BLUE FISH PEDIATRICS

IN ASSOCIATION WITH Children's MEMORIAL HERMANN

2018

Benefits Enrollment Guide

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The following descriptions of available benefit election options are purely informational and provided to you for illustrative purposes only. Payment of benefits will vary from claim to claim within a particular benefit option and will be paid at the sole discretion of the applicable insurance provider for each benefit option. The terms and conditions of each applicable policy or certificate of coverage will provide specific details and will govern in all matters relating to each particular benefit option described in this summary. In no case will any information in this summary amend, modify, expand, enhance, improve or otherwise change any term, condition or element of the policies or certificates of coverage that govern the benefit options described in this summary.

powered by

ONEDIGITAL HEALTH AND BENEFITS

Enrollment and Eligibility

Offering a comprehensive and competitive benefits package is one way we recognize your contribution to the success of the organization and our role in helping you and your family to be healthy, feel secure and maintain work/life balance. This enrollment guide has been designed to provide you with information about the benefit choices available to you. Remember, open enrollment is your only opportunity each year to make changes to your elections, unless you or your family members experience an eligible "change in status."

How to Enroll in the Plans

Read your materials and make sure you understand all of the options available.

- Locate your enrollment/change forms.
- Fill out any necessary personal information.
- Make your benefit choices.
- If you have questions or concerns, please contact your HR department.

Whom Can You Add to Your Plan?

Eligible:

- Legally married spouse
- Natural or adopted children up to age 26, regardless of student and marital status
- Children under your legal guardianship
- Stepchildren
- Children under a qualified medical child support order
- Disabled children 19 years or older
- Children placed in your physical custody for adoption

Ineligible:

- Divorced or legally separated spouse
- Common law spouse, even if recognized by your state unless your company covers domestic partners
- Foster children
- Sisters, brothers, parents or in-laws, grandchildren, etc.

Change in Status

Generally, you may enroll in the plan, or make changes to your benefits, when you are first eligible. However, you can make changes/enroll during the plan year if you experience a change in status. As with a new enrollee, you must submit your paperwork within 30 days of the change or you will be considered a late enrollee.

Examples of changes in status:

- You get married, divorced or legally separated
- You have a baby or adopt a child
- You or your spouse takes an unpaid leave of absence
- You or your spouse has a change in employment status
- Your spouse dies
- You become eligible for or lose Medicaid coverage
- Significant increase or decrease in plan benefits or cost

Open Enrollment is the only chance to make changes, unless you experience a "change in status."

Client Advocate Center

Insurance is complicated, OneDigital understands.

We respond. We act. We help.

Through our **Client Advocate Center**, you have access to live representatives who will help you get the most out of your benefits and answer your questions. The OneDigital Client Advocate Center can help educate you about your benefits and teach you how to navigate within the healthcare system.

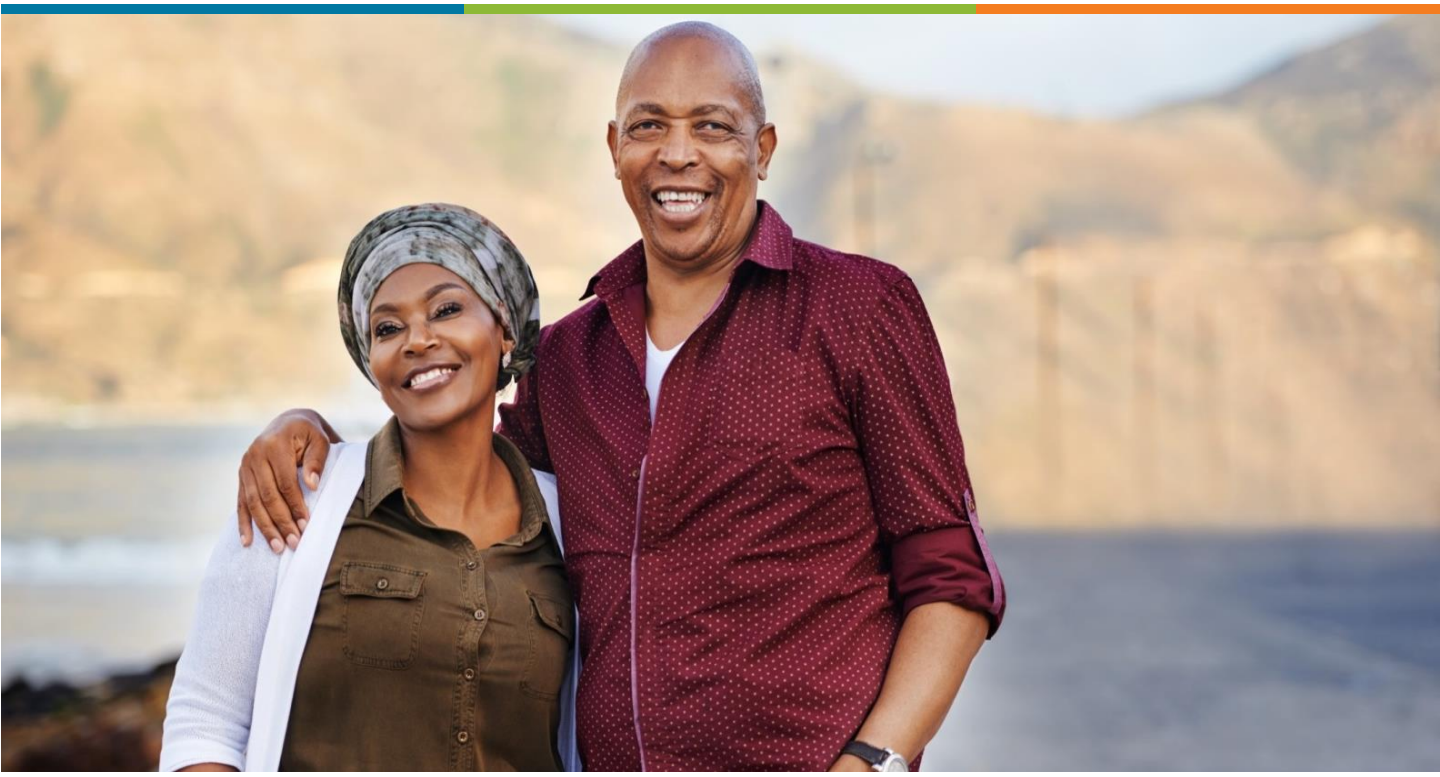
- Help you facilitate enrollment changes in status including ID requests
- Coverage assistance
- Facilitate resolution on eligibility/billing issues
- Assist you with claims
- Locate in-network providers
- And much, much more

ONEDIGITAL
HEALTH AND BENEFITS

Client Advocate Center
Call: 1.866.736.6640
Email: service@onedigital.com

Monday through Friday 8am to 8pm (EST).
We are available by phone, email, fax, or online chat.

Package Overview & Contact Information



Blue Fish Pediatrics LLP offers eligible employees a comprehensive benefit package that provides both financial stability and protection. Our offering provides flexibility for employees to design a package to meet their unique needs.

After you have enrolled in insurance coverage, you will receive additional information in the mail from the insurance carriers. This information will contain your personal identification cards.

Effective December 1, 201:

- Medical benefit plan with Blue Cross Blue Shield of TX
- Dental and Vision benefit plans with Principal

HR at Blue Fish Pediatrics LLP:
Denny Yu, Office Manager
denny@bluefishmd.com
713-467-1741

Broker Contact:
Daniela Canales, Benefits Consultant
dcanales@onedigital.com
713-333-4706

Medical Plans

For this plan year, you can choose from the following medical options. Refer to the carrier benefits summaries for the exact benefit levels associated with your plan choice.

Carrier Name	BCBS TX			
Name of Plan	**RSB3**		**RSH3**	
Type of Plan	PPO		PPO/ HDHP	
Office Visits	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Primary	$30 Copay	Deductible then 30%	Deductible then 0%	Deductible then 30%
Specialist	$30 Copay	Deductible then 30%	Deductible then 0%	Deductible then 30%
Pharmacy				
Deductible	Not Applicable	Covered at out of network benefit level. Please see plan design.	Integrated with Medical Deductible	Covered at out of network benefit level. Please see plan design.
Retail Standard	$10/$40/$60		Deductible then 0%	
Retail Specialty	$10/$40/$60			
Mail Order (90 days - Standard)	3x Copay			
Common Services				
In-Patient Facility	Deductible then 20%	Deductible then 40%	Deductible then 0%	Deductible then 30%
Out-Patient Facility	Deductible then 20%		Deductible then 0%	Deductible then 30%
Urgent Care	$55 Copay plus Deductible	Deductible then 30%	Deductible then 0%	Deductible then 30%
Emergency Room	$100 Copay plus Deductible then 20%		Deductible then 0%	
Annual Deductible				
Individual	$3,000		$5,000	$10,000
Family	$9,000		$10,000	$20,000
Coinsurance	0%	30%	0%	30%
Annual Out of Pocket	Includes Deductible		Includes Deductible	
Individual	$6,000	$9,000	$5,000	$20,000
Family	$18,000	$27,000	$10,000	$40,000
Maximum Benefits	Unlimited - LTM		Unlimited - LTM	

The benefit plan information shown in this guide is illustrative only. To the extent the benefit plan information summarized herein differs from the underlying plan details specified in the insurance documents that govern the terms and conditions of the plans of insurance described in this guide, the underlying insurance documents will govern in all cases.

Health Savings Account (HSA)

Option for High Deductible Health Plan (HDHP)

For employees who elect the HDHP, you have the option of opening a Health Savings Account (HSA). The HSA-eligible plan provides a way to save money for health care expenses .

- In 2018, individuals can contribute up to $3,450 and families can contribute up to $6,900 to their HSA (these totals represent the total of employee and employer contributions).
- If you are 55 or older, you can make a $1,000 catch-up contribution.
- Contributions to an HSA can be made on a pre-tax or post-tax basis, and funds within the HSA grow without incurring taxes. Funds are withdrawn tax-free for healthcare related needs without having to file receipts, although you should keep your receipts in case you are ever audited.
- Money deposited in the HSA by the employee AND employer immediately become the employee's asset and is portable.

Tax-Advantaged Plan	What is this account and how does it work?	Maximum Contribution Allowed	Can money in accounts be "rolled over?"
Health Savings Account (HSA)	An HSA account can be funded with pre-tax dollars by you, your employer or both to help pay for eligible medical expenses.	Employee only coverage: $3,450 Family coverage 6,900 Catch up contribution (55 year of age or older): $1,000	Yes, amounts left in your HSA account can be rolled over year to year and is portable if you leave employment of the company

Dental Plan

For this plan year, you can choose from the following dental option. Refer to the carrier benefits summary for the exact benefit level associated with your plan.

Carrier Name	Principal	
Name of Plan	Plan 1	
Type of Plan	PPO	
Class:	**In Network**	**Out of Network**
Preventive	0%	Information Available Upon Request
Basic Restorative	Deductible then 20%	
Major Services	Deductible then 50%	
Orthodontia	Not Covered	
Plan Details		
Deductible applies to Preventive	No	Information Available Upon Request
Endodontics/ Periodontics: Basic or Major	Major	
Orthodontics (Adult/Children)	Not Covered	
Waiting Periods Applied	No	
Deductible		
Person – Calendar Year	$50	Information Available Upon Request
Family – Calendar Year	$150	
Plan Maximums		
Calendar Year Max	$1,000	Information Available Upon Request
Ortho Lifetime Max	Not Covered	

Learn More!

Find more information about oral health from the American Dental Association:

http://www.mouthhealthykids.org/en/educators/smile-smarts-dental-health-curriculum

The benefit plan information shown in this guide is illustrative only. To the extent the benefit plan information summarized herein differs from the underlying plan details specified in the insurance documents that govern the terms and conditions of the plans of insurance described in this guide, the underlying insurance documents will govern in all cases.

Vision Plan

Did you know?

Scientific evidence shows that early detection and treatment can prevent some blindness and vision impairment.*

*Source: CDC Vision Health Initiative
https://www.cdc.gov/visionhealth/basic_information/vision_loss.htm

For this plan year, you can choose from the following vision option. Refer to the carrier benefit summary for the exact benefit level associated with your plan.

Carrier	Principal	
Name of Plan	VSP Network	
Exam	**In Network**	**Out of Network**
Copay	$10 Copay	Information Available Upon Request
Frequency	12 Months	
Lenses		
Frequency	12 Months	
Single	$25 Copay	Information Available Upon Request
Bifocal	$25 Copay	
Trifocal	$25 Copay	
Contacts Elective	$150 Allowance	
Contacts Medically Necessary	$25 Copay	
Frames		
Frequency	24 Months	
Frames	$150 Retail Allowance plus 20% Off Balance	Information Available Upon Request

The benefit plan information shown in this guide is illustrative only. To the extent the benefit plan information summarized herein differs from the underlying plan details specified in the insurance documents that govern the terms and conditions of the plans of insurance described in this guide, the underlying insurance documents will govern in all cases.

Employee Deductions

Blue Fish Pediatrics LLP contributes to the cost of the medical, dental, and vision plans for you.

Coverage Tier	Per Pay Period - 26 weeks	
Medical Plans	**BlueCross BlueShield RSB3**	**BlueCross BlueShield RSH3 (H.S.A)**
Employee Only	$9[illegible]	$[illegible]
Employee/Spouse	$[illegible]9	$[illegible]
Employee/Child(ren)	$[illegible]	$[illegible]
Employee/Family	$[illegible]	$[illegible]
Dental Plan		
Employee Only	$6.[illegible]	
Employee/Spouse	$1[illegible]	
Employee/Child(ren)	$2[illegible]	
Employee/Family	$[illegible]	
Vision Plan		
Employee Only	$1.98	
Employee/Spouse	$5.47	
Employee/Child(ren)	$6.16	
Employee/Family	$10.70	

The rates shown in this guide are illustrative only. To the extent the rates contained herein differ from those in the insurance documents that govern the terms and conditions of the plans of insurance described in this guide, the rates in the underlying insurance documents will govern in all cases.

Required Notices

Newborn and Mothers' Health Protection Act

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 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 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 the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act

In October 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains some important provisions of the Act. Please review this information carefully. As specified in the Women's Health and Cancer Rights Act, a plan participant or beneficiary who elects breast reconstruction in connection with a covered mastectomy is also entitled to the following benefits: 1. All stages of reconstruction of the breast on which the mastectomy has been performed: 2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and 3. Prostheses and treatment of physical complications of the mastectomy , including lymphedemas. Health plans must provide coverage of mastectomy related benefits in a manner to determine in consultation with the attending physician and the patient. Coverage for breast reconstruction and related services may be subject to deductibles and insurance amounts that are consistent with those that apply to other benefits under the plan.

Required CHIP Notice

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2018. Contact your State for more information on eligibility –

Alabama – Medicaid	Florida – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
Alaska – Medicaid	**Georgia – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
Arkansas – Medicaid	Indiana – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	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
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**Iowa – Medicaid**
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	Website: http://www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562

Required CHIP Notice

Kansas – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512	Website: https://www.dhhs.nh.gov/ombp/nhhpp/ Phone: 603-271-5218 Hotline: NH Medicaid Service Center at 1-888-901-4999
Kentucky – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	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
Louisiana – Medicaid	**NEW YORK – Medicaid**
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
Maine – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: https://dma.ncdhhs.gov/ Phone: 919-855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
Minnesota – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
Missouri – Medicaid	**OREGON – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075
Montana – Medicaid	**PENNSYLVANIA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: 1-800-692-7462
Nebraska – Medicaid	**RHODE ISLAND – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: (855) 632-7633 Lincoln: (402) 473-7000 Omaha: (402) 595-1178	Website: http://www.eohhs.ri.gov/ Phone: 855-697-4347
NEVADA – Medicaid	**South Carolina – Medicaid**
Medicaid Website: https://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: http://www.scdhhs.gov Phone: 1-888-549-0820

Required CHIP Notice

South Dakota - Medicaid	Washington – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/premium-payment-program Phone: 1-800-562-3022 ext. 15473
Texas – Medicaid	**West Virginia – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
Utah – Medicaid and CHIP	**Wisconsin – Medicaid and CHIP**
Medicaid Website:https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
Vermont– Medicaid	Wyoming – Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531
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	

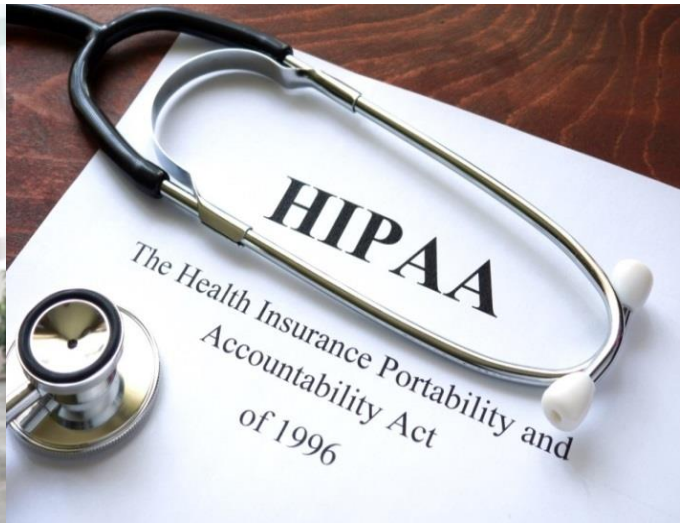
To see if any other states have added a premium assistance program since July 31, 2018, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/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

OMB Control Number 1210-0137 (expires 12/31/2019)

Required CHIP Notice



Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

Required HIPAA Notices

HIPAA Privacy Notices

HIPAA requires group health plans to provide a notice of current privacy practices regarding protected personal health information (PHI) to enrolled participants.

All employers must distribute HIPAA Privacy Notices if the plan is self-funded or if the plan is fully- insured and the employer has access to PHI.

If the employer maintains a benefits website, the HIPAA Privacy Notice must be included on the website.

The HIPAA Privacy Notice must be written in plain language and must describe three things: (1) the use and disclosures of PHI that may be made by the group health plan; (2) plan participants' privacy rights; and (3) the group health plan's legal responsibilities with respect to the PHI.

The Department of Health and Human Services (HHS) has developed three different model Privacy Notices for health plans to choose from: booklet version, layered version, and full-page version.

More information can be found at: https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/privacy-practices-for-protected-health-information/index.html

Link to model notice:
http://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/nppbooklet_health_plan.pdf

Model Special Enrollment Notice

The following is language that group health plans may use as a guide when crafting the special enrollment notice: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and 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' other coverage). However, you must request enrollment within the appropriate time period that applies under the plan after you or your dependents' other 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. However, you must request enrollment within the appropriate time period that applies under the plan after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the appropriate plan representative.

More information can be found at: https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/faqs/hipaa-compliance

Link to model notice: https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/compliance-assistance-guide-appendix-c.pdf

Confidentiality Notice

OneDigital Health and Benefits, a division of Digital Insurance, Inc., does not sell or share any information we learn about our clients and understands you may have to answer sensitive questions about your medical history, physical condition and personal health habits as required by our insurance carrier partners.

We collect nonpublic personal information from the following sources:

- Information from you, including data provided on applications or other forms, such as name, address, telephone number, date of birth and Social Security number

- Information from your transactions with us and/or our partners such as policy coverage, premium, claim, and payment history.

OneDigital Health and Benefits recognizes the importance of safeguarding the privacy of our clients and prospective clients, and we pledge to protect the confidential nature of your personal information. We understand our ability to provide access to affordable health insurance to businesses and individuals can only succeed with an environment of complete trust.

In the course of business, we may disclose all or part of your customer information without your permission to the following persons or entities for the following reasons:

- To an insurance carrier, agent or credit reporting agency to detect, prevent or prosecute actual or potential criminal activity, fraud, misrepresentation, unauthorized transactions, claims or other liabilities in connection with an insurance transaction;

- To a medical care institution or medical professional to verify coverage or benefits, to inform you of a medical problem of which you may or may not be aware or to conduct an audit that would enable us to verify treatment:

- To an insurance regulatory authority, law enforcement or other governmental authority to protect our interests in detecting, preventing or prosecuting actual or potential criminal activity, fraud, misrepresentation, unauthorized transactions, claims or other liabilities in connection with an insurance transaction.

- To a third party, for any other disclosures required or permitted by law. We may disclose all of the information that we collect about you, as described above.

Our practices regarding information confidentiality and security: We restrict access to your customer information only to those individuals who need it to provide you with products or services, or to otherwise service your account. In addition, we have security measures in place to protect against the loss, misuse and/or unauthorized alternation of the customer information under our control, including physical, electronic and procedural safeguards that meet or exceed applicable federal and state standards.

Carriers, Vendors & Contacts

Program	Vendor	Contact Information
Medical/Rx	Blue Cross Blue Shield of TX	800-521-2227 www.bcbstx.com
Dental and Vision	Principal	800-843-1371 www.principal.com
Client Advocate Center	OneDigital	866-736-6640 service@onedigital.com

BLUE FISH PEDIATRICS | IN ASSOCIATION WITH Children's MEMORIAL HERMANN

Know Where to Go!

BLUE FISH PEDIATRICS

Employee Benefits At-A-Glance December 2018-2019

Medical - BlueCross BlueShield

		RSH3	RSB3
Co-Insurance		**100% / 70%**	**80% / 60%**
Calendar Year Deductible			
In-Network	**Individual**	**$5,000**	**$3,000**
	Family	**$10,000**	**$9,000**
Out-of-Network	**Individual**	**$10,000**	**$3,000**
	Family	**$20,000**	**$9,000**
Out-of-Pocket Maximum (Includes Deductible)			
In-Network	**Individual**	**$5,000**	**$6,000**
	Family	**$10,000**	**$18,000**
Out-of-Network	**Individual**	**$20,000**	**$9,000**
	Family	**$40,000**	**$27,000**
Preventive Care Copay			
In-Network		**100%**	**100%**
Out-of-Network		**30% Coinsurance after Deductible**	**30% Coinsurance after Deductible**
Office Visit Copay			
In-Network		**Deductible Only**	**$30 copay**
Out-of-Network		**30% Coinsurance after Deductible**	**30% Coinsurance after Deductible**
Hospital/Inpatient Services			
In-Network		**Deductible Only**	**20% Coinsurance after Deductible**
Out-of-Network		**30% Coinsurance after Deductible**	**40% Coinsurance after Deductible**
Hospital/Outpatient Services			
In-Network		**Deductible Only**	**20% Coinsurance after Deductible**
Out-of-Network		**30% Coinsurance after Deductible**	**40% Coinsurance after Deductible**
Emergency Room Facility Charge			
In-Network		**Deductible Only**	**20% after $100 copay**
Out-of-Network		**Deductible Only**	**20% after $100 copay**
Urgent Care Services			
In-Network		**$45 Copay**	**$55 Copay**
Out-of-Network		**30% Coinsurance after Deductible**	**30% Coinsurance after Deductible**
Imaging (CT, PET scans, MRI)			
In-Network		**Deductible Only**	**20% after Ded.**
Out-of-Network		**30% after Ded.**	**40% after Ded.**
Prescription Coverage (30 day supply)	**•Generic**	**Deductible Only**	**$10**
	•Brand Name		**$40**
	•Non-Preferred		**$60**
Mail Order (90 day supply)			**3x RX Copay**

Dental - Principal

Deductible	
Individual	$50
Family	$150
Calendar Year Maximum	$1,000 + Max. Rollover
Preventive (Unit 1)	100%
Oral exams, Cleanings, X-Rays, Sealants (under age 14)	
Space Maintainers (under age 14)	
Fluoride treatments (under age 14)	
Basic (Unit 2)	80%
Preiodontal prophylaxis, Emergency exams	
Fillings and stainless steel crowns	
Major (Unit 3)	50%
Gral. Anesthesia, Endodontics	
Periodontics, Oral Surgery, Crowns, Inlays/Onlays	
Bridges, Dentures	

* In Network Benefits Only. Please refer to plan summary for Out of Network Benefit details.

Vision - Principal (VSP Network)

Frequency (exam/lenses/frames)	12/12/24 months
Exam (with Dilation as Necessay)	$10 Copay
Lenses (Single, Bifocals, Trifocals & Lenticular)	$25 Copay
Standard Frames	$150 allowance; 20% off balance over $150
Contacts (instead of frames & lenses)	
Exams (fitting and evaluation)	Up to $60 copay
Medically Necessary	$25 Copay
Elective	$150 Allowance

Virtual Visits available 24/7

Immediately video visit with a doctor 24 hours a day, 7 days a week from any location.

Virtual Visits : $44 or PCP Copay* (whichever is less)

Website: www.mdlive.com
Toll Free: 1-888-680-8646

MDLIVE®

*Could be $80-$175 copay for behavioral health.

BlueCross BlueShield - Member Services

BlueCross BlueShield of Texas

Toll Free:	1-800-521-2227
Website:	www.bcbstx.com
Member Access Site:	www.bcbstx.com/member
Provider Finder:	www.bcbstx.com/onlinedirectory

Principal - Member Services

Principal℠

Toll Free:	800-843-1371
Website:	http://www.principal.com

OneDigital - Member Services

ONEDIGITAL

Daniela Canales, Benefits Consultant
****dcanales@onedigital.com** 713-333-4706**

Per Pay Period Employee Contributions

*Bi-weekly (26 deductions)

	Base RSH3	Buy-Up RSB3	Dental	Vision
Employee	$68.16	$91.96	$6.48	$1.98
EE + Spouse	$187.67	$253.19	$17.71	$5.47
EE + Child(ren)	$247.12	$333.40	$24.15	$6.16
Family	$366.62	$494.63	$37.50	$10.70

This Benefits at a Glance summarizes some but not all services and is not meant to replace your certificate of coverage. The certificate of coverage from the carrier supercedes any discrepancies .

Revised 11/5/2018

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/2018 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 $5,000 Individual/$10,000 Family. Out-of-Network $10,000 Individual/$20,000 Family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive Care does not apply to the Networkdeductible.	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/$10,000 Family. For Out-of-Network $20,000 Individual/$40,000 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, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.bcbstx.com or call 1-800-810-2583 for a list of Network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		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	No Charge after deductible	30% coinsurance	None
	Specialist visit	No Charge after deductible	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 after deductible	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	No Charge after deductible	No Charge after deductible	Benefit payments are based on a 30-day supply for retail and mail order. With appropriate Prescription Order, up to a 90-day supply.
	Preferred brand drugs	No Charge after deductible	No Charge after deductible	
	Non-preferred brand drugs	No Charge after deductible	No Charge after deductible	
	Specialty drugs	No Charge after deductible	No Charge after deductible	Benefit payments are based on a 30-day supply for retail only, no mail order. With appropriate Prescription Order, up to a 90-day supply.
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	No Charge after deductible	No Charge after deductible	None
	Emergency medical transportation	No Charge after deductible	No Charge after deductible	

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)	
	Urgent care	No Charge after deductible	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.
	Physician/surgeon fees	No Charge after deductible	30% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge after deductible	30% coinsurance	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	Not Covered	Not Covered	Only Complications of Pregnancy covered.
	Childbirth/delivery professional services	No Charge after deductible	30% coinsurance	
	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.
If your child needs dental or eye care	Children's eye exam	No Charge	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	• Cosmetic surgery	• Private-duty nursing
• Acupuncture	• Dental Care (Adult)	• Weight loss programs
• Bariatric surgery	• Long-term care	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document)		
• Chiropractic care (Max. 35 visits/year)	• Infertility treatment (Invitro and artificial insemination are not covered)	• Routine eye care (Adult)
• Hearing aids	• Non-emergency care when traveling outside the U.S.	• 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. Contact the Texas Department of Insurance at 1-800-252-3439 or visit www.texashealthoptions.com.

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.

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.

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	$0
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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$5,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$2,500
The total Peg would pay is	**$7,500**

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	$0
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	$5,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$5,060**

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

The plan's overall deductible	$5,000
Specialist	$0
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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,900**

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 áká 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	اگر 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.

BlueCross BlueShield of Texas

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

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/2018 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 $3,000 Individual/$9,000 Family.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive Care, copayments, and prescription drugs do not apply to the Networkdeductible.	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 $6,000 Individual/$18,000 Family. For Out-of-Network $9,000 Individual/$27,000 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 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 copayment/visit	30% coinsurance	In addition to the office visit copayment/coinsurance, Network services are subject to 20% coinsurance and Out-of-Network services are subject to 40% coinsurance.
	Specialist visit	$30 copayment/visit	30% coinsurance	
	Preventive care/screening/ immunization	No Charge	30% coinsurance	In addition to the office visit copayment/coinsurance, Network services are subject to 20% coinsurance and Out-of-Network services are subject to 40% 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)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% 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 copayment/prescription	20% coinsurance plus copayment	Copayment amounts are per 30-day supply for retail and mail order.
	Preferred brand drugs	$40 copayment/prescription	20% coinsurance plus copayment	
	Non-preferred brand drugs	$60 copayment/prescription	20% coinsurance plus copayment	
	Specialty drugs	$10/$40/$60 copayment/prescription	20% coinsurance plus copayment	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	None
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	20% coinsurance after $100 copayment/visit	20% coinsurance after $100 copayment/visit	Copayment amount waived if admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	None

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)	
	Urgent care	$55 copayment/visit	30% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization is required and there is a $250 penalty if Out-of-Network is not preauthorized.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	$30 copayment per office visit in lieu of coinsurance for Network, and 30% coinsurance for Out-of-Network office visit. Coverage is limited to 25 visits per calendar year. Certain services must be preauthorized; refer to benefit booklet for details.
	Inpatient services	20% coinsurance	40% coinsurance	Preauthorization is required. Coverage is limited to 10 days per calendar year.
If you are pregnant	Office visits	Not Covered	Not Covered	Only Complications of Pregnancy covered.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	
If you need help recovering or have other special health needs	Home health care	No Charge	30% coinsurance	Preauthorization is required. Limited to 60 visits per calendar year.
	Rehabilitation services	20% coinsurance	40% coinsurance	Limited to combined 35 visits per year, including Chiropractic.
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	No Charge	30% coinsurance	Preauthorization is required. Limited to 25 days per calendar year.
	Durable medical equipment	20% coinsurance	40% coinsurance	None
	Hospice services	No Charge	30% coinsurance	Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	$30 copayment/visit	30% coinsurance	In addition to the office visit copayment/coinsurance, Network services are subject to 20% coinsurance and Out-of-Network services are subject to 40% coinsurance.
	Children's glasses	Not Covered	Not Covered	None
	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	• Cosmetic surgery	• Private-duty nursing
• Acupuncture	• Dental Care (Adult)	• Weight loss programs
• Bariatric surgery	• Long-term care	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document)		
• Chiropractic care (Max. 35 visits/year)	• Infertility treatment (Invitro and artificial insemination are not covered)	• Routine eye care (Adult)
• Hearing aids	• Non-emergency care when traveling outside the U.S.	• 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. Contact the Texas Department of Insurance at 1-800-252-3439 or visit www.texashealthoptions.com.

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.

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.

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	$3,000
Specialist copayment	$30
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$90
Coinsurance	$1,400
What isn't covered	
Limits or exclusions	$2,500
The total Peg would pay is	**$6,990**

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

The plan's overall deductible	$3,000
Specialist copayment	$30
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$1,400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,560**

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

The plan's overall deductible	$3,000
Specialist copayment	$30
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,000
Copayments	$90
Coinsurance	$100
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 áká 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	اگر 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.

BlueCross BlueShield of Texas

Health care coverage is important for everyone.

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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

Principal®

Policyholder: BLUE FISH PEDIATRICS

Dental Benefit Summary

Effective Date: 12/01/2017

Predetermination of Benefits: Before treatment begins for inlays, onlays, single crowns, prosthetics, periodontics and oral surgery, you may file a dental treatment plan with Principal Life Insurance Company. Principal Life will provide a written response indicating benefits that may be payable for the proposed treatment.

This chart provides you a brief summary of the key benefits of the dental coverage available from Principal Life Insurance Company. Following the chart, you will find additional information to answer questions you may have. For a complete list of all your dental coverage benefits and restrictions, please refer to your booklet or contact your employer.

Eligibility	
Job Class	All Members

Benefits Payable				
Network	Dental Contracted Network			
	Calendar Year Deductible		**Coinsurance (Policy Pays)**	
	In-Network	**Non-Network**	**In-Network**	**Non-Network**
Unit 1 – Preventive	$0	$0	100%	100%
Unit 2 – Basic	$50	$50	80%	80%
Unit 3 – Major	$50	$50	50%	50%
Family Deductible Maximum	3 times the per person deductible amount			
Combined Deductible	In-network deductibles for basic and major procedures are combined. Non-network deductibles for basic and major procedures are combined.			
Combined Maximums	Maximums for preventive, basic, and major procedures are combined. In-network Calendar year maximums are $1,000 per person. Non-network Calendar year maximums are $1,000 per person.			
Maximum Accumulation	This allows for a portion of unused maximum benefit to carry over to next year's maximum benefit amount. To qualify, you must have had a dental service performed within the Calendar year and used less than the maximum threshold. The threshold is equal to the lesser of 50% of the maximum benefit or $1000. If qualification is met, 50% of the threshold is carried over to next year's maximum benefit. You can accumulate no more than four times the carry over amount.			

How Are Dental Procedures Covered?

The list of common procedures shows what unit the procedure is included in and how often they are covered.

Unit 1 – Preventive Procedures	• Routine exams - one per six months • Routine cleaning (prophylaxis) - one per six months (Expectant mothers, diabetics and those with heart disease receive one additional routine or periodontal cleaning within a calendar year.) • Second Opinion Consultation • Fluoride – one treatment each calendar year (covered only for dependent children under age 14) • Space maintainers - covered only for dependent children under age 14; repairs not covered • Sealants – on first and second permanent molars for dependent children under age 14; one each tooth each 36 months • Harmful Habit Appliance - covered only for dependent children under age 14 • X-rays - Bitewing (one set every calendar year), occlusal, periapical • X-rays – Full mouth survey (one every 60 months), extraoral
Unit 2 – Basic Procedures	• Periodontal prophylaxis - if three months have elapsed after active surgical periodontal treatment; subject to Routine cleaning frequency limit (Expectant mothers, diabetics and those with heart disease receive one additional routine or periodontal cleaning within a calendar year.) • Emergency exams – subject to Routine exam frequency limit • Fillings and stainless steel crowns
Unit 3 – Major Procedures	• General Anesthesia (covered only for specific procedures)/IV Sedation • Simple Oral Surgery • Complex Oral Surgical Procedures • Non-surgical Periodontics, including scaling and root planing - once each quadrant each 24 months (For expectant mothers, diabetics and those with heart disease, this procedure is provided with no deductible and 100% coinsurance.) • Periodontal Surgical Procedures – one each quadrant each 36 months • Simple Endodontics (root canal therapy for anterior teeth) • Complex Endodontics (root canal therapy for molar teeth) • Repairs to Partial Denture, Bridge, Crown, Relines, Rebasing, Tissue Conditioning and Adjustment to Bridge/Denture, within policy limitations • Crowns – each 120 months per tooth if tooth cannot be restored by a filling. • Inlays, Onlays, Cast Post and Core, Core Buildup - each 120 months per tooth • Bridges - Initial placement / Replacement of bridges 120 months old. • Dentures - Initial placement of complete or partial dentures / Replacement of complete or partial dentures over 60 months old

There is Coordination of Benefits, which is a procedure for limiting benefits from two or more carriers to 100% of the claimant's covered expenses.

Understanding Your Dental Benefits

Am I Eligible For Coverage?

To be eligible for coverage, you must qualify as an eligible member and be considered actively at work.

You must be enrolled for dental coverage before it can be offered to your dependents. Eligible dependents include your spouse and children. Additional eligibility requirements may apply.

An annual enrollment applies. Members can enroll for dental coverage during the annual enrollment period and not be subject to the late entrant waiting period. Certain restrictions apply.

How Do I Find A Participating Provider?

Use the Provider Directory on www.principal.com to locate nearby dentists or see if your dentist participates in your network.

1	Visit www.principal.com/dentist.
2	Begin your search by picking the **state** where you would like to find a provider. Next, specify a **network**. Depending on the network chosen, you may be transferred to a partner site.
3	Enter the **name of the provider** you are looking for (if known). If you are looking for a nearby dentist, enter the **city and state and/or ZIP code**. Be sure to indicate **how far you are willing to travel**.
4	Select the **desired specialty** or use the No Specialty Preference default. Click **Continue**.
5	Select a **language** if your preference is other than English. Click **Continue**.

You may nominate your dentist for inclusion in our network. Please submit the dentist's name, address, phone and specialty by calling 1-800-832-4450, or submit through www.principal.com/refer-dental-provider.

What Are The Restrictions Of My Coverage?

This Benefit Summary is a summary only. For a complete list of benefit restrictions, please refer to your booklet.

Limitations & Exclusions	
Late Entrant Provision	Those members enrolling more than 31 days after becoming eligible will be subject to an individual benefit waiting period, subject to policy guidelines.
Missing Tooth	Benefits for the initial placement of bridges, partials and dentures are not covered if those teeth were missing prior to becoming insured under the Principal Life policy. When the policy replaces coverage under a prior plan, continuous coverage under the prior plan may be applied to the missing tooth provision requirement.
Prevailing Charge	When using non-network providers, you pay any amount over the allowable charge.
Other Limitations	There are additional limitations to your coverage. A complete list is included in your booklet.

Principal Life Insurance Company, Des Moines, Iowa 50392-0002, www.principal.com

This is a summary of dental coverage underwritten by or with administrative services provided by Principal Life Insurance Company. This benefit summary is for administrative purposes and is not a complete statement of benefits and restrictions. You'll receive a benefit booklet with details about your coverage. If there is a discrepancy between this summary and your benefit booklet, the benefit booklet prevails.

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Policyholder: BLUE FISH PEDIATRICS

Vision Benefit Summary

Effective Date: 12/01/2017

This chart provides you a brief summary of the key benefits of the vision coverage available from Principal Life Insurance Company. Following the chart, you will find additional information to answer questions you may have. For a complete list of all your vision coverage benefits and restrictions, please refer to your booklet or contact your employer.

Eligibility	
Job Class	All Members

Your Coverage with a VSP Preferred Provider		
Doctor Network	VSP Choice Network	
Covered Charges	**Benefit**	**Frequency**
Exams	$10 copay	One exam every 12 months
Prescription Glasses	$25 copay	
Lenses	Single vision, lined bifocal, lined trifocal and lenticular lenses; polycarbonate lenses for dependent children under age 18 Members pay for lens enhancements as an out-of-pocket expense after the copay; they are discounted 20-25% by VSP providers.***	Two lenses (one pair) every 12 months
Frames*	$150 allowance for a wide selection of frames; 20% off amount over allowance***	One set every 24 months
Elective Contacts	Up to $60 copay for your elective contact lens exam (fitting and evaluation) $150 allowance for elective contacts	Once every 12 months Contacts are instead of frames and lenses
Necessary Contacts**	$25 copay Covered in full for members who have specific conditions	Once every 12 months Contacts are instead of frames and lenses

Additional Savings ***	
Glasses and Sunglasses	Members save an average of 20-25% off additional glasses and sunglasses, including lens options, from any VSP doctor within 12 months of your last covered vision exam
Laser Vision Correction	Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities

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Your Coverage with Other Providers (Non-Network)		
Covered Charges	**Scheduled Benefit Amount**	**Frequency**
Vision Exams	Up to $45	One per 12 month period
Single Vision lenses	Up to $30	One pair per 12 month period
Lined bifocal lenses	Up to $50	One pair per 12 month period
Lined trifocal lenses	Up to $65	One pair per 12 month period
Lenticular lenses	Up to $100	One pair per 12 month period
Frames	Up to $70	One set per 24 month period
Elective Contacts	Up to $105	In lieu of lenses and frame benefits
Necessary Contacts**	Up to $210	In lieu of lenses and frame benefits

*VSP has agreements established with some Participating Retail Chain Providers that may also provide benefits for this covered service. Up to an $80 allowance is given for a wide selection of frames from Costco. Please talk to your provider or contact VSP customer care for further details.

** Necessary contact lenses are prescribed to correct extreme visual problems that cannot be corrected with regular lenses.

*** Based on applicable laws; benefits may vary by doctor location.

There is Coordination of Benefits, which is a procedure for limiting benefits from two or more carriers to 100% of the claimant's covered expenses.

Understanding Your Vision Benefits

Am I Eligible For Coverage?

To be eligible for coverage, you must qualify as an eligible member and be considered actively at work.

You must be enrolled for vision coverage before it can be offered to your dependents. Eligible dependents include your spouse and children. Additional eligibility requirements may apply.

How Do I Find a VSP Provider?

Use the Provider Directory on www.vsp.com to locate nearby VSP providers or to see if your current eye care professional participates in the VSP network. To speak to a representative by phone, please call 800-877-7195.

How Do I Submit A Claim?

When visiting a VSP provider for services, the provider submits the claim for payment. If visiting a non-network provider for services, you are responsible for submitting the claim to VSP. Obtain a claim form by logging on to vsp.com or by calling 800-877-7195. Include a copy of your itemized receipt with your claim form and mail it to the following address.

Vision Service Plan
P.O. Box 385018
Birmingham, AL 35238-5018

What Are The Restrictions Of My Coverage?

This Benefit Summary is a summary only. For a complete list of benefit restrictions, please refer to your booklet.

Late Entrant Waiting Period	Those members enrolling more than 31 days after becoming eligible will be subject to an individual benefit waiting period, subject to coverage guidelines.
Non-Medically Necessary Services	The coverage does not pay for visual analysis or vision aids that are not medically necessary.
Benefit Limitations	The following items are excluded under this coverage: • Two pairs of glasses instead of bifocals • Replacement of lenses, frames or contacts • Medical or surgical treatment • Orthoptics, vision training or supplemental testing • Plano lenses (lenses with refractive correction of less than ± .50 diopter)
Contact Lens Limitations	The following items are not covered under the contact lens coverage: • Insurance policies or service agreements • Artistically painted or non-prescription lenses • Additional office visits for contact lens pathology • Contact lens modification, polishing or cleaning • Refitting of contact lenses after the initial (90 day) fitting period
Other Limitations	There are additional limitations to your coverage. A complete list is included in your booklet.

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Principal Life Insurance Company, Des Moines, Iowa 50392-0002, www.principal.com

This is a summary of vision coverage underwritten by or with administrative services provided by Principal Life Insurance Company. This benefit summary is for administrative purposes and is not a complete statement of the rights, benefits, limitations or exclusions of the coverage. You'll receive a benefit booklet with details about your coverage. If there is a discrepancy between this summary and your benefit booklet, the benefit booklet prevails.


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