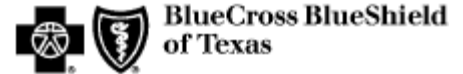


BestChoice Benefits
RSB4
Lab & X-Ray (Ded & Coins)



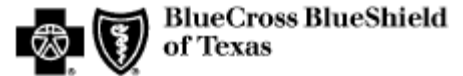
BENEFIT HIGHLIGHTS

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.

Overall Payment Provisions	In-Network Benefits	Out-of-Network Benefits
<p>Calendar Year Deductible Applies to all Eligible Expenses (unless otherwise indicated) Three-month Deductible carryover does not apply Deductible credit from prior carrier (applied on initial group enrollment only)</p>	\$5,000 Individual / \$15,000 Family	
<p>Copayment Amounts Required Physician office visit/consultation <i>Refer to Medical/Surgical Expenses section for more information</i></p>	\$40 Copayment Amount	
<p>Urgent Care center visit <i>Refer to Urgent Care Services section for more information</i></p>	\$65 Copayment Amount	
<p>Outpatient Hospital Emergency Room visit <i>Refer to Emergency Care section for more information</i></p>	\$100 Copayment Amount	\$100 Copayment Amount
<p>Coinsurance Stop-Loss Amount Deductibles are not applied to the Coinsurance Stop-Loss Amount. Copayment Amounts are applied but will continue to be required after the benefit percentages increase to 100%. Your benefit booklet will provide more details.</p>	\$5,000 Individual / \$15,000 Family	\$10,000 Individual / \$30,000 Family
<p>No credit given for Coinsurance Stop-Loss Amount from prior carrier</p>	<i>Network Coinsurance Stop-Loss Amount will only apply toward Network Coinsurance Stop-Loss Amount</i>	<i>Out-of-Network Coinsurance Stop-Loss Amount will also apply toward Network Coinsurance Stop-Loss Amount</i>
<p>Maximum Lifetime Benefits Per individual</p>	Unlimited	
Inpatient Hospital Expenses		
<p>Inpatient Hospital Expenses (must be preauthorized) Inpatient Hospital Expenses (including Maternity Care)</p>	70% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
<p>Penalty for failure to preauthorize</p>	None	\$250
Medical/Surgical Expenses		
<p>Medical / Surgical Expenses Physician office visit/consultation</p>	100% of Allowable Amount after \$40 Copayment Amount	70% of Allowable Amount after Calendar Year Deductible
<p>Lab, & x-ray, and Certain Diagnostic Procedures, such as: Bone Scan, Cardiac Stress Test, CT Scan (with or without contrast), Ultrasound, MRI, Myelogram, PET Scan and all other office services and supplies</p>	70% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
<p>Physician surgical services in any setting, Physician inpatient visits, and Maternity Care</p>	70% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
<p>Home Infusion Therapy (must be preauthorized)</p>	70% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
<p>All other outpatient services and supplies</p>	70% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible

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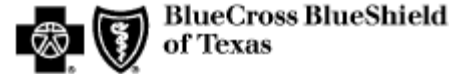
Extended Care Expenses	In-Network Benefits	Out-of-Network Benefits
Extended Care Expenses (must be preauthorized) Skilled Nursing Facility Home Health Care Hospice Care	100% of Allowable Amount	70% of Allowable Amount
	Limited to 25 days maximum each Calendar Year* Limited to 60 visits each Calendar Year* Unlimited	
Special Provisions Expenses		
★ Treatment of Chemical Dependency (must be preauthorized) Inpatient treatment must be provided in a Chemical Dependency Treatment Center All other outpatient treatment	Three separate series of treatments for each covered individual* Covered as any other physical illness	
	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)	70% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Physician services	70% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Outpatient Services Physician office visit/psychotherapy session	100% of Allowable Amount after \$40 Copayment Amount	70% of Allowable Amount after Calendar Year Deductible
Other outpatient services, including psychological testing	70% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Calendar Year Maximum	Limited to 10 inpatient hospital days and 25 outpatient visits each Calendar Year*	
Emergency Care/Outpatient Hospital Emergency Room		
Accidental Injury & Emergency Care Facility Room Charge	100% of Allowable Amount after \$100 Copayment Amount (If admitted for the emergency condition, the Copayment Amount is waived and Inpatient Hospital Expenses benefits and provisions will apply)	
Other services and supplies, including Lab & X-Ray Physician charges	70% of Allowable Amount after Calendar Year Deductible 70% of Allowable Amount after Calendar Year Deductible	
Non-Emergency Situations Facility Room Charge	100% of Allowable Amount after \$100 Copayment Amount (If admitted for the condition, the Copayment Amount is waived and Inpatient Hospital Expenses benefits and provisions will apply)	70% of Allowable Amount after \$100 Copayment Amount & Calendar Year Deductible (If admitted for the condition, the Copayment Amount is waived and Inpatient Hospital Expenses benefits and provisions will apply)
Other services and supplies, including Lab & X-Ray	70% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Physician charges	70% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible

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

★ **Mental Health Parity and Addiction Equity Act of 2008:** The Mental Health Parity and Addiction Equity (MHPAE) Act is a federal law that applies to employers who employed an average of more than 50 employees on business days during the preceding Calendar Year. The law generally requires that group health insurers apply the same treatment and financial limits to mental health and substance use disorder benefits as apply to the predominant medical- surgical benefits of the plan. If this law applies to your coverage, you will receive a Benefit Highlights amendment form that shows your mental health and substance use disorder (chemical dependency) benefits.

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Urgent Care Services

Each Urgent Care center visit	100% of Allowable Amount after \$65 Copayment Amount	70% of Allowable Amount after Calendar Year Deductible
Lab & x-ray charges, Certain Diagnostic Procedures, and all other Medically Necessary services and supplies	70% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible

Special Provisions Expenses, cont.

In-Network Benefits

Out-of-Network Benefits

Preventive Care

Routine annual physical exam office visit & well-baby exam office visit	100% of Allowable Amount	70% of Allowable Amount after Calendar Year Deductible
Lab & x-ray charges (excluding Certain Diagnostic Procedures)	100% of Allowable Amount	50% of Allowable Amount after Calendar Year Deductible
Routine immunizations (any Deductibles will not be applicable to immunizations of a Dependent child age seven years of age or younger)	100% of Allowable Amount	50% of Allowable Amount after Calendar Year Deductible

Speech and Hearing Services

Services to restore loss of or correct an impaired speech or hearing function	Covered same as any other sickness	Covered same as any other sickness
Hearing Aids	70% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Hearing Aids Maximum Benefit	Hearing aids are subject to a \$1,000 maximum amount each 36-month period*	

Organ and Tissue Transplant Services

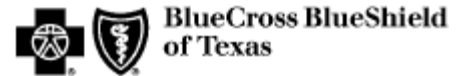
All services must be preauthorized	Covered same as any other sickness Refer to benefit booklet for details	Covered same as any other sickness Refer to benefit booklet for details
Calendar Year Maximum	\$15,000 maximum benefit for donor search and acceptability testing of potential live donors*	

Physical Medicine Services

Physical Medicine Services (includes but is not limit to physical, occupational, and manipulative therapy)	70% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Calendar Year Maximum	Limited to 35 visits each Calendar Year*	

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

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Prescription Drug Program	Participating Pharmacy	Non-Participating Pharmacy (member files claim)
Retail Pharmacies* (All Copayment Amounts are per 30-day supply and will not apply to Coinsurance Stop-Loss Amount)		
Generic	\$20 Copayment Amount	80% of Allowable Amount minus Copayment Amount
Preferred Brand Name	\$40 Copayment Amount	80% of Allowable Amount minus Copayment Amount
Non-Preferred Brand Name	\$60 Copayment Amount	80% of Allowable Amount minus Copayment Amount
Mail Service Pharmacy* (All Copayment Amounts are per 30-day supply and will not apply to Coinsurance Stop-Loss Amount)		
Generic		\$20 Copayment Amount
Preferred Brand Name		\$40 Copayment Amount
Non-Preferred Brand Name		\$60 Copayment Amount
<p><i>* Members electing to purchase Preferred/Non-Preferred Brand Name Drugs when a Generic equivalent is available, will be required to pay the difference between the cost of the Generic and Preferred/Non-Preferred Brand Name Drug, plus the Preferred Brand Name Copayment Amount.</i></p> <p>Diabetes Supplies are available under the Prescription Drug Program portion of your plan. Diabetes Supplies include insulin and insulin analog preparations, insulin syringes necessary for self-administration, prescriptive and non-prescriptive oral agents, all required test strips and tablets which test for glucose, ketones, and protein, lancets and lancet devices, biohazard disposable containers, glucagon emergency kits, and other injection aids. All provisions of this portion of the plan will apply including Copayment Amounts and any pricing differences that may apply to the items dispensed.</p>		

EMPLOYEE INFORMATION

The following benefits apply 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.

Preexisting conditions Provision: Benefits for Eligible Expenses incurred for treatment of a Preexisting Condition will not be available during the twelve-month period following the individual's initial Effective Date, or if a Waiting Period applies, the first day of the Waiting Period. In accordance with state and federal law, certain conditions will not be considered Preexisting Conditions and the Preexisting Condition exclusion will not apply to certain individuals. Details are provided 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):

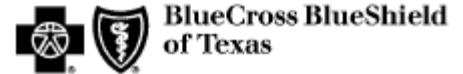
- Benefits for eligible expenses incurred for any service or supplies prior to the contract date, are not covered under the contract.
- Eligible expenses for services or supplies incurred on or after the effective date will be considered for benefits subject to all applicable contract provisions.

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. 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

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.

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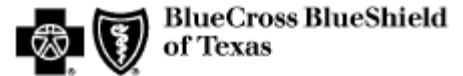
BENEFIT HIGHLIGHTS

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.

Overall Payment Provisions	In-Network Benefits	Out-of-Network Benefits
<p>Calendar Year Deductible Applies to all Eligible Expenses (unless otherwise indicated) Three-month Deductible carryover does not apply Deductible credit from prior carrier (applied on initial group enrollment only)</p>	\$5,000 Individual / \$15,000 Family	
<p>Copayment Amounts Required Physician office visit/consultation <i>Refer to Medical/Surgical Expenses section for more information</i></p>	\$40 Copayment Amount	
<p>Urgent Care center visit <i>Refer to Urgent Care Services section for more information</i></p>	\$65 Copayment Amount	
<p>Outpatient Hospital Emergency Room visit <i>Refer to Emergency Care section for more information</i></p>	\$100 Copayment Amount	\$100 Copayment Amount
<p>Coinsurance Stop-Loss Amount Deductibles are not applied to the Coinsurance Stop-Loss Amount. Copayment Amounts are applied but will continue to be required after the benefit percentages increase to 100%. Your benefit booklet will provide more details.</p>	\$5,000 Individual / \$15,000 Family	\$10,000 Individual / \$30,000 Family
<p>No credit given for Coinsurance Stop-Loss Amount from prior carrier</p>	Network Coinsurance Stop-Loss Amount will only apply toward Network Coinsurance Stop-Loss Amount	Out-of-Network Coinsurance Stop-Loss Amount will also apply toward Network Coinsurance Stop-Loss Amount
<p>Maximum Lifetime Benefits Per individual</p>	Unlimited	
Inpatient Hospital Expenses		
<p>Inpatient Hospital Expenses (must be preauthorized) Inpatient Hospital Expenses (Maternity Complications Only)</p>	70% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
<p>Penalty for failure to preauthorize</p>	None	\$250
Medical/Surgical Expenses		
<p>Medical / Surgical Expenses Physician office visit/consultation</p>	100% of Allowable Amount after \$40 Copayment Amount	70% of Allowable Amount after Calendar Year Deductible
<p>Lab, & x-ray, and Certain Diagnostic Procedures, such as: Bone Scan, Cardiac Stress Test, CT Scan (with or without contrast), Ultrasound, MRI, Myelogram, PET Scan and all other office services and supplies</p>	70% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
<p>Physician surgical services in any setting, Physician inpatient visits (Maternity Complications Only)</p>	70% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
<p>Home Infusion Therapy (must be preauthorized)</p>	70% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
<p>All other outpatient services and supplies</p>	70% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible

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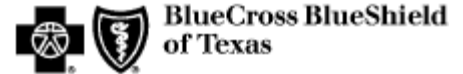
Extended Care Expenses	In-Network Benefits	Out-of-Network Benefits
Extended Care Expenses (must be preauthorized) Skilled Nursing Facility Home Health Care Hospice Care	100% of Allowable Amount	70% of Allowable Amount
	Limited to 25 days maximum each Calendar Year* Limited to 60 visits each Calendar Year* Unlimited	
Special Provisions Expenses		
☆ Treatment of Chemical Dependency (must be preauthorized) Inpatient treatment must be provided in a Chemical Dependency Treatment Center All other outpatient treatment	Three separate series of treatments for each covered individual* Covered as any other physical illness	
	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)	70% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Physician services	70% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Outpatient Services Physician office visit/psychotherapy session	100% of Allowable Amount after \$40 Copayment Amount	70% of Allowable Amount after Calendar Year Deductible
Other outpatient services, including psychological testing	70% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Calendar Year Maximum	Limited to 10 inpatient hospital days and 25 outpatient visits each Calendar Year*	
Emergency Care/Outpatient Hospital Emergency Room		
Accidental Injury & Emergency Care Facility Room Charge	100% of Allowable Amount after \$100 Copayment Amount (If admitted for the emergency condition, the Copayment Amount is waived and Inpatient Hospital Expenses benefits and provisions will apply)	
Other services and supplies, including Lab & X-Ray	70% of Allowable Amount after Calendar Year Deductible	
Physician charges	70% of Allowable Amount after Calendar Year Deductible	
Non-Emergency Situations Facility Room Charge	100% of Allowable Amount after \$100 Copayment Amount (If admitted for the condition, the Copayment Amount is waived and Inpatient Hospital Expenses benefits and provisions will apply)	70% of Allowable Amount after \$100 Copayment Amount & Calendar Year Deductible (If admitted for the condition, the Copayment Amount is waived and Inpatient Hospital Expenses benefits and provisions will apply)
Other services and supplies, including Lab & X-Ray	70% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Physician charges	70% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible

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

☆ **Mental Health Parity and Addiction Equity Act of 2008:** The Mental Health Parity and Addiction Equity (MHPAE) Act is a federal law that applies to employers who employed an average of more than 50 employees on business days during the preceding Calendar Year. The law generally requires that group health insurers apply the same treatment and financial limits to mental health and substance use disorder benefits as apply to the predominant medical- surgical benefits of the plan. If this law applies to your coverage, you will receive a Benefit Highlights amendment form that shows your mental health and substance use disorder (chemical dependency) benefits.

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Urgent Care Services

Each Urgent Care center visit	100% of Allowable Amount after \$65 Copayment Amount	70% of Allowable Amount after Calendar Year Deductible
Lab & x-ray charges, Certain Diagnostic Procedures, and all other Medically Necessary services and supplies	70% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible

Special Provisions Expenses, cont.

In-Network Benefits

Out-of-Network Benefits

Preventive Care

Routine annual physical exam office visit & well-baby exam office visit	100% of Allowable Amount	70% of Allowable Amount after Calendar Year Deductible
Lab & x-ray charges (excluding Certain Diagnostic Procedures)	100% of Allowable Amount	50% of Allowable Amount after Calendar Year Deductible
Routine immunizations (Deductibles will not be applicable to immunizations of a Dependent child age seven years or younger)	100% of Allowable Amount	50% of Allowable Amount after Calendar Year Deductible

Speech and Hearing Services

Services to restore loss of or correct an impaired speech or hearing function	Covered same as any other sickness	Covered same as any other sickness
Hearing Aids	70% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Hearing Aids Maximum Benefit	Hearing aids are subject to a \$1,000 maximum amount each 36-month period*	

Organ and Tissue Transplant Services

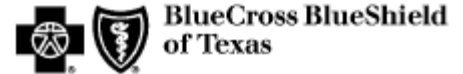
All services must be preauthorized	Covered same as any other sickness Refer to benefit booklet for details	Covered same as any other sickness Refer to benefit booklet for details
Calendar Year Maximum	\$15,000 maximum benefit for donor search and acceptability testing of potential live donors*	

Physical Medicine Services

Physical Medicine Services (includes but is not limit to physical, occupational, and manipulative therapy)	70% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Calendar Year Maximum	Limited to 35 visits each Calendar Year*	

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Prescription Drug Program	Participating Pharmacy	Non-Participating Pharmacy (member files claim)
Retail Pharmacies* (All Copayment Amounts are per 30-day supply and will not apply to Coinsurance Stop-Loss Amount)		
Generic	\$20 Copayment Amount	80% of Allowable Amount minus Copayment Amount
Preferred Brand Name	\$40 Copayment Amount	80% of Allowable Amount minus Copayment Amount
Non-Preferred Brand Name	\$60 Copayment Amount	80% of Allowable Amount minus Copayment Amount
Mail Service Pharmacy* (All Copayment Amounts are per 30-day supply and will not apply to Coinsurance Stop-Loss Amount)		
Generic	\$20 Copayment Amount	
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Non-Preferred Brand Name	\$60 Copayment Amount	
<p><i>* Members electing to purchase Preferred/Non-Preferred Brand Name Drugs when a Generic equivalent is available, will be required to pay the difference between the cost of the Generic and Preferred/Non-Preferred Brand Name Drug, plus the Preferred Brand Name Copayment Amount.</i></p> <p>Diabetes Supplies are available under the Prescription Drug Program portion of your plan. Diabetes Supplies include insulin and insulin analog preparations, insulin syringes necessary for self-administration, prescriptive and non-prescriptive oral agents, all required test strips and tablets which test for glucose, ketones, and protein, lancets and lancet devices, biohazard disposable containers, glucagon emergency kits, and other injection aids. All provisions of this portion of the plan will apply including Copayment Amounts and any pricing differences that may apply to the items dispensed.</p>		

EMPLOYEE INFORMATION

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Preexisting conditions Provision: Benefits for Eligible Expenses incurred for treatment of a Preexisting Condition will not be available during the twelve-month period following the individual's initial Effective Date, or if a Waiting Period applies, the first day of the Waiting Period. In accordance with state and federal law, certain conditions will not be considered Preexisting Conditions and the Preexisting Condition exclusion will not apply to certain individuals. Details are provided in the benefit booklet.

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- 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. 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

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.