Medical Plan
Payroll Deductions (semi-monthly)

HSA 300 Base Plan	Rates
Employee Only	$0.00
Employee + Child	$58.67
Employee + Children	$129.08
Employee + Spouse	$293.38
Employee + Family	$363.79

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BENEFIT HIGHLIGHTS

BlueChoice Network

This is a general summary of your benefits. Please refer to your benefit booklet for additional details and a description of the plan requirements and benefit design. This plan does not cover all health care expenses. Upon receipt of your benefit booklet, carefully review the plan's limitations and exclusions.

Over all Payment Provisions	PPO (In-Network)	Non-PPO (Out-of-Network)
Plan Year Deductible		
Applies to all Eligible Expenses (unless otherwise indicated)		
Family coverage: When one family member meets the individual Deductible, benefits become available under the plan for that individual.	*$5,000 Individual / $10,000 Family*	*$10,000 Individual / $20,000 Family*
NOTE: The individual Deductible amount must be equal to or greater than the minimum family Deductible amount. This qualification is established by the U. S. Treasury for a plan to be considered a qualified HSA plan.		
Out-of-Pocket Maximum	*$5,000 Individual / $10,000 Family*	*$20,000 Individual / $40,000 Family*
Deductible, Coinsurance Amounts, and Copayments (if any) apply to Out-of-Pocket Maximum	*Network Deductible & Out-of-Pocket Max **will only** apply toward Network Deductible & Out-of-Pocket maximum*	*Out-of-Network Deductible & Out-of-Pocket Max **do not** apply toward Network Deductible & Out-of-Pocket maximum*
No credit given for Out-of-Pocket Maximum (or Coinsurance Stop-Loss Amount) from prior carrier		
Maximum Lifetime Benefits		
Per individual	*Unlimited*	
Inpatient Hospital Expenses		
Inpatient Hospital Expenses *(must be preauthorized)*	*100% of Allowable Amount after Plan Year Deductible*	*70% of Allowable Amount after Plan Year Deductible*
Inpatient Hospital Expenses (including Maternity Care)		
Penalty for failure to preauthorize	*None*	*$250*
Medical/Surgical Expenses		
Medical / Surgical Expenses		
Physician office visit/consultation, including lab & x-ray	*100% of Allowable Amount after Plan Year Deductible*	*70% of Allowable Amount after Plan Year Deductible*
Physician surgical services in any setting and Maternity Care	*100% of Allowable Amount after Plan Year Deductible*	*70% of Allowable Amount after Plan Year Deductible*
Lab & x-ray in other outpatient facilities and Certain Diagnostic Procedures: Bone Scan, Cardiac Stress Test, CT Scan (with or without contrast), Ultrasound, MRI, Myelogram, PET Scan.	*100% of Allowable Amount after Plan Year Deductible*	*70% of Allowable Amount after Plan Year Deductible*
Home Infusion Therapy (must be preauthorized)	*100% of Allowable Amount after Plan Year Deductible*	*70% of Allowable Amount after Plan Year Deductible*
In Vitro Fertilization Services	*Declined*	
All other outpatient services and supplies	*100% of Allowable Amount after Plan Year Deductible*	*70% of Allowable Amount after Plan Year Deductible*

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Extended Care Expenses	PPO (In-Network)	Non-PPO (Out-of-Network)
Extended Care Expenses *(must be preauthorized)*	*100% of Allowable Amount after Plan Year Deductible*	*70% of Allowable Amount after Plan Year Deductible*
Skilled Nursing Facility	*Limited to 25 days maximum each Plan Year**	
Home Health Care	*Limited to 60 visits each Plan Year**	
Hospice Care	*Unlimited*	

Special Provisions Expenses		
Treatment of Chemical Dependency *(must be preauthorized)*		
Inpatient treatment must be provided in a Chemical Dependency Treatment Center	*Three separate series of treatments for each covered individual* Covered as any other physical illness*	
All other outpatient treatment	*Covered as any other physical illness*	*Covered as any other physical illness*
Serious Mental Illness / Mental Health Care *(must be preauthorized)*		
Inpatient Services		
Hospital services (facility)	*100% of Allowable Amount after Plan Year Deductible*	*70% of Allowable Amount after Plan Year Deductible*
Physician services	*100% of Allowable Amount after Plan Year Deductible*	*70% of Allowable Amount after Plan Year Deductible*
Outpatient Services		
Services performed in a Physician's office, including lab & x-ray	*100% of Allowable Amount after Plan Year Deductible*	*70% of Allowable Amount after Plan Year Deductible*
Other outpatient services and psychological testing Plan	*100% of Allowable Amount after Plan Year Deductible*	*70% of Allowable Amount after Plan Year Deductible*
Year Maximum	*30 outpatient visits each Plan Year**	
Emergency Care/Outpatient Hospital Emergency Room		
Accidental Injury & Medical Emergency Care		
Facility charges	*100% of Allowable Amount after Plan Year Deductible*	
Physician charges	*100% of Allowable Amount after Plan Year Deductible*	
Non-Emergency Situations		
Facility charges	*100% of Allowable Amount after Plan Year Deductible*	*70% of Allowable Amount after Plan Year Deductible*
Physician charges	*100% of Allowable Amount after Plan Year Deductible*	*70% of Allowable Amount after Plan Year Deductible*
Urgent Care		
Urgent Care center visit, including all lab & x-ray services, Certain Diagnostic Procedures, and all other services and supplies	*100% of Allowable Amount after Plan Year Deductible*	*70% of Allowable Amount after Plan Year Deductible*

* All benefit payments made for both In-Network and Out-of-Network services will apply toward any maximum amounts indicated.

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Preventive Care		
Routine annual physicals, well-baby exam, immunizations, and other preventive health services as determined by the USPSTF	*100% of Allowable Amount*	*70% of Allowable Amount*

Special Provisions Expenses, cont.	***PPO*** ***(In-Network)***	***Non-PPO*** ***(Out-of-Network)***
Speech and Hearing Services		
Services to restore loss of or correct an impaired speech or hearing function without hearing aids	*100% of Allowable Amount after Plan Year Deductible*	*70% of Allowable Amount after Plan Year Deductible*
Physical Medicine Services		
Physical Medicine Services (includes but is not limited to physical, occupational, and manipulative therapy) Plan Year Maximum	*100% of Allowable Amount after* *Plan Year Deductible Limited to 35 visits each Plan Year**	*70% of Allowable Amount after Plan Year Deductible*

* All benefit payments made for both In-Network and Out-of-Network services will apply toward any maximum amounts indicated.

Prescription Drug Program	***Participating Pharmacy***	***Non-Participating Pharmacy*** ***(member files claim)***
Prescription Drugs*		
Retail Pharmacy (Benefit payments are based on a 30-day supply – With appropriate Prescription Order, up to a 90-day supply)	*100% of Allowable Amount after the Plan Year Deductible*	
Mail Service Pharmacy (Benefit payments are based on a 30-day supply – With appropriate Prescription Order, up to a 90-day supply)	*100% of Allowable Amount after the Plan Year Deductible*	

*Benefits used In-Network and Out-of-Network will apply toward satisfying any day, visit, or Plan Year Maximum amounts indicated

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EMPLOYEE INFORMATION

- The following applies to dependent coverage:
  - Dependent children are covered for maternity benefits
  - Automatic coverage for newborns for the first 31 days following birth. Infants not enrolled for coverage within the first 31 days after birth will not be eligible for coverage until the following open enrollment period or special enrollment event.
- Payments: Network providers agree to accept amounts negotiated with BCBSTX and are paid according to this BCBSTX-determined Allowable Amount. Covered individuals are responsible for any required Deductibles, Coinsurance Amounts, and Copayments. Plan benefits paid to Out-of-Network providers are also based on the BCBSTX-determined Allowable Amount. Covered individuals will be responsible for charges in excess of the Allowable Amount in addition to any applicable Deductibles, Coinsurance Amounts, and Copayments. For cost savings information, refer to the section on ParPlan Providers and the definition of Allowable Amount in the benefit booklet.
- Replacement of Medical Coverage: In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Texas State law, the following provisions apply to each eligible participant who has health coverage under the employer's plan immediately prior to the effective date of the health contract between the employer and BCBSTX (the Contract Date):
  - Benefits for eligible expenses incurred for any service or supplies prior to the contract date, are not covered under the contract.
  - Eligible Expenses for services or supplies incurred on or after the effective date will be considered for benefits subject to all applicable contract provisions.
- Members residing in other states may use that state's network through the BlueCard program. To locate a participating provider in your state, please contact 1-800-810-BLUE or visit our web site at www.bcbstx.com to use our Provider Finder® tool. n addition to the benefits stated herein, benefits for covered persons who reside outside of Texas will conform to all extraterritorial requirements of those states
- 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.
  - The replacement of coverage stipulation in the contract.
- Deductible (Embedded): The benefits of the Plan will be available after satisfaction of the applicable Deductible. The Deductible will be increased in the future in direct proportion to the increase as determined from the cost-of-living adjustments based on the Consumer Price Index (CPI-U). The Deductibles are explained as follows:
  1. The individual Deductible amount as shown on this Benefits Highlights under "Plan Year Deductible," must be satisfied by each Participant under your coverage each Plan Year. This Deductible, unless otherwise indicated, will apply to all combined Inpatient Hospital Expenses, Medical-Surgical Expenses, Extended Care Expenses, and Special Provisions Expenses you incur during a Plan Year.
  2. If you have several covered Dependents, all charges used to apply toward a "per individual" Deductible amount will be applied toward the "per family" Deductible amount shown on this Benefits Highlights. When that family Deductible amount is reached, no further individual Deductibles will have to be satisfied for the remainder of that Plan Year. No Participant will contribute more than the individual Deductible amount to the "per family" Deductible amount.
- Out-of-Pocket Maximum: Most of your Eligible Expense payment obligations are applied to the Out-of-Pocket Maximum. The Out-of-Pocket Maximum will be increased in the future in direct proportion to the increase as determined from the 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 BCBXTX is the Secondary Plan for purposes of coordination of benefits;
     - Penalties for failing to obtain preauthorization;
  2. When the Out-of-Pocket Maximum amount for the In-Network or Out-of-Network Benefits level for a Participant in a Plan Year equals the "per individual" "Out-of-Pocket Maximum" shown on this Benefits Highlights for that level, the benefit percentages automatically increase to 100% for purposes of determining the benefits available for additional Eligible Expenses incurred by that Participant for the remainder of that Plan Year for that level.
  3. When the Out-of-Pocket Maximum amount for the In-Network or Out-of-Network Benefits level for all Participants under your coverage in a Plan Year equals the "per family" "Out-of-Pocket Maximum" shown on this Benefits Highlights for that level, the benefit percentages automatically increase to 100% for purposes of determining the benefits available for additional Eligible Expenses incurred by all family Participants for the remainder of the Plan Year for that level. No Participant will be required to contribute more than the individual Out-of-Pocket Maximum to the family Out-of-Pocket Maximum.

± Please be reminded that Health Savings Accounts(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.

Initials _____ Date _____