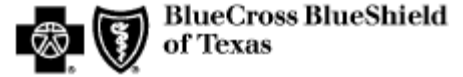


**BestChoice BlueEdge HSA
Embedded Deductible
Plan RSH3**



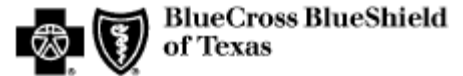
BENEFIT HIGHLIGHTS

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	PPO (In-Network)	Non-PPO (Out-of-Network)
<p>Calendar Year Deductible Applies to all Eligible Expenses (unless otherwise indicated)</p> <p><i>Family coverage: When one family member meets the individual Deductible, benefits become available under the plan for that individual.</i></p> <p><i>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.</i></p> <p>4th quarter Deductible carryover provision does not apply</p> <p>Deductible credit from prior carrier (applied on initial group enrollment only)</p>	<p>\$5,000 Individual / \$10,000 Family</p>	<p>\$10,000 Individual / \$20,000 Family</p>
<p>Out-of-Pocket Maximum Deductible, Coinsurance Amounts, and Copayments (if any) apply to Out-of-Pocket Maximum</p> <p>No credit given for Out-of-Pocket Maximum (or Coinsurance Stop-Loss Amount) from prior carrier</p>	<p>\$5,000 Individual / \$10,000 Family</p> <p><i>Network Deductible & Out-of-Pocket Max will only apply toward Network Deductible & Out-of-Pocket maximum</i></p>	<p>\$20,000 Individual / \$40,000 Family</p> <p><i>Out-of-Network Deductible & Out-of-Pocket Max will also apply toward Network Deductible & Out-of-Pocket maximum</i></p>
<p>Maximum Lifetime Benefits Per individual</p>	<p>Unlimited</p>	
<p>Inpatient Hospital Expenses</p>		
<p>Inpatient Hospital Expenses (must be preauthorized) Inpatient Hospital Expenses (including Maternity Care) Penalty for failure to preauthorize</p>	<p>100% of Allowable Amount after Calendar Year Deductible</p> <p>None</p>	<p>70% of Allowable Amount after Calendar Year Deductible</p> <p>\$250</p>
<p>Medical/Surgical Expenses</p>		
<p>Medical / Surgical Expenses Physician office visit/consultation, including lab & x-ray</p> <p>Physician surgical services in any setting and Maternity Care</p> <p>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.</p> <p>Home Infusion Therapy (must be preauthorized)</p> <p>In Vitro Fertilization Services</p> <p>All other outpatient services and supplies</p>	<p>100% of Allowable Amount after Calendar Year Deductible</p> <p>100% of Allowable Amount after Calendar Year Deductible</p> <p>100% of Allowable Amount after Calendar Year Deductible</p> <p>100% of Allowable Amount after Calendar Year Deductible</p> <p>Declined</p> <p>100% of Allowable Amount after Calendar Year Deductible</p>	<p>70% of Allowable Amount after Calendar Year Deductible</p> <p>70% of Allowable Amount after Calendar Year Deductible</p> <p>70% of Allowable Amount after Calendar Year Deductible</p> <p>70% of Allowable Amount after Calendar Year Deductible</p>

**BestChoice BlueEdge HSA
Embedded Deductible
Plan RSH3**

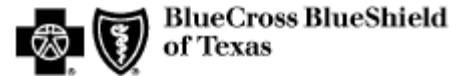


Extended Care Expenses	PPO (In-Network)	Non-PPO (Out-of-Network)
Extended Care Expenses (must be preauthorized)	100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
Skilled Nursing Facility Home Health Care Hospice Care	Limited to 25 days maximum each Calendar Year* Limited to 60 visits each Calendar Year* Unlimited	
Special Provisions Expenses		
☆ Treatment of Chemical Dependency (must be preauthorized)	Three separate series of treatments for each covered individual* Covered as any other physical illness	
Inpatient treatment must be provided in a Chemical Dependency Treatment Center		
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 Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
Physician services	100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
Outpatient Services		
Services performed in a Physician's office, including lab & x-ray	100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
Other outpatient services and psychological testing	100% of Allowable Amount after Calendar Year Deductible	70% 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 & Medical Emergency Care		
Facility charges	100% of Allowable Amount after Calendar Year Deductible	
Physician charges	100% of Allowable Amount after Calendar Year Deductible	
Non-Emergency Situations		
Facility charges	100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
Physician charges	100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar 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 Calendar Year Deductible	70% 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.

**BestChoice BlueEdge HSA
Embedded Deductible
Plan RSH3**



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 with hearing aids
Hearing Aids

Covered same as any other sickness

Covered same as any other sickness

Hearing Aids Maximum Benefit

100% of Allowable Amount after
Calendar Year Deductible
Hearing aids are subject to a \$1,000 maximum amount each 36-month period*

70% of Allowable Amount after
Calendar Year Deductible

Physical Medicine Services

Physical Medicine Services (includes but is not limited to physical, occupational, and manipulative therapy)

100% of Allowable Amount after
Calendar Year Deductible

70% of Allowable Amount after
Calendar Year Deductible

Calendar Year Maximum

Limited to 35 visits each Calendar Year*

* 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)

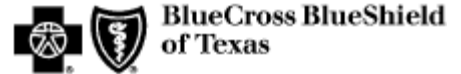
100% of Allowable Amount after the Calendar Year Deductible

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 Calendar Year Deductible

**BestChoice BlueEdge HSA
Embedded Deductible
Plan RSH3**

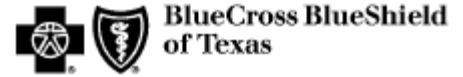


EMPLOYEE INFORMATION

- **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.
- **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.
- **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 "Calendar Year Deductible," must be satisfied by each Participant under your coverage each Calendar 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 Calendar 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 Calendar 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 BCBSTX 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 Calendar 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 Calendar 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 Calendar 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 Calendar 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.

**BestChoice BlueEdge HSA
Embedded Deductible
Plan RSH3**



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

**PPO
(In-Network)**

**Non-PPO
(Out-of-Network)**

Calendar 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.

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.

4th quarter Deductible carryover provision does not apply

Deductible credit from prior carrier (applied on initial group enrollment only)

\$5,000 Individual /
\$10,000 Family

\$10,000 Individual /
\$20,000 Family

Out-of-Pocket Maximum

Deductible, Coinsurance Amounts, and Copayments (if any) apply to Out-of-Pocket Maximum

No credit given for Out-of-Pocket Maximum (or Coinsurance Stop-Loss Amount) from prior carrier

\$5,000 Individual /
\$10,000 Family

\$20,000 Individual /
\$40,000 Family

*Network Deductible & Out-of-Pocket Max **will only** apply toward Network Deductible & Out-of-Pocket maximum*

*Out-of-Network Deductible & Out-of-Pocket Max **will also** apply toward Network Deductible & Out-of-Pocket maximum*

Maximum Lifetime Benefits

Per individual

Unlimited

Inpatient Hospital Expenses

Inpatient Hospital Expenses (must be preauthorized)

Inpatient Hospital Expenses (Maternity Complications Only)

Penalty for failure to preauthorize

100% of Allowable Amount after
Calendar Year Deductible

70% of Allowable Amount after
Calendar Year Deductible

None

\$250

Medical/Surgical Expenses

Medical / Surgical Expenses

Physician office visit/consultation, including lab & x-ray

Physician surgical services in any setting (Maternity Complications Only)

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.

Home Infusion Therapy (must be preauthorized)

In Vitro Fertilization Services

All other outpatient services and supplies

100% of Allowable Amount after
Calendar Year Deductible

70% of Allowable Amount after
Calendar Year Deductible

100% of Allowable Amount after
Calendar Year Deductible

70% of Allowable Amount after
Calendar Year Deductible

100% of Allowable Amount after
Calendar Year Deductible

70% of Allowable Amount after
Calendar Year Deductible

100% of Allowable Amount after
Calendar Year Deductible

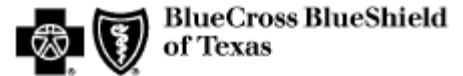
70% of Allowable Amount after
Calendar Year Deductible

Declined

100% of Allowable Amount after
Calendar Year Deductible

70% of Allowable Amount after
Calendar Year Deductible

**BestChoice BlueEdge HSA
Embedded Deductible
Plan RSH3**

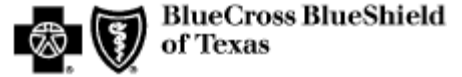


Extended Care Expenses	PPO (In-Network)	Non-PPO (Out-of-Network)
Extended Care Expenses (must be preauthorized)	100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
Skilled Nursing Facility Home Health Care Hospice Care	Limited to 25 days maximum each Calendar Year* Limited to 60 visits each Calendar Year* Unlimited	
Special Provisions Expenses		
☆ Treatment of Chemical Dependency (must be preauthorized)	Three separate series of treatments for each covered individual* Covered as any other physical illness	
Inpatient treatment must be provided in a Chemical Dependency Treatment Center		
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 Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
Physician services	100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
Outpatient Services		
Services performed in a Physician's office, including lab & x-ray	100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
Other outpatient services and psychological testing	100% of Allowable Amount after Calendar Year Deductible	70% 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 & Medical Emergency Care		
Facility charges	100% of Allowable Amount after Calendar Year Deductible	
Physician charges	100% of Allowable Amount after Calendar Year Deductible	
Non-Emergency Situations		
Facility charges	100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
Physician charges	100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar 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 Calendar Year Deductible	70% 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.

**BestChoice BlueEdge HSA
Embedded Deductible
Plan RSH3**



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 with hearing aids
Hearing Aids

Covered same as any other sickness

Covered same as any other sickness

100% of Allowable Amount after
Calendar Year Deductible

70% 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*

Physical Medicine Services

Physical Medicine Services (includes but is not limited to physical, occupational, and manipulative therapy)

100% of Allowable Amount after
Calendar Year Deductible

70% of Allowable Amount after
Calendar Year Deductible

Calendar Year Maximum

Limited to 35 visits each Calendar Year*

* 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)

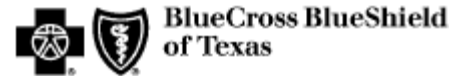
100% of Allowable Amount after the Calendar Year Deductible

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 Calendar Year Deductible

**BestChoice BlueEdge HSA
Embedded Deductible
Plan RSH3**



EMPLOYEE INFORMATION

- **The following applies to dependent coverage:**
 - 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.
- **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 "Calendar Year Deductible," must be satisfied by each Participant under your coverage each Calendar 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 Calendar 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 Calendar 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 BCBSTX 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 Calendar 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 Calendar 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 Calendar 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 Calendar 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.