	$0

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$10
Copayments	$1,400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,470**

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

The plan's overall deductible	$5,000
Specialist copayment	$30
Hospital (facility)	$0
Other	$0

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	**$2,000**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,100
Copayments	$90
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,190**

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

BlueCross BlueShield of Texas

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost.
To speak to an interpreter, call the customer service number on the back of your member card. If you are not a member, or don't have a card, call 855-710-6984.

العربية Arabic	إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث إلى مترجم فوري، اتصل على رقم خدمة العملاء المذكور على ظهر بطاقة عضويتك. فإن لم تكن عضوًا، أو كنت لا تملك بطاقة، فاتصل على 855-710-6984.
繁體中文 Chinese	如果您, 或您正在協助的對象, 對此有疑問, 您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員, 請致電印在您的會員卡背面的客戶服務電話號碼。如果您不是會員, 或沒有會員卡, 請致電 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, composez le numéro du service client indiqué au verso de votre carte de membre. Si vous n'êtes pas membre ou si vous n'avez pas de carte, veuillez composer le 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Kundenservicenummer auf der Rückseite Ihrer Mitgliedskarte an. Falls Sie kein Mitglied sind oder keine Mitgliedskarte besitzen, rufen Sie bitte 855-710-6984 an.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ.બી.એમ. દુભાષિયા સાથે વાત કરવા માટે, તમારા સભ્યપદના કાર્ડની પાછળ આપેલ ગ્રાહક સેવા નંબર પર કૉલ કરો. જો આપ સભ્યપદ ના ધરાવતા હોવ, અથવા આપની પાસે કાર્ડ નથી તો 855-710-6984 નંબર પર કૉલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए, अपने सदस्य कार्ड के पीछे दिए गए ग्राहक सेवा नंबर पर कॉल करें। यदि आप सदस्य नहीं हैं, या आपके पास कार्ड नहीं है, तो 855-710-6984 पर कॉल करें।
日本語 Japanese	ご本人様、またはお客様の身の回りの方でも、ご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、メンバーカードの裏のカスタマーサービス番号までお電話ください。メンバーでない場合またはカードをお持ちでない場合は 855-710-6984 までお電話ください。
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 회원 카드 뒷면에 있는고객 서비스 번호로 전화하십시오. 회원이 아니시거나 카드가 없으시면 855-710-6984 으로 전화주십시오.
ພາສາລາວ Laotian	ຖ້າທ່ານ ຫຼື ຄົນທີ່ທ່ານກຳລັງໃຫ້ການຊ່ວຍເຫຼືອມີຄຳຖາມ, ທ່ານມີສິດຂໍເອົາການຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໄດ້ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອລົມກັບນາຍແປພາສາ, ໃຫ້ໂທຫາເບີຜ່າຍບໍລິການລູກຄ້າທີ່ມີຢູ່ດ້ານຫຼັງບັດສະມາຊິກຂອງທ່ານ. ຖ້າທ່ານບໍ່ແມ່ນສະມາຊິກ, ຫຼື ບໍ່ມີບັດ, ໃຫ້ໂທຫາເບີ 855-710-6984.
Diné Navajo	T'áá ni, éí doodago ła'da bíká anánílwo'ígíí, na'ídíłkidgo, ts'ídá bee ná ahóóti'i' t'áá níík'e níká a'doolwoł. Ata' halne'í bich'į' hadeesdzih nínízingo éí kwe'é da'íníishgi ákká anídaalwo'ígíí bich'į' hodíílnih, bee nééhózinii bine'dęę' bikáá'. Kojí atah naaltsoos ná hadít'éégóó éí doodago bee nééhózinígíí ádingo kojį' hodíílnih 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک مي کنید، سؤالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با خدمات مشتری به شماره ای که در پشت کارت عضویت شما درج شده است تماس بگیرید. اگر عضو نیستید، یا کارت عضویت ندارید، با شماره 855-710-6984 تماس حاصل نمایید.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы поговорить с переводчиком, позвоните в отдел обслуживания клиентов по телефону, указанному на обратной стороне вашей карточки участника. Если вы не являетесь участником или у вас нет карточки, позвоните по телефону 855-710-6984.
Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete comuníquese con el número del Servicio al Cliente que figura en el reverso de su tarjeta de miembro. Si usted no es miembro o no posee una tarjeta, llame al 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa numero ng serbisyo para sa kustomer sa likod ng iyong kard ng miyembro. Kung ikaw ay hindi isang miyembro, o kaya ay walang kard, tumawag sa 855-710-6984.
اردو Urdu	گر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کررہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، کسٹمر سروس نمبر پر کال کریں جو آپ کے کارڈ کی پشت پر درج ہے۔ اگر آپ ممبر نہیں ہیں، یا آپ کے پاس کارڈ نہیں ہے تو، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị hoặc người mà quý vị giúp đỡ có bất kỳ câu hỏi nào, quý vị có quyền được hỗ trợ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với thông dịch viên, gọi số dịch vụ khách hàng nằm ở phía sau thẻ hội viên của quý vị. Nếu quý vị không phải là hội viên hoặc không có thẻ, gọi số 855-710-6984.

bcbstx.com

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance.
We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St.
35th Floor
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960
Email: CivilRightsCoordinator@hcsc.net

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html

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: BestChoice PPO RS41MAT

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, visit www.bcbstx.com/member/policy-forms/2017 or by calling 1-800-521-2227. 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 https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf or call 1-855-756-4448 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For Network and Out-of-Network $10,000 Individual/$30,000 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?	Preventive Care, copays, and Prescription Drugs do not apply to the Network 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 https://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?	Yes. For Network $10,000 Individual/$30,000 Family. For Out-of-Network $20,000 Individual/$60,000 Family.	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, pharmacy/drugs, 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 don't need a Referral to see a Specialist.	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
		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	$25 copay/visit	30% coinsurance	none
	Specialist visit	$25 copay/visit	30% coinsurance	
	Preventive care/screening/ immunization	No Charge	30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	30% coinsurance	none
	Imaging (CT/PET scans, MRIs)	No charge after Deductible	30% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.bcbstx.com/member/rx_drugs.html	Generic drugs	$15 copay/prescription	20% coinsurance plus copay	Copay amounts are per 30-day supply for retail and mail order.
	Preferred brand drugs	$40 copay/prescription	20% coinsurance plus copay	
	Non-preferred brand drugs	$60 copay/prescription	20% coinsurance plus copay	
	Specialty drugs	$15/$40/$60 copay/prescription	20% coinsurance plus copay	Copay amounts are per 30-day supply for retail only, no mail order.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge after Deductible	30% coinsurance	none
	Physician/surgeon fees	No charge after Deductible	30% coinsurance	
If you need immediate medical attention	Emergency room care	$100 copay/visit	$100 copay/visit	Copay amount waived if admitted.
	Emergency medical transportation	No charge after Deductible	No charge after Deductible	none
	Urgent care	$50 copay/visit	30% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after Deductible	30% coinsurance	Preauthorization is required and there is a $250 penalty if Out-of-Network is not preauthorized.

For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com/member/policy-forms/2017.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Physician/surgeon fees	No charge after Deductible	30% coinsurance	none
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge after Deductible	30% coinsurance	$25 copay per office visit in lieu of coinsurance for Network. Coverage is limited to 25 visits per calendar year. Certain services must be preauthorized; refer to benefit booklet for details.
	Inpatient services	No charge after Deductible	30% coinsurance	Preauthorization is required. Coverage is limited to 10 days per calendar year.
If you are pregnant	Office visits	$25 copay/visit	30% coinsurance	Copay applies to first prenatal visit (per pregnancy).Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge after Deductible	30% coinsurance	Preauthorization is only required if extension of minimum length of stay is requested.
	Childbirth/delivery facility services	No charge after Deductible	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge after Deductible	30% coinsurance	Preauthorization is required. Limited to 60 visits per calendar year.
	Rehabilitation services	No charge after Deductible	30% coinsurance	Limited to combined 35 visits per year, including Chiropractic.
	Habilitation services	No charge after Deductible	30% coinsurance	
	Skilled nursing care	No charge after Deductible	30% coinsurance	Preauthorization is required. Limited to 25 days per calendar year.
	Durable medical equipment	No charge after Deductible	30% coinsurance	none
	Hospice services	No charge after Deductible	30% coinsurance	Preauthorization is required.

For more information about limitations and exceptions, see the plan or policy document at www.bcbstx.com/member/policy-forms/2017.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		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	$25 copay/visit	30% coinsurance	none
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	

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.)

- Abortions
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental Care(Adult)
- Long-term care
- Private-duty nursing
- 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
- Infertility treatment (Invitro and artificial insemination are not covered unless shown in your Plan document)
- Non-emergency care when traveling outside the U.S.
- Routine eye care(Adult)
- Routine foot care (Only covered in connection with diabetes, circulatory disorders of the lower extremities, peripheral vascular disease, peripheral neuropathy, or chronic arterial or venous insufficiency)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the plan at 1-800-521-2227, U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or **www.cciio.cms.gov**.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Blue Cross and Blue Shield of Texas at 1-800-521-2227 or visit **www.bcbstx.com**, or contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit **www.dol.gov/ebsa/healthreform.**

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

* For more information about limitations and exceptions, see the plan or policy document at **www.bcbstx.com/member/policy-forms/2017**.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Spanish (Español): Para obtener asistencia en Español, llame al 1-800-521-2227.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-521-2227.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-521-2227.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-521-2227.

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

For more information about limitations and exceptions, see the plan or policy document at **www.bcbstx.com/member/policy-forms/2017**.

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	$10,000
Specialist copayment	$25
Hospital (facility)	$0
Other	$0

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	$9,100
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$9,260**

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

The plan's overall deductible	$10,000
Specialist copayment	$25
Hospital (facility)	$0
Other	$0

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$10
Copayments	$1,600
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,670**

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

The plan's overall deductible	$10,000
Specialist copayment	$25
Hospital (facility)	$0
Other	$0

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	**$2,000**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,100
Copayments	$80
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,180**

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

BlueCross BlueShield of Texas

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost.
To speak to an interpreter, call the customer service number on the back of your member card. If you are not a member, or don't have a card, call 855-710-6984.

العربية Arabic	إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث إلى مترجم فوري، اتصل على رقم خدمة العملاء المذكور على ظهر بطاقة عضويتك. فإن لم تكن عضوًا، أو كنت لا تملك بطاقة، فاتصل على 855-710-6984.
繁體中文 Chinese	如果您, 或您正在協助的對象, 對此有疑問, 您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員, 請致電印在您的會員卡背面的客戶服務電話號碼。如果您不是會員, 或沒有會員卡, 請致電 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, composez le numéro du service client indiqué au verso de votre carte de membre. Si vous n'êtes pas membre ou si vous n'avez pas de carte, veuillez composer le 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Kundenservicenummer auf der Rückseite Ihrer Mitgliedskarte an. Falls Sie kein Mitglied sind oder keine Mitgliedskarte besitzen, rufen Sie bitte 855-710-6984 an.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ.બી.એમ. દુભાષિયા સાથે વાત કરવા માટે, તમારા સભ્યપદના કાર્ડની પાછળ આપેલ ગ્રાહક સેવા નંબર પર કૉલ કરો. જો આપ સભ્યપદ ના ધરાવતા હોવ, અથવા આપની પાસે કાર્ડ નથી તો 855-710-6984 નંબર પર કૉલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए, अपने सदस्य कार्ड के पीछे दिए गए ग्राहक सेवा नंबर पर कॉल करें। यदि आप सदस्य नहीं हैं, या आपके पास कार्ड नहीं है, तो 855-710-6984 पर कॉल करें।
日本語 Japanese	ご本人様、またはお客様の身の回りの方でも、ご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、メンバーカードの裏のカスタマーサービス番号までお電話ください。メンバーでない場合またはカードをお持ちでない場合は 855-710-6984 までお電話ください。
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 회원 카드 뒷면에 있는고객 서비스 번호로 전화하십시오. 회원이 아니시거나 카드가 없으시면 855-710-6984 으로 전화주십시오.
ພາສາລາວ Laotian	ຖ້າທ່ານ ຫຼື ຄົນທີ່ທ່ານກຳລັງໃຫ້ການຊ່ວຍເຫຼືອມີຄຳຖາມ, ທ່ານມີສິດຂໍເອົາການຊ່ວຍເຫຼືອ ແລະ ຂໍ້ມູນເປັນພາສາຂອງທ່ານໄດ້ໂດຍບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ເພື່ອລົມກັບນາຍແປພາສາ, ໃຫ້ໂທຫາເບີຜ່າຍບໍລິການລູກຄ້າທີ່ມີຢູ່ດ້ານຫຼັງບັດສະມາຊິກຂອງທ່ານ. ຖ້າທ່ານບໍ່ແມ່ນສະມາຊິກ, ຫຼື ບໍ່ມີບັດ, ໃຫ້ໂທຫາເບີ 855-710-6984.
Diné Navajo	T'áá ni, éí doodago ła'da bíká anánílwo'ígíí, na'ídíłkidgo, ts'ídá bee ná ahóóti'i' t'áá níík'e níká a'doolwoł. Ata' halne'í bich'į' hadeesdzih nínízingo éí kwe'é da'íníishgi ákká anídaalwo'ígíí bich'į' hodíílnih, bee nééhózinii bine'dęę' bikáá'. Kojí atah naaltsoos ná hadít'éégóó éí doodago bee nééhózinígíí ádingo kojį' hodíílnih 855-710-6984.
فارسی Persian	اگر شما، یا کسی که شما به او کمک مي کنید، سؤالی داشته باشید، حق این را دارید که به زبان خود، به طور رایگان کمک و اطلاعات دریافت نمایید. جهت گفتگو با یک مترجم شفاهی، با خدمات مشتری به شماره ای که در پشت کارت عضویت شما درج شده است تماس بگیرید. اگر عضو نیستید، یا کارت عضویت ندارید، با شماره 855-710-6984 تماس حاصل نمایید.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы поговорить с переводчиком, позвоните в отдел обслуживания клиентов по телефону, указанному на обратной стороне вашей карточки участника. Если вы не являетесь участником или у вас нет карточки, позвоните по телефону 855-710-6984.
Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete comuníquese con el número del Servicio al Cliente que figura en el reverso de su tarjeta de miembro. Si usted no es miembro o no posee una tarjeta, llame al 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa numero ng serbisyo para sa kustomer sa likod ng iyong kard ng miyembro. Kung ikaw ay hindi isang miyembro, o kaya ay walang kard, tumawag sa 855-710-6984.
اردو Urdu	گر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کررہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، کسٹمر سروس نمبر پر کال کریں جو آپ کے کارڈ کی پشت پر درج ہے۔ اگر آپ ممبر نہیں ہیں، یا آپ کے پاس کارڈ نہیں ہے تو، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị hoặc người mà quý vị giúp đỡ có bất kỳ câu hỏi nào, quý vị có quyền được hỗ trợ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với thông dịch viên, gọi số dịch vụ khách hàng nằm ở phía sau thẻ hội viên của quý vị. Nếu quý vị không phải là hội viên hoặc không có thẻ, gọi số 855-710-6984.

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If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St.
35th Floor
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960
Email: CivilRightsCoordinator@hcsc.net

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html

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Disclaimer: This Benefit Guide provides a brief summary of the benefits available under the Cogent Energy Services Program. In the event of any discrepancy (ies) between this summary and any Document, Insurance Contract or Certificate, the Insurance Document(s) will prevail. Cogent Energy Services reserves the right to modify or eliminate these benefits at any time and for any reason.

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