

Summary of BestChoice Benefits
BlueEdge Integrated HSA± Plan H350 BlueChoice Network
Blue Cross® and Blue Shield® of Texas (BCBSTX)¹

TYPE OF SERVICE	NETWORK	OUT-OF-NETWORK
CALENDAR YEAR DEDUCTIBLE	\$5000 EO or \$10000 Family	\$10000 EO or \$20000 Family
OUT-OF-POCKET MAXIMUM (Calendar Year) Includes Deductible	\$5000 EO or \$10000 Family Network deductible and out-of-pocket will only apply toward Network deductible and out-of-pocket maximum	\$20000 EO or \$40000 Family Out-of-Network deductible and out-of-pocket will also apply toward Network deductible and out-of-pocket maximum
LIFETIME MAXIMUM PER PARTICIPANT*	\$2,000,000	
HOSPITAL SERVICES** Semiprivate Room & Board, Services & Supplies, Intensive Care Unit, Maternity Care Non-Preauthorization Penalty	100% after cal. yr. deductible None	70% after cal. yr. deductible \$250
EMERGENCY ROOM / TREATMENT ROOM Accident & Medical Emergency Situation within 48 hrs*** Facility Charges Physician Charges	100% after cal. yr. deductible 100% after cal. yr. deductible	
Non-Emergency Situations Facility Charges Physician Charges	100% after cal. yr. deductible 100% after cal. yr. deductible	70% after cal. yr. deductible 70% after cal. yr. deductible
PHYSICIAN SERVICES Services performed in physician office, including lab & x-ray Preventive Care including Routine Physicals, Well Baby Exam, Vision & Hearing Exams and Immunizations Office & Outpatient Surgery Inpatient Visits / Surgery & Certain Diagnostic Procedures Maternity Care	100% after cal. yr. deductible 100% 100% after cal. yr. deductible 100% after cal. yr. deductible 100% after cal. yr. deductible	70% after cal. yr. deductible 70% 70% after cal. yr. deductible 70% after cal. yr. deductible 70% after cal. yr. deductible
INDEPENDENT LAB / FREESTANDING IMAGING CENTERS / OUTPATIENT FACILITY SERVICES All Knee / Shoulder Arthroscopies, Bone Scans, Cardiovascular Stress Tests, CT Scans, Carotid Ultrasounds, Endoscopic Procedures, MRIs, Myelogram and PET Scans All other Diagnostic Outpatient Medical Services Home Infusion Therapy**, Radiation Therapy, Inhalation Therapy, Chemotherapy, Durable Medical Equipment & Renal Dialysis	100% after cal. yr. deductible 100% after cal. yr. deductible 100% after cal. yr. deductible	70% after cal. yr. deductible 70% after cal. yr. deductible 70% after cal. yr. deductible
EXTENDED CARE SERVICES**	100% after cal. yr. deductible	70% after cal. yr. deductible
Skilled Nursing Facility / Cal. Yr. Max.* Hospice Care / Lifetime Max.* Home Health Care / Cal. Yr. Max.*	\$10,000 \$20,000 \$10,000	
MENTAL HEALTH CARE** Office Visits Outpatient Visits Psychological Testing Hospital Inpatient (Facility) Hospital Inpatient (Physician) Calendar Year Maximum* Lifetime Maximum*	100% after cal. yr. deductible 100% after cal. yr. deductible 100% after cal. yr. deductible 100% after cal. yr. deductible 100% after cal. yr. deductible	70% after cal. yr. deductible 70% after cal. yr. deductible 70% after cal. yr. deductible 70% after cal. yr. deductible 70% after cal. yr. deductible
	\$5,000 \$10,000	
CHEMICAL DEPENDENCY**** Provides lifetime maximum of 3 series of treatments	Same As Any Other Sickness** Treatment in a physician's or other professional provider's office after completion of a treatment program is considered mental health care.	
PHYSICAL MEDICINE SERVICES*	100% after cal. yr. deductible	70% after cal. yr. deductible
	\$1500 calendar year maximum	
PRESCRIPTION DRUG BENEFIT	100% after cal. yr. deductible	

¹ A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

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BlueEdge Integrated HSA± Plan H350 BlueChoice Network

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- * Maximums include Network and Out-of-Network.
- ** Must be preauthorized.
- *** A serious accident or medical condition, if not treated immediately, might result in a life-threatening situation. Medical conditions not considered an emergency will pay the non-emergency benefit ratio.
- **** State mandated offering.

NETWORK – Employees and their eligible dependents may seek care from network providers listed in the provider directory. When care is received from network providers, participants will receive network benefits (the maximum benefits available).

OUT-OF-NETWORK – Employees and their eligible dependents may seek care from providers outside the network (providers not listed in the provider directory) and receive out-of-network benefits (the lower level of benefits).

The plan also includes the following provisions:

- Employees and dependents, who were covered under the employer’s group health care contract with another carrier immediately prior to the effective date of this contract and whose coverage became effective on the group contract effective date, will be credited with the amount of the calendar year deductible reached with the employer’s prior carrier.
- This plan does not include a 4th quarter calendar year deductible carryover provision.
- Dependent unmarried children are covered until age 25. Disabled dependent children can be covered beyond age 25.
- Automatic coverage for newborn infants for the first 31 days following birth. Infants not enrolled for coverage within the first 31 days after birth will be treated as a late enrollee.
- Provider charges are paid according to BCBSTX determined Allowable Amount and negotiated prices.
- Pre-existing conditions are defined in the contract and are excluded for 12 months. Appropriate credit will be given for time served under another eligible health benefit plan as defined under the law.
- Services rendered after the group’s termination date are not covered except as provided in the Extension of Benefits section of the General Provisions portion of the Benefit Booklet.
- Refer to the Benefit Booklet for Limitations and Exclusions.
- This plan does not credit prior carrier out-of-pocket.
- Coverage is contingent upon the following:
 - The employer must maintain enrollment of at least 75% of eligible employees and pay at least 50% of the employee only cost.
 - No additional taxes may be imposed and no increase in existing taxes.
 - The replacement of coverage stipulation in the contract.
- In addition to the benefits stated herein, benefits for covered persons who reside outside of Texas will conform to all Extraterritorial requirements of those states.
- The benefits of the Plan will be available after satisfaction of the applicable Deductibles. The Deductibles may be increased in the future as determined for cost-of-living adjustments based on the Consumer Price Index (CPI-U). The Deductibles are explained as follows:
 1. If “Employee Only” is selected on your *Group Enrollment Application/Change Form*, the individual Deductible amount as shown on your Summary of Benefits under “Deductibles,” will apply to all combined Inpatient Hospital Expense, Medical-Surgical Expense, and Special Provisions Expenses you incur during a Calendar Year and must be satisfied before any benefits are available under the Plan.
 2. If “Family” coverage is selected on your *Group Enrollment Application/Change Form*, the family Deductible amount as shown on your Summary of Benefits under “Deductibles,” will apply to all combined Inpatient Hospital Expense, Medical-Surgical Expense, and Special Provisions Expense each Participant incurs during each Calendar Year and must be satisfied before any benefits are available under the Plan. The family Deductible amount may be satisfied by one Participant or a combination of two or more Participants.
- Most of your Eligible Expense payment obligations are applied to the Out-of-Pocket Maximum. The Out-of-Pocket Maximum may be increased in the future as determined for cost-of-living adjustments based on the Consumer Price Index (CPI-U).
 1. The Out-of-Pocket Maximum **will not** include:
 - Services, supplies, or charges limited or excluded by the Plan;
 - Expenses not covered because of a benefit maximum has been reached;
 - Any Eligible Expense paid by the Primary Plan when BCBSTX is the Secondary Plan for purposes of coordination of benefits;
 - Penalties for failing to obtain preauthorization;
 2. If you selected “Employee Only” on your *Group Enrollment Application/Change Form*, when the individual “Out-of-Pocket Maximum” for a Calendar Year equals the amount shown on this Summary of Benefits, the benefit percentage automatically increases to 100% for purposes of determining the benefits available for additional Eligible Expenses incurred by you during the remainder of that Calendar Year.
 3. If you selected the “Family” coverage on your *Group Enrollment Application/Change Form*, when the family “Out-of-Pocket Maximum” for a Calendar Year equals the amount shown on this Summary of Benefits, the benefit percentage automatically increases to 100% for purposes of determining the benefits available for additional Eligible Expenses incurred by all family Participants during the remainder of that Calendar Year. The family Out-of-Pocket Maximum may be satisfied by one or more covered Participants.

± Please be reminded that Health Savings Account (HSA’s) have tax and legal ramifications. Blue Cross and Blue Shield of Texas does not provide legal or tax advice, and nothing herein should be construed as legal or tax advice. These materials, and any tax-related statements in them, are not intended or written to be used, and cannot be used or relied on, for the purpose of avoiding tax penalties. Tax-related statements, if any, may have been written in connection with the promotion or marketing of the transaction(s) or matter(s) addressed by these materials. You should seek advice based on your particular circumstances from an independent tax advisor regarding the tax consequences of specific health insurance plans or products.

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