

**BENEFIT HIGHLIGHTS** *Prepared*  
For City of McAllen ACTIVE  
Effective 10-1-2011

**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.*

<b>Overall Payment Provisions</b>	<b>In-Network Benefits</b>	<b>Out-of-Network Benefits</b>
<p><b>Deductibles</b> Per-admission Deductible Calendar Year Deductible <i>Applies to all Eligible Expenses except Inpatient Hospital Expenses</i> Three-month Deductible carryover applies</p>	<p>None \$750 Individual / \$1,500 Family</p> <p>Yes</p> <p><i>In-Network Deductible will ONLY apply toward In-Network Deductible</i></p>	<p>None \$1,500 Individual / \$3,000 Family</p> <p>Yes</p> <p><i>Out-of-Network Deductible will ALSO apply toward In-Network Deductible</i></p>
<p><b>CoShare Stoploss Maximum</b> Deductibles and Copayment Amounts are not applied to the CoShare Stoploss Maximum. Copayment Amounts will continue to be required after the benefit percentages increase to 100%.</p>	<p>\$2,000 Per each covered Individual</p> <p><i>In-Network CoShare Stoploss will only apply toward In-Network CoShare Stoploss Maximum</i></p>	<p>\$4,000 Per each Covered Individual</p> <p><i>Out-of-Network CoShare Stoploss will also apply toward In-Network CoShare Stoploss Maximum</i></p>
<p><b>Copayment Amounts Required</b></p> <p>Physician office visit/consultation:</p> <p><b>Primary Care Copayment Amount</b> 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</p> <p><b>Specialty Care Copayment Amount</b> for office visit/consultation when services rendered by a Specialty Care Provider <i>Refer to Medical/Surgical Expenses section for more information</i></p>	<p>\$25 Primary Care Copayment</p> <p>\$35 Specialty Care Copayment</p>	
<p><b>Maximum Lifetime Benefits</b> Per Participant</p>	<p>Unlimited</p>	
<p><b>Inpatient Hospital Expenses</b></p>		
<p><b>Inpatient Hospital Expenses</b> <i>All services must be preauthorized</i></p> <p><i>All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units</i></p> <p>Penalty for failure to preauthorize services</p> <p><i>In-Network providers are responsible for preauthorization process. When using an Out-of-Network provider, it is the members' responsibility to preauthorize.</i></p>	<p>80% of Allowable Amount</p> <p>\$0</p>	<p>50% of Allowable Amount</p> <p>\$1,000</p>

**Medical/Surgical Expenses**

**In-Network  
Benefits**

**Out-of-Network  
Benefits**

**Medical / Surgical Expenses**

Physician office visit/consultation ( all other Specialty Care Providers)	100% of Allowable Amount after \$35 Specialty Care Copayment	50% of Allowable Amount after Calendar Year Deductible
Lab & X-Ray (with office visit)	80% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Independent Lab & X-Ray	100% of Allowable Amount	50% of Allowable Amount after Calendar Year Deductible
- Physician surgical services performed in any setting	80% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
- Physician inpatient hospital visits	80% of Allowable Amount after Calendar Year Deductible	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.	80% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
- Home Infusion Therapy ( <i>Services must be preauthorized</i> )	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 Lifetime Maximum \$5,000	80% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible

**Extended Care Expenses**

**Extended Care Expenses**

*All services must be preauthorized*

Skilled Nursing Facility Home Health Care Hospice Care	80% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
	<i>Limited to 25 day maximum each Calendar Year*</i> <i>Limited to 60 visit maximum each Calendar Year*</i> <i>Unlimited</i>	

**Special Provisions Expenses**

**Serious Mental Illness**

**Mental Health Care**

**Treatment of Chemical Dependency**

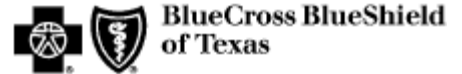
<b>Inpatient Services (All services must be preauthorized)</b> - Hospital services (facility) <i>(Inpatient Chemical Dependency treatment must be provided in a Chemical Dependency Treatment Center)</i>	80% of Allowable Amount	50% of Allowable Amount
- Physician services	80% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
<b>Outpatient Services (All services must be preauthorized)</b> - Services performed during office visit/consultation when rendered by a Primary Care Provider (does not include psychological testing)	100% of Allowable Amount after \$25 Primary Care Copayment Amount	50% of Allowable Amount after Calendar Year Deductible
- Services performed during office visit/consultation when rendered by a Specialty Care Provider (does not include psychological testing)	100% of Allowable Amount after \$35 Specialty Care Copayment Amount	50% of Allowable Amount after Calendar Year Deductible
- All outpatient services and psychological testing	80% 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.

<b>Special Provisions Expenses, cont.</b>		<b>In-Network Benefits</b>	<b>Out-of-network Benefits</b>
<b>Emergency Room/Treatment Room</b>			
Accidental Injury & Emergency Care - Facility charges - Physician charges  <i>Deductible Waived for Accidents</i>		<i>80% of Allowable Amount 80% of Allowable Amount after Calendar Year Deductible</i>	
<b>Non-Emergency Care</b> - Facility charges  - Physician charges		<i>80% of Allowable Amount  80% of Allowable Amount after Calendar Year Deductible</i>	<i>50% of Allowable Amount  50% of Allowable Amount after Calendar Year Deductible</i>
<b>Urgent Care Services</b>			
Urgent Care center visit, including lab & x-ray services ( <i>does not include Certain Diagnostic Procedures and surgical services</i> ) 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.		<i>80% of Allowable Amount after Calendar Year Deductible  80% of Allowable Amount after Calendar Year Deductible</i>	<i>50% of Allowable Amount after Calendar Year Deductible  50% of Allowable Amount after Calendar Year Deductible</i>
<b>Ground and Air Ambulance Services</b>		<i>80% of Allowable Amount after Calendar Year Deductible</i>	
<b>Preventive Care</b>			
Routine annual physical examinations, well-baby care exams, immunizations 6 years of age & over, and any other preventive health services as determined by USPSTF  Immunizations for Dependent children through the date of the child's 6 <sup>th</sup> birthday		<i>100% of Allowable Amount  100% of Allowable Amount</i>	<i>50% of Allowable Amount after Calendar Year Deductible  100% of Allowable Amount</i>
<b>Speech and Hearing Services</b>			
Speech and Hearing Services, excluding hearing aids		<i>80% of Allowable Amount after Calendar Year Deductible</i>	<i>50% of Allowable Amount after Calendar Year Deductible</i>
<b>Special Provisions Expenses, cont.</b>		<b>In-Network Benefits</b>	<b>Out-of-network Benefits</b>
<b>Physical Medicine Services</b>			
Chiropractic Care-Office Services  Calendar Year Maximum		<i>80% of Allowable Amount after Calendar Year Deductible</i>	<i>50% of Allowable Amount after Calendar Year Deductible</i>
		<i>Limited to 35 visits each Calendar Year All other Physical Medicine Services rendered by any other eligible Provider will be allowed on the same basis as any other sickness.</i>	
Physical Medicine Services (includes, but is not limited to physical, occupational, and manipulative therapy) Calendar Year Maximum		<i>80% of Allowable Amount after Calendar Year Deductible</i>	<i>50% of Allowable Amount after Calendar Year Deductible</i>
		<i>Limited to 35 visits each Calendar Year*</i>	
<b>Pharmacy Benefits*</b>		<b>Participating Pharmacy</b>	<b>Non-Participating Pharmacy (member files claim)</b>
Flu vaccinations obtained through Pharmacies***          <i>Retail Pharmacy</i> (All Copayment Amounts are per 30-day supply and will not apply to Coshare Stoploss Maximum)		<i>Selected Participating Pharmacy** 100% of Allowable Amount  Any Other Participating Pharmacy 80% of Allowable Amount minus Copayment</i>	<i>80% of Allowable Amount minus Copayment</i>

# PPO-ASO-Standard-with Network Deductible



Generic Drug	\$5 Copayment Amount	80% of Allowable Amount minus Copayment Amount
Preferred Brand Name Drug	\$30 Copayment Amount	80% of Allowable Amount minus Copayment Amount
Non-Preferred Brand Name Drug	\$50 Copayment Amount	80% of Allowable Amount minus Copayment Amount
<b>Mail Order Program</b> (All Copayment Amounts are per 90-day supply and will not apply to Coshare Stoploss Maximum)		<input checked="" type="checkbox"/> Yes / <input type="checkbox"/> No
Generic Drug	\$10 Copayment Amount	
Preferred Brand Name Drug	\$60 Copayment Amount	
Non-Preferred Brand Name Drug	\$100 Copayment Amount	
<p><b>Rx Enhanced</b> - Members electing to purchase Preferred/Non-Preferred Brand Name Drugs when "Brand Medically Necessary" is not indicated and 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. If "Brand Medically Necessary" is indicated on the prescription, the member will pay the Preferred or Non-Preferred Brand Name Copayment Amount.</p> <p>** A Select Participating Pharmacy is a Pharmacy that has specifically contract with BCBSTX to administer flu vaccinations to Participates. Not all Participating Pharmacies are Select Participating Pharmacies.</p> <p>*** 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.</p> <p>Diabetes Supplies are available under the Pharmacy Benefits portion 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.</p> <p>Copayment will be waived when Diabetic Supplies are dispensed on the same day the Insulin prescription is filled.</p> <p>Step Therapy Applies                  Specialty Drug Program through Triessent Mandatory</p>		

**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](http://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.

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Group Executive Name and Title  
(Please type or print)

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Signature

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Date

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Agent of Record Name  
(Please print or type)

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Signature

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Date

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BCBSTX Representative Name  
(Please print or type)

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Signature

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Date