

City of Weslaco

"The City on the Grow"



Miguel D. Wise, Mayor
John F. Cuellar, Mayor Pro-Tem, District 2
Robert J. Garza, Commissioner, District 1
Rene Rodríguez, Jr., Commissioner, District 3
Gerardo "Jerry" Tafolla, Commissioner, District 4
Lupe V. Rivera, Commissioner, District 5
Joe A. Martinez, Commissioner, District 6

Leonardo Olivares, City Manager

Addendum No. 3

September 3, 2010

Notice is hereby given to all prospective respondents for the **Group Health, Proposal No.: 2009-10-18**, for the City of Weslaco as follows:

- BCBS Summary of Benefits
Plan 1
Plan 2
Plan 3
- Art. 21.49-16 Waiver
No approval on this Waiver

City of Weslaco,

Gloria Sepulveda by MM

Gloria Sepulveda,
Purchasing Director

Benefit of Summary Plan 1



BENEFIT HIGHLIGHTS Prepared for City of Weslaco Plan 1

BlueChoice Network
 BlueChoice Solutions 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 <i>Applies to all Eligible Expenses, unless otherwise indicated, except Inpatient Hospital Expenses</i> Three-month Deductible carryover applies Deductible credit from prior carrier (applied on initial group enrollment only)	None* \$2,500 Individual / \$5,000 Family <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$ 500 \$7,500 Individual / \$15,000 Family <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Out-of-Pocket Maximum Deductibles are not applied to the Out-of-Pocket 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. Credit for Out-of-Pocket Maximum from prior carrier (applied on initial group enrollment only)	N/A Individual / N/A Family Network Deductible & Out-of-Pocket maximum will only apply toward Network Deductible & Out-of-Pocket Maximum <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	\$6,000 Individual / \$18,000 Family Out-of-Network Deductible & Out-of-Pocket maximum will also apply toward Network Deductible & Out-of-Pocket Maximum <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Copayment Amounts Required Physician office visit/consultation <i>Refer to Medical/Surgical Expenses section for more information</i> Outpatient Hospital Emergency Room/Treatment Room visit <i>Refer to Emergency Room/Treatment Room section for more information</i>	\$25 Copayment Amount \$200 Copayment Amount	\$200 Copayment Amount
Maximum Lifetime Benefits Per Participant	\$1,000,000*	

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	100% of Allowable Amount after per-admission Deductible None	70% of Allowable Amount after per-admission Deductible \$250
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Medical/Surgical Expenses

Medical / Surgical Expenses Services performed during the Physician office visit/consultation, including lab & x-ray (does not include Certain Diagnostic Procedures and surgical services) 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 -Home Infusion Therapy (Services must be preauthorized) -All other outpatient services and supplies In Vitro Fertilization Services	100% of Allowable Amount after \$25 Copayment Amount 100% of Allowable Amount 100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible 70% of Allowable Amount after Calendar Year Deductible 70% of Allowable Amount after Calendar Year Deductible
<input checked="" type="checkbox"/> Decline <input type="checkbox"/> Accept (If accepted, Medical/Surgical Expenses covered same as any other sickness)		

* Benefits used In-Network and Out-of-Network will apply toward satisfying any Calendar year, Plan Year, Annual Maximum, or Maximum Lifetime benefits Indicated

PPO-Insured-Standard-with Network Deductible



BlueCross BlueShield
of Texas

Extended Care Expenses

**In-Network
Benefits**

**Out-of-Network
Benefits**

Extended Care Expenses
All services must be preauthorized

	100% of Allowable Amount	70% of Allowable Amount after Calendar Year Deductible
Skilled Nursing Facility	\$10,000 Calendar Year maximum*	
Home Health Care	\$10,000 Calendar Year maximum*	
Hospice Care	\$20,000 lifetime maximum*	

Special Provisions Expenses

Serious mental illness

Mental Health Care

Treatment of Chemical Dependency

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

Outpatient Services (All services must be preauthorized)

-Services performed during Physician office visit (does not include
psychological testing)

-All outpatient services and psychological testing

100% of Allowable Amount after per- admission Deductible	70% of Allowable Amount after per- admission Deductible
100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
100% of Allowable Amount after \$25 Copayment Amount	70% of Allowable Amount after Calendar Year Deductible
100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible

* Benefits used In-Network and Out-of-Network will apply toward satisfying any Calendar Year, Plan Year, Annual Maximum, or Maximum Lifetime benefits indicated

Special Provisions Expenses, cont. **In-Network Benefits** **Out-of-Network Benefits**

<p>Emergency Room/Treatment Room Accidental Injury & Emergency Care (within 48 hours) -Facility charges -Physician charges</p>	<p>100% of Allowable Amount after \$200 Copayment Amount (Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply) 100% of Allowable Amount after Calendar Year Deductible</p>	
<p>Non-Emergency Care (after 48 hours) -Facility charges -Physician charges</p>	<p>100% of Allowable Amount after \$200 Copayment Amount (Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply) 100% of Allowable Amount after Calendar Year Deductible</p>	<p>70% of Allowable Amount after \$200 Copayment Amount & Calendar Year Deductible (Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply) 70% of Allowable Amount after Calendar Year Deductible</p>
<p>Ground and Air Ambulance Services</p>	<p>100% of Allowable Amount after Calendar Year Deductible</p>	
<p>Preventive Care Routine annual physical examinations, well-baby care exams, immunizations for Participants 6 years & over, vision exams, and hearing exams Immunizations for Dependent children through the date of the child's 6th birthday</p>	<p>100% of Allowable Amount after \$25 Copayment Amount 100% of Allowable Amount</p>	<p>70% of allowable Amount after Calendar Year Deductible 100% of Allowable Amount</p>
<p>Speech and Hearing Services Services to restore loss of or correct an Impaired speech or hearing function Hearing Aids Hearing Aid Maximum</p>	<p>Covered same as any other sickness 100% of Allowable Amount after Calendar Year Deductible Hearing aids are subject to a \$1,000 maximum amount each 36-month period*</p>	<p>Covered same as any other sickness 70% of Allowable Amount after Calendar Year Deductible</p>
<p>Organ and Tissue Transplant Services Calendar Year Maximum</p>	<p>Covered same as any other sickness Refer to benefit booklet for details \$15,000 maximum benefit for donor search and acceptability testing of potential live donors</p>	<p>Covered same as any other sickness Refer to benefit booklet for details</p>
<p>Physical Medicine Services Physical Medicine Services (includes, but is not limited to physical, occupational, and manipulative therapy) Calendar Year Maximum</p>	<p>100% of Allowable Amount after Calendar Year Deductible 70% of Allowable Amount after Calendar Year Deductible \$1,500 maximum benefit each Calendar Year*</p>	

* Benefits used In-Network and Out-of-Network will apply toward satisfying any Calendar Year, Plan Year, Annual Maximum, or Maximum Lifetime benefits indicated



Prescription Drug Benefits

Participating Pharmacy

**Non-Participating Pharmacy
(member files claim)**

Prescription Drug Benefits*

Vaccinations obtained through Pharmacies***	<input checked="" type="checkbox"/> Yes / <input type="checkbox"/> No	
	Flu vaccination- \$ 5.00 Copayment Amount Deductibles do not apply	
Retail Pharmacies (All Copayment Amounts are per 30-day supply and will not apply to Coshare Stoploss Maximum)		
Mail Service Pharmacy (All Copayment Amounts are per 30-day supply and will not apply to Coshare Stoploss Maximum)	<input checked="" type="checkbox"/> Yes / <input type="checkbox"/> No	
Generic Drug	\$15 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	\$45 Copayment Amount	80% of Allowable Amount minus Copayment Amount
Generic Drug	\$15 Copayment Amount	
Preferred Brand Name Drug	\$30 Copayment Amount	
Non-Preferred Brand Name Drug	\$45 Copayment Amount	

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

Rx Enhanced-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.

** Three-month Deductible carryover does not apply to prescription drug deductible.

*** 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.

Benefit of Summary Plan 2

PPO-Insured-Standard-with Network Deductible



BlueCross BlueShield of Texas

BENEFIT HIGHLIGHTS Prepared for City of Weslaco Plan 2

BlueChoice Network
 BlueChoice Solutions 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, unless otherwise indicated, except Inpatient Hospital Expenses

None*
 \$750 Individual /
 \$1,500 Family

\$ 500
 \$2,250 Individual /
 \$4,500 Family

Three-month Deductible carryover applies
 Deductible credit from prior carrier (applied on initial group enrollment only)

Yes / No
 Yes / No

Yes / No
 Yes / No

Out-of-Pocket Maximum

Deductibles are not applied to the Out-of-Pocket 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.

\$3,000 Individual /
 \$6,000 Family

\$9,000 Individual /
 \$18,000 Family

Network Deductible & Out-of-Pocket maximum will only apply toward Network Deductible & Out-of-Pocket Maximum
 Yes / No

Out-of-Network Deductible & Out-of-Pocket maximum will also apply toward Network Deductible & Out-of-Pocket Maximum
 Yes / No

Credit for Out-of-Pocket Maximum from prior carrier (applied on initial group enrollment only)

Copayment Amounts Required

Physician office visit/consultation
Refer to Medical/Surgical Expenses section for more information

\$25 Copayment Amount

Outpatient Hospital Emergency Room/Treatment Room visit
Refer to Emergency Room/Treatment Room section for more information

\$200 Copayment Amount

\$200 Copayment Amount

Maximum Lifetime Benefits

Per Participant

\$1,000,000*

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

80% of Allowable Amount after per-admission Deductible

50% of Allowable Amount after per-admission Deductible

Penalty for failure to preauthorize services

None

\$250

Medical/Surgical Expenses

Medical / Surgical Expenses

Services performed during the Physician office visit/consultation, including lab & x-ray (does not include Certain Diagnostic Procedures and surgical services)

100% of Allowable Amount after \$25 Copayment Amount

70% of Allowable Amount after Calendar Year Deductible

Lab & x-ray in other outpatient facilities (excluding Certain Diagnostic Procedures)

100% of Allowable Amount

70% of Allowable Amount after Calendar Year Deductible

-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
 -Home Infusion Therapy (Services must be preauthorized)
 -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

Decline

Accept (If accepted, Medical/Surgical Expenses covered same as any other sickness)

* Benefits used In-Network and Out-of-Network will apply toward satisfying any Calendar year, Plan Year, Annual Maximum, or Maximum Lifetime benefits indicated

PPO-Insured-Standard-with Network Deductible



BlueCross BlueShield
of Texas

Extended Care Expenses

**In-Network
Benefits**

**Out-of-Network
Benefits**

Extended Care Expenses

All services must be preauthorized

	100% of Allowable Amount	70% of Allowable Amount after Calendar Year Deductible
Skilled Nursing Facility	\$10,000 Calendar Year maximum*	
Home Health Care	\$10,000 Calendar Year maximum*	
Hospice Care	\$20,000 lifetime maximum*	

Special Provisions Expenses

Serious mental illness

Mental Health Care

Treatment of Chemical Dependency

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

Outpatient Services (All services must be preauthorized)

-Services performed during Physician office visit (does not include psychological testing)

-All outpatient services and psychological testing

80% of Allowable Amount after per- admission Deductible	50% of Allowable Amount after per- admission Deductible
80% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
100% of Allowable Amount after \$25 Copayment Amount	70% of Allowable Amount after Calendar Year Deductible
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 Calendar Year, Plan Year, Annual Maximum, or Maximum Lifetime benefits indicated



Special Provisions Expenses, cont.

**In-Network
Benefits**

**Out-of-Network
Benefits**

Emergency Room/Treatment Room

Accidental Injury & Emergency Care (within 48 hours)

-Facility charges

-Physician charges

80% of Allowable Amount after \$200 Copayment Amount
(Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply)

80% of Allowable Amount after Calendar Year Deductible

Non-Emergency Care (after 48 hours)

-Facility charges

80% of Allowable Amount after \$200
Copayment Amount (Copayment
Amount waived if admitted, Inpatient
Hospital Expenses will apply)

50% of Allowable Amount after \$200
Copayment Amount & Calendar Year
Deductible (Copayment Amount
waived if admitted, Inpatient Hospital
Expenses will apply)

-Physician charges

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 for Participants 6 years & over, vision exams, and hearing
exams

100% of Allowable Amount after \$25
Copayment Amount

70% of allowable Amount after
Calendar Year Deductible

Immunizations for Dependent children through the date of the child's 6th
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

Covered same as any other sickness

Covered same as any other sickness

Hearing Aids

80% of Allowable Amount after Calendar
Year Deductible

50% of Allowable Amount after
Calendar Year Deductible

Hearing Aid Maximum

Hearing aids are subject to a \$1,000 maximum amount each 36-month period*

Organ and Tissue Transplant Services

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 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

\$1,500 maximum benefit each Calendar Year*

* Benefits used In-Network and Out-of-Network will apply toward satisfying any Calendar Year, Plan Year, Annual Maximum, or Maximum Lifetime benefits indicated

PPO-Insured-Standard-with Network Deductible



Prescription Drug Benefits **Participating Pharmacy** **Non-Participating Pharmacy (member files claim)**

Prescription Drug Benefits*

Vaccinations obtained through Pharmacies***	<input checked="" type="checkbox"/> Yes / <input type="checkbox"/> No	
	Flu vaccination- \$ 5.00 Copayment Amount Deductibles do not apply	
Retail Pharmacies (All Copayment Amounts are per 30-day supply and will not apply to Coshare Stoploss Maximum)		
Mail Service Pharmacy (All Copayment Amounts are per 30-day supply and will not apply to Coshare Stoploss Maximum)	<input checked="" type="checkbox"/> Yes / <input type="checkbox"/> No	
Generic Drug Preferred Brand Name Drug Non-Preferred Brand Name Drug	\$15 Copayment Amount \$30 Copayment Amount \$45 Copayment Amount	80% of Allowable Amount minus Copayment Amount 80% of Allowable Amount minus Copayment Amount 80% of Allowable Amount minus Copayment Amount

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

Rx Enhanced-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.

** Three-month Deductible carryover does not apply to prescription drug deductible.

*** 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.

**Benefit of Summary
Plan 3**



BENEFIT HIGHLIGHTS Prepared for City of Weslaco Plan 3

BlueChoice Network
 BlueChoice Solutions 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) Applies to Out-of-Pocket Maximum Family coverage: When one family member meets the individual Deductible, benefits become available under the plan for that individual.</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>Deductible credit from prior carrier (applied on initial group enrollment only)</p>	<p>\$2,000 Individual / \$4,000 Family</p> <p>Yes</p>	<p>\$4,000 Individual / \$8,000 Family</p> <p>Yes</p>
<p>Out-of-Pocket Maximum Deductible applies to Out-of-Pocket Maximum</p> <p>Credit for Out-of-Pocket Maximum from prior carrier (applied on initial group enrollment only)</p>	<p>N/A Individual / N/A Family</p> <p>Network Deductible & Out-of-Pocket will only apply toward Network Deductible & Out-of-Pocket Maximum</p> <p>Yes</p>	<p>\$11,000 Individual / \$22,000 Family</p> <p>Out-of-Network Deductible & Out-of-Pocket will also apply toward Network Deductible & Out-of-Pocket Maximum</p> <p>Yes</p>
<p>Maximum Lifetime Benefits Per Participant</p>	<p>\$2,000,000*</p>	

Inpatient Hospital Expenses

<p>Inpatient Hospital Expenses All services must be preauthorized Inpatient Hospital Expenses Each admission must be preauthorized</p> <p>All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units</p> <p>Penalty for failure to preauthorize services</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>
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Medical/Surgical Expenses

<p>Medical / Surgical Expenses -Services performed during the Physician's office, including lab & x-ray -Lab & x-ray in other outpatient facilities -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. -Home Infusion Therapy (Services must be preauthorized) -All other outpatient services and supplies</p> <p>In Vitro Fertilization Services</p>	<p>100% of Allowable Amount after Calendar Year Deductible</p>	<p>70% of Allowable Amount after Calendar Year Deductible</p>
<p><input checked="" type="checkbox"/> Decline</p>		

* Benefits used In-Network and Out-of-Network will apply toward satisfying any Calendar Year, Plan Year, Annual Maximum, or Maximum Lifetime benefits indicated.



Extended Care Expenses	In-Network Benefits	Out-of-Network Benefits
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	\$10,000 Calendar Year maximum*	
Home Health Care	\$10,000 Calendar Year maximum	
Hospice Care	\$20,000 lifetime maximum*	
Special Provisions Expenses		
Serious Mental Illness		
Mental Health Care		
Treatment of Chemical Dependency		
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	100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
Outpatient Services (All services must be preauthorized)		
-Services performed during Physician office visit/consultation (does not include psychological testing)	100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
-All outpatient services and psychological testing		

* Benefits used In-Network and Out-of-Network will apply toward satisfying any Calendar Year, Plan Year, Annual Maximum, or Maximum Lifetime benefits indicated.



Special Provisions Expenses, cont.

**In-Network
Benefits**

**Out-of-Network
Benefits**

Special Provisions Expenses, cont.	In-Network Benefits	Out-of-Network Benefits
Emergency Room/Treatment Room		
Accidental Injury & Emergency Care (within 48 hours) -Facility charges	100% of Allowable Amount after Calendar Year Deductible	
-Physician charges		
Non-Emergency Care (after 48 hours) -Facility charges	100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
-Physician charges		
Ground and Air Ambulance Services		
	100% of Allowable Amount after Calendar Year Deductible	
Preventive Care		
Routine annual physical examinations, well-baby care exams, immunizations for Participants 6 years of age & over, vision exams, and hearing exams	100% of Allowable Amount	70% of allowable Amount
Immunizations for Dependent children through the date of the child's 6 th birthday		
Speech and Hearing Services		
Services to restore loss of or correct an impaired speech or hearing function Hearing Aids	Covered same as any other sickness 100% of Allowable Amount after Calendar Year Deductible	Covered same as any other sickness 70% of Allowable Amount after Calendar Year Deductible
Hearing Aid Maximum	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 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	\$1,500 maximum benefit each Calendar Year*	

* Benefits used In-Network and Out-of-Network will apply toward satisfying any Calendar Year, Plan Year, Annual Maximum, or Maximum Lifetime benefits indicated.

Prescription Drug Benefits

**Participating
Pharmacy**

**Non-Participating
Pharmacy
(member files claim)**

Prescription Drug Benefits*

<p>Vaccinations obtained through Pharmacies***</p>	<p><input checked="" type="checkbox"/> Yes/ <input type="checkbox"/> No Flu Vaccination- \$ 5.00 Copayment Amount Deductibles do not apply</p>
<p>Retail Pharmacies (Benefit payments are based on a 30-day supply - With appropriate Prescription Order, up to a 90-day supply available)</p> <p>Generic Drug</p> <p>Preferred Brand Name Drug</p> <p>Non-Preferred Brand Name Drug</p>	<p>100% of Allowable Amount after the Calendar Year Deductible</p>
<p>Mail Service Pharmacy (Benefit payments are based on a 30-day supply - With appropriate Prescription Order, up to a 90-day supply available)</p> <p>Generic Drug</p> <p>Preferred Brand Name Drug</p> <p>Non-Preferred Brand Name Drug</p>	<p>100% of Allowable Amount after the Calendar Year Deductible</p>

* Benefits used In-Network and Out-of-Network will apply toward satisfying any Calendar Year, Plan Year, Annual Maximum, or Maximum Lifetime benefits indicated.

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

*** 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 Prescription Drug provisions of the plan will apply including Copayment Amounts and any pricing differences that may apply to the items dispensed.