Summary of BestChoice Benefits
M802 BlueChoice Network
Blue Cross and Blue Shield of Texas (BCBSTX)*

TYPE OF SERVICE	NETWORK	OUT-OF-NETWORK
CALENDAR YEAR DEDUCTIBLE (Combined)	$500 Individual / $1500 Family	
COINSURANCE STOPLOSS MAXIMUM (calendar year)	$2000 Individual / $6000 Family Network coinsurance **will not apply** toward Out-of-Network coinsurance	$4000 per person Out-of-Network coinsurance **will apply** toward Network coinsurance
LIFETIME MAXIMUM PER PARTICIPANT*	$2,000,000	
HOSPITAL SERVICES**		
Semiprivate Room & Board, Services & Supplies, Intensive Care Unit, Maternity Care	80% after cal. yr. deductible	60% after cal. yr. deductible
Non-Precertification Penalty	None	$250
EMERGENCY ROOM / TREATMENT ROOM		
Accident & Medical Emergency Situation within 48 hrs***		
Facility Charges (Copayment (copay) waived if admitted)	80% after $100 copay	
Physician Charges	80% after cal. yr. deductible	
Non-Emergency Situations		
Facility Charges (copay waived if admitted)	80% after $100 copay	60% after $100 copay & cal. yr. deductible
Physician Charges	80% after cal. yr. deductible	60% after cal. yr. deductible
PHYSICIAN SERVICES		
Services performed in physician office, including lab & x-ray	100% after $20 copay	70% after cal. yr. deductible
Preventive Care including Routine Physicals, Well Baby Exam, and Vision & Hearing Exams, Immunizations thru age 7 (deductible is not applicable to immunizations of a Dependent child age seven years of age or younger)	100% after $20 copay	70% after cal. yr. deductible
Office & Outpatient Surgery	80% after cal. yr. deductible	60% after cal. yr. deductible
Inpatient Visits / Surgery & Certain Diagnostic Procedures	80% after cal. yr. deductible	60% after cal. yr. deductible
Maternity Care	80% after cal. yr. deductible	60% 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	80% after cal. yr. deductible	60% after cal. yr. deductible
All other Diagnostic Outpatient Medical Services	100%	70% after cal. yr. deductible
Home Infusion Therapy**, Radiation Therapy, Inhalation Therapy, Chemotherapy, Durable Medical Equipment & Renal Dialysis	80% after cal. yr. deductible	60% after cal. yr. deductible
EXTENDED CARE SERVICES**	100%	70%
Skilled Nursing Facility / Cal. Yr. Max.*	$10,000	
Hospice Care / Lifetime Max.*	$20,000	
Home Health Care / Cal. Yr. Max.*	$10,000	
MENTAL HEALTH CARE**		
Office Visits	100% after $20 copay	70% after cal. yr. deductible
Outpatient Visits	80% after cal. yr. deductible	60% after cal. yr. deductible
Psychological Testing	80% after cal. yr. deductible	60% after cal. yr. deductible
Hospital Inpatient (Facility)	80% after cal. yr. deductible	60% after cal. yr. deductible
Hospital Inpatient (Physician)	80% after cal. yr. deductible	60% after cal. yr. deductible
Calendar Year Maximum*	$5,000	
Lifetime Maximum*	$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*	80% after cal. yr. deductible	60% after cal. yr. deductible
	$1500 calendar year maximum	

*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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PRESCRIPTION DRUG PROGRAM / MAIL SERVICE PRESCRIPTION DRUG PROGRAM +
(All copays are for 30-day supply)

	PARTICIPATING PHARMACY	NON-PARTICIPATING PHARMACY
Non-Preferred Brand Name Drug Copayment Amount	$45	80% of Allowable Amount******
Preferred Brand Name Drug Copayment Amount	$30	80% of Allowable Amount******
Generic Drug Copayment Amount	$15	80% of Allowable Amount******

	MAIL SERVICE PRESCRIPTION DRUG PROGRAM
Non-Preferred Brand Name Drug Copayment Amount	$45
Preferred Brand Name Drug Copayment Amount	$30
Generic Drug Copayment Amount	$15

* 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.
\+ If there is no Generic Drug for your Preferred or Non-Preferred Brand Name Drug Prescription Order, you will pay no more than the applicable Preferred or Non-Preferred Brand Name Drug Copayment Amount. If you receive a Preferred or Non-Preferred Brand Name Drug when a Generic Drug is available, your payment amount will be the sum of (a) the difference between the allowable amount of the Preferred or Non-Preferred Brand Name Drug and the cost of the Generic Drug, plus (b) the Preferred Brand Name Drug Copayment amount.
****** Non-Participating Pharmacy reimbursement is also subject to deduction of any applicable Pharmacy Deductible, the appropriate Copayment Amount, and any pricing differences that may apply.
NOTE: Copays apply toward meeting coinsurance stoploss maximums and continue after coinsurance maximums are reached. Prescription Drug Program copay will not satisfy coinsurance maximum.

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 coinsurance.
- 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.

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