



BENEFIT HIGHLIGHTS Prepared for City of Mission Plan 10/01/2011

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

Deductibles

Per-admission Deductible
 Calendar Year Deductible
Applies to all Eligible Expenses except Inpatient Hospital Expenses (unless otherwise indicated)
 Three-month Deductible carryover applies
 Deductible credit from prior carrier (Applied on initial group enrollment only)

None
 \$500 Individual /
 \$1,000 Family

\$500
 \$2,500 Individual /
 \$5,000 Family

Yes/ No
 Yes/ No

Yes/ No
 Yes/ No

CoShare Stop-loss Maximum

Deductibles are not applied to the Coshare Stop-loss Maximum. Copayment Amounts are applied but will continue to be required after the benefit percentages increase to 100%. Your benefit booklet will provide more details.

\$2,000 Individual /
 \$4,000 Family

\$6,000 Individual /
 \$10,000 Family

Network Deductible & Coshare Stop-loss will only apply toward Network Deductible & Coshare Stop-loss Maximum
 Yes/ No

Out-of-Network Deductible & Coshare Stop-loss will also apply toward Network Deductible & Coshare Stop-loss Maximum
 Yes/ No

Credit for Coshare Stop-loss Maximum from prior carrier (Applied on initial group enrollment only)

Copayment Amounts Required

Physician office visit/consultation:
Primary Care Copayment Amount for office visit/consultation when services rendered by a Family Practitioner, OB/GYN, Pediatrician, Behavioral Health Practitioner, or Internist and Physician Assistant or Advanced Practice Nurse who works under the supervision of one of these listed physicians
Specialty Care Copayment Amount for office visit/consultation when services rendered by a Specialty Care Provider
Refer to Medical/Surgical Expenses section for more information
 Urgent Care center visit
Refer to Urgent Care Services section for more information
 Outpatient Hospital Emergency Room/Treatment Room visit
Refer to Emergency Room/Treatment Room section for more information

\$20 Primary Care Copayment

\$35 Specialty Care Copayment

\$45 Copayment Amount

\$125 Copayment Amount

\$125 Copayment Amount

Maximum Lifetime Benefits

Per Participant

Unlimited

Inpatient Hospital Expenses

Inpatient Hospital Expenses

All services must be preauthorized

All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units
 Penalty for failure to preauthorize services

80% of Allowable Amount

50% of Allowable Amount after per-admission Deductible
 \$250

None

Medical/Surgical Expenses

In-Network Benefits

Out-of-Network Benefits

Medical / Surgical Expenses

Services performed during the office visit/consultation when rendered by a Primary Care Provider, including lab and x-ray
 Services performed during the office visit/consultation when services rendered by a Specialty Care Provider, including lab & x-ray
 Lab & x-ray in other outpatient facilities (excluding Certain Diagnostic Procedures)
 -Physician surgical services performed in any setting
 -Physician inpatient hospital visits
 -Certain Diagnostic Procedures; such as Bone Scan, Cardiac Stress Test, CT -Scan (with or without contrast), Ultrasound, MRI, Myelogram, PET Scan.

100% of Allowable Amount after \$20 Primary Care Copayment**

100% of Allowable Amount after \$35 Specialty Care Copayment

100% of Allowable Amount

80% of Allowable Amount after Calendar Year Deductible

80% of Allowable Amount after Calendar Year Deductible

80% of Allowable Amount after Calendar Year Deductible

50% of Allowable Amount after Calendar Year Deductible

50% of Allowable Amount after Calendar Year Deductible

50% of Allowable Amount after Calendar Year Deductible

50% of Allowable Amount after Calendar Year Deductible

50% of Allowable Amount after Calendar Year Deductible

50% of Allowable Amount after Calendar Year Deductible

PPO-ASO-Standard-with Network Deductible



BlueCross BlueShield
of Texas

-Home Infusion Therapy (Services must be preauthorized)	80% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
-All other outpatient services and supplies	80% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
In Vitro Fertilization Services	<input checked="" type="checkbox"/> Decline	

Extended Care Expenses

Extended Care Expenses
All services must be preauthorized

Skilled Nursing Facility Home Health Care Hospice Care	100% of Allowable Amount Limited to 25 day maximum each Calendar Year* Limited to 60 visit maximum each Calendar Year*	50% of Allowable Amount after Calendar Year Deductible Unlimited
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Special Provisions Expenses

Serious Mental Illness

Inpatient Services (All services must be preauthorized) -Hospital services (facility) (Inpatient Chemical Dependency treatment must be provided in a Chemical Dependency Treatment Center) -Physician services	80% of Allowable Amount after per- admission Deductible (if applicable) 80% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible 50% of Allowable Amount after Calendar Year Deductible
Outpatient Services (All services must be preauthorized) -Services performed during office visit/consultation when rendered by a Primary Care Provider (does not include psychological testing) -All outpatient services and psychological testing	100% of Allowable Amount after \$20 Primary Care Copayment Amount 80% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible 50% of Allowable Amount after Calendar Year Deductible

* Benefits used In-Network and Out-of-Network will apply toward satisfying any Annual Maximum benefits indicated

** Primary Care/Specialty Care copayments are defined in the Overall Payment Provisions section in this document.

Special Provisions Expenses, cont.

	In-Network Benefits	Out-of-network Benefits
Emergency Room/Treatment Room		
Accidental Injury & Emergency Care -Facility charges -Physician charges	80% of Allowable Amount after \$125 Copayment Amount (Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply) 80% of Allowable Amount after Calendar Year Deductible	
Non-Emergency Care -Facility charges -Physician charges	80% of Allowable Amount after \$125 Copayment Amount (Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply) 80% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after \$125 Copayment Amount & Calendar Year Deductible (Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply) 50% of Allowable Amount after Calendar Year Deductible
Urgent Care Services		
Urgent Care center visit, including lab & x-ray services (does not include Certain Diagnostic Procedures and surgical services)	100% of Allowable Amount after \$45 Copayment Amount	50% of Allowable Amount after Calendar Year Deductible
Certain Diagnostic Procedures; such as Bone Scan, Cardiac Stress Test, CT -Scan (with or without contrast), Ultrasound, MRI, Myelogram, PET Scan, surgical procedures and all other services and supplies.	80% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Ground and Air Ambulance Services	80% of Allowable Amount after Calendar Year Deductible	
Preventive Care		
Routine annual physical examinations, well-baby care exams, immunizations 6 years of age & over, and any other preventive health services as determined by USPSTF	100% of Allowable Amount	50% of Allowable Amount after Calendar Year Deductible

PPO-ASO-Standard-with Network Deductible



BlueCross BlueShield of Texas

Immunizations for Dependent children through the date of the child's 6 th birthday	100% of Allowable Amount	100% of Allowable Amount
Speech and Hearing Services		
Services to restore loss of or correct an impaired speech or hearing function without hearing aids	80% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Calendar Year Maximum	Limited to 12 visits each Calendar Year*	

* Benefits used In-Network and Out-of-Network will apply toward satisfying any Annual Maximum benefits indicated

Special Provisions Expenses, cont.

	In-Network Benefits	Out-of-network Benefits
Physical Medicine Services		
Chiropractic Care-Office Services	80% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Calendar Year Maximum	Limited to 10 visits each Calendar Year*	
Physical Medicine Services (includes, but is not limited to physical, occupational, and manipulative therapy)	80% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Calendar Year Maximum	Limited to 12 visits each Calendar Year*	

* Benefits used In-Network and Out-of-Network will apply toward satisfying any Annual Maximum benefits indicated

Pharmacy Benefits*

Participating Pharmacy

Non-Participating Pharmacy (member files claim)

	Participating Pharmacy	Non-Participating Pharmacy (member files claim)
Vaccinations obtained through Pharmacies***		<input checked="" type="checkbox"/> Yes
Retail Pharmacy (All Copayment Amounts are per 30-day supply and will not apply to Coshare Stop-loss Maximum)		Flu vaccination-Covered
Generic Drug	\$10 Copayment Amount	80% of Allowable Amount minus Copayment Amount
Preferred Brand Name Drug	\$25 Copayment Amount	80% of Allowable Amount minus Copayment Amount
Non-Preferred Brand Name Drug	\$40 Copayment Amount	80% of Allowable Amount minus Copayment Amount
4 th Tier Specialty Drugs (Triessent Specialty Drug List)	\$75 Copayment Amount	80% of Allowable Amount minus Copayment Amount
Mail Order Program – 90 day supply only (All Copayment Amounts are per 90-day supply and will not apply to Coshare Stop-loss Maximum)		<input checked="" type="checkbox"/> Yes
Generic Drug		\$20 Copayment Amount
Preferred Brand Name Drug		\$50 Copayment Amount
Non-Preferred Brand Name Drug		\$80 Copayment Amount
4 th Tier		\$150 Copayment Amount

Generic Incentive-Members who purchase Preferred/Non-Preferred Brand Name Drugs when a Generic equivalent exists, 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.

*** Each Participating Pharmacy that has contracted to provide vaccination services may have age, scheduling, or other requirements that will apply. You are encouraged to contact the store in advance. Childhood immunizations subject to state regulations are not available under this pharmacy benefit. Refer to your BCBSTX medical coverage for benefits available for childhood immunizations.

Diabetes Supplies are available under the Prescription Drug benefits of your plan. Diabetic 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.

All medications with over-the-counter (OTC) equivalents are excluded from coverage except for Omeprazole 20 mg.

EMPLOYEE INFORMATION

This is a general Summary of your benefit design. Please refer to your benefit booklet for other details and for limitations and exclusions.

The following benefits apply to dependent coverage:

- Dependent children are covered to age 26.
- 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.

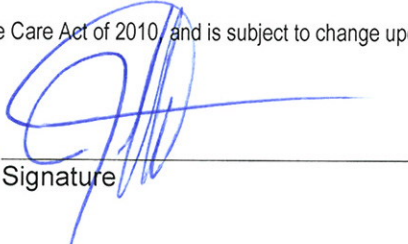
Replacement of Medical Coverage: In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the following provisions apply to each eligible participant who has health coverage under the employer's plan immediately prior to the effective date of the health contract between 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.

This benefit plan design includes provisions mandated by the Affordable Care Act of 2010, and is subject to change upon direction by federal and state agencies.

Julio C. Cerda, City Manager
Group Executive Name and Title
(Please type or print)


Signature

8/23/11
Date

Agent of Record Name
(Please print or type)

Signature

Date

Tita Iruegas
BCBSTX Representative Name
(Please print or type)

Signature

8.15.11
Date