MEMORANDUM

To: Members of the City Commission

From: Jack Redmon, Acting City Manager

Date: December 7, 2018

Subject: Consider and take action awarding Blue Cross Blue Shield the contract for Employee/Retiree Medical and Pharmacy Insurance as per the terms offered for January 1, 2019 – December 31, 2019

The Blue Cross Blue Shield contract for employee/retiree medical and pharmacy insurance is being provided for consideration by the Commission.

PPO Insured/Cost Basic with Network Deductible, Split Copays

BlueCross BlueShield of Texas

BENEFIT HIGHLIGHTS *Prepared for*
City of Marshall Employee Benefits Trust - Actives
Funding: ☒ Fully Insured
Effective Date: 01/01/2019
BA# 0003

BlueChoice Network

This is a general summary of your benefits. *Please refer to your Summary of Benefits and Coverage (SBC), or you may request a copy of the policy or plan document for additional details and a description of the plan requirements and benefit design. This plan does not cover all health care expenses. Please carefully review the plan's limitations and exclusions.*

Overall Payment Provisions	In-Network Benefits	Out-of-Network Benefits
Deductibles		
Per-admission Deductible	None	$250
Calendar Year Deductible	$1,000 Individual / $3,000 Family	$1,500 Individual / $4,500 Family
Applies to all Eligible Expenses, unless otherwise indicated, except Inpatient Hospital Expenses		
Three-month Deductible carryover applies***	Yes	Yes
Deductible credit from prior carrier (applied on initial group enrollment only)	Yes	Yes
Out-of-Pocket Maximum		
Standard (2014 forward)	$3,500 Individual / $10,500 Family	$7,000 Individual / $21,000 Family
Deductible applies to Out-of-Pocket	Yes – no option	Yes**
Copayment applies to Out-of-Pocket	Yes – no option	Yes**
** Copayment amounts and per are admission deductibles applied but will continue to be required after the benefit percentage increases to 100%.	Network Deductible & Out-of-Pocket **will only** apply toward Network Deductible & Out-of-Pocket Maximum	Out-of-Network Deductible & Out-of Network Out-of-Pocket **will only** apply toward Out-of-Network Deductible & Out-of-Network Out-of-Pocket Maximum
Credit for Out-of-Pocket Maximum from prior carrier (applied on initial group enrollment only)	Yes	Yes
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	$30 Primary Care Copayment	
Specialty Care Copayment Amount for office visit/consultation when services rendered by a Specialty Care Provider	$50 Specialty Care Copayment	
Refer to Medical/Surgical Expenses section for more information		
Urgent Care center visit	$50 Copayment Amount	
Refer to Urgent Care Services section for more information		
Outpatient Hospital Emergency Room/Treatment Room visit	$250 Copayment Amount	$250 Copayment Amount
Refer to Emergency Room/Treatment Room section for more information		
Maximum Lifetime Benefits		
Per Participant	Unlimited	
Inpatient Hospital Expenses		
Inpatient Hospital Expenses		
All services must be preauthorized		
All usual services and supplies, including semiprivate room, intensive care, and coronary care units.	80% of Allowable Amount after Calendar year Deductible	60% of Allowable Amount after per-admission Deductible and Calendar Year
Penalty for failure to preauthorize	None	$250
For Inpatient Facility Services, Blue Cross Blue Shield of TX or the Host Blue's Participating Provider is required to obtain preauthorization. If preauthorization is not obtained, the Participating Provider will be sanctioned		

BENEFIT HIGHLIGHTS *Prepared for*
City of Marshall Employee Benefits Trust - Actives
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BlueChoice Network

based on Blue Cross Blue Shield of TX or the Host Blue's contractual agreement with the Provider, therefore the member will be held harmless for the Provider sanction		

Medical/Surgical Expenses

Medical / Surgical Expenses

Services performed during the office visit/consultation when rendered by a Primary Care Provider *(does not include lab & x-ray, Certain Diagnostic Procedures and surgical services)*	*100% of Allowable Amount after $30 Primary Care Copayment***	*60% of Allowable Amount after Calendar Year Deductible*
Services performed during the office visit/consultation when services rendered by a Specialty Care Provider *(does not include lab & x-ray, Certain Diagnostic Procedures and surgical services)*	*100% of Allowable Amount after $50 Specialty Care Copayment*	*60% of Allowable Amount after Calendar Year Deductible*
-Lab & x-ray in Physician office or any outpatient facility (excluding Certain Diagnostic Procedures)	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*

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

PPO Insured/Cost Basic with Network Deductible, Split Copays

BlueCross BlueShield of Texas

Medical / Surgical Expenses, cont.	In-Network Benefits	Out-of-Network Benefits
-Certain Diagnostic Procedures; such as Bone Scan, Cardiac Stress Test, CT Scan (with or without contrast), MRI, Myelogram, PET Scan.	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
-Physician surgical services performed in any setting	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
-Physician inpatient hospital visits	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
-Home Infusion Therapy *(Services must be preauthorized)*	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
-All other outpatient services and supplies	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
In Vitro Fertilization Services	*Not Covered*	
Virtual Visit MDLIVE (standard offering) **Note:** Must mirror PCP office visit benefit Medical & Behavioral Health		
Medical	*100% of Allowable Amount after $30 Copayment Amount*	*60% of Allowable Amount after Calendar Year Deductible*
Note: Behavioral Health benefit must mirror benefit under Mental Health and Substance Use Disorder		
Behavioral Health	*100% of Allowable Amount after $30 Copayment Amount*	*60% of Allowable Amount after Calendar Year Deductible*
Note: Behavioral Health Virtual Visit applies to MHP		

Extended Care Expenses

Extended Care Expenses *All services must be preauthorized*	*100% of Allowable Amount*	*60% of Allowable Amount after Calendar Year Deductible*
Skilled Nursing Facility	*Limited to 25 day maximum each Year**	
Home Health Care	*Limited to 60 visit maximum each Year**	
Hospice Care	*Unlimited*	

Special Provisions Expenses

Mental Health (Serious Mental Illness (SMI) included) and Chemical Dependency (Substance Use Disorder)		
Inpatient Services *Inpatient Chemical Dependency treatment must be provided in a Chemical Dependency/Residential Treatment Center (RTC)*		
-Hospital services (facility)	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after per-admission Deductible and Calendar Year Deductible*
-Physician services	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
Penalty for failure to preauthorize	*None*	*$250*
Preauthorization required for inpatient, residential treatment centers (RTC), partial hospital program admissions, and certain outpatient professional services		
Outpatient Services		
-Services performed during office visit/consultation when rendered by Primary Care Provider (does not include psychological testing)	*100% of Allowable Amount after $30 Primary Care Copayment Amount*	*60% of Allowable Amount after Calendar Year Deductible*
-All outpatient services, lab & x-ray and psychological testing	*80% of Allowable Amount after Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
Emergency Room/Treatment Room		
Accidental Injury & Emergency Care		
-Facility charges	*80% of Allowable Amount after $250 Copayment Amount (Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply)*	
-Physician charges	*80% of Allowable Amount after Calendar Year Deductible*	
Non-Emergency Care		
-Facility charges	*80% of Allowable Amount after $250 Copayment Amount (Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply)*	*60% of Allowable Amount after $250 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*	*60% of Allowable Amount after Calendar Year Deductible*
Urgent Care Services		
Urgent Care center visit services *(does not include lab & x-ray, Certain Diagnostic Procedures and surgical services)*	*100% of Allowable Amount after $50 Copayment Amount*	*60% of Allowable Amount after Calendar Year Deductible*
Lab & x-ray, Certain Diagnostic Procedures; such as Bone Scan, Cardiac Stress Test, CT Scan (with or without contrast), MRI, Myelogram, PET Scan, and surgical procedures	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*

* 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***
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*	*60% 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*	*60% of Allowable Amount after Calendar Year Deductible*
Hearing Aid Maximum	*Hearing aids are subject to 1 per ear per 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*
Physical Medicine Services		
Physical Medicine Services (includes, but is not limit to physical, occupational, and manipulative therapy)	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
Maximum	*Limited to 35 visits each Year**	

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

PPO Insured/Cost Basic with Network Deductible, Split Copays

BlueCross BlueShield of Texas

Pharmacy Benefits	Participating Pharmacy*	Non-Participating Pharmacy (member files claim)
Drug List**	*Enhanced* *Broad Advantage Network*	
Compound Drugs	*Not Covered*	
Non-sedating antihistamine (NSA) drugs and combination medications containing a non-sedating antihistamine and decongestant	*Exclude Prescription Strength NSA's*	
Proton Pump Inhibitors NOTE: For the Performance drug list, coverage will be based on the drug list. Customization is not allowed.	*Generics coverage only*	
Prescribed over-the-counter (OTC) medications	*Not covered* *Exclude prescription orders for which there is an OTC product available with the same active ingredient(s) in the same strength (standard exclusion).* *Cover Omeprazole 20 mg Yes*	
Prescription Drug Deductible***	*None*	
Prescription Drug Out-of-Pocket Maximum	☒ *Separate Prescription Drug Out-of-Pocket Maximum applies: $1500 Combined (per family) Retail & Mail Service Pharmacy Out of Pocket Maximum per Calendar Year*	
Vaccinations obtained through Pharmacies****	*Yes, all ACA vaccines, including flu, covered at pharmacies participating in Prime's Vaccination Network only:* *Zero Copayment* ***Deductible does not apply*** ***(No OON Benefits)***	
Retail Pharmacy (Copayment amounts are based on a 30-day supply. With appropriate prescription order, up to a 90-day supply is available. Copayment amounts apply to Out-of-Pocket Maximum.)		
Generic Drug	*$10 Copayment Amount*	*80% of Allowable Amount minus Copayment Amount*
Preferred Name Brand	*$35 Copayment Amount*	*80% of Allowable Amount minus Copayment Amount*
Non-Preferred Brand Name	*$50 Copayment Amount*	*80% of Allowable Amount minus Copayment Amount*
Specialty Drugs†	*Mandatory Specialty applies (standard): Available at in-network benefit level through specialty pharmacy network provider only. All other pharmacies will be payable at the non-participating pharmacy benefit level.*	
Mail Order Program (Copayment amounts are based on a 30-day supply. With appropriate prescription order, up to a 90-day supply is available. Copayment amounts apply to Out-of-Pocket Maximum.)	*Yes*	
Generic Drug	*$10 Copayment Amount*	
Preferred Brand Name Drug	*$35 Copayment Amount*	
Non-Preferred Brand Name Drug	*$50 Copayment Amount*	

MAC 3 - Generic Incentive (Standard)- *Members electing to purchase brand name drugs when a generic equivalent is available, will be required to pay the difference between the cost of the generic and brand name drug, plus the applicable copay.*

** To locate a preferred/participating pharmacy in your area, go to myprime.com or contact customer service at the phone number on the back of your identification card.*

***The drug lists are available at: bcbstx.com/member/rx_drugs.html*

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

*****Select Participating Pharmacies have been contracted to provide vaccination services. Each pharmacy may have age, scheduling, or other requirements that will apply. Members are encouraged to contact the store in advance.* ***Benefit does not include childhood immunizations, subject to state***

regulations.

†For more information on the specialty drug program, call (877)627-6337.

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.

Standard UM Programs (prior authorization and step therapy) and exclusions apply, including auto updates and FastPath.

***Note:** To confirm standard benefits, refer to the Pharmacy page on Product Central on FYIBlue.*

EMPLOYER INFORMATION
RATES

Plan I – Four Rate Structure

Employee Only	$583.96
Employee + Child(ren)	$1,058.22
Employee + Spouse	$1,301.12
Employee + Family	$1,775.45

The above proposed rates are projected to be effective for the 12-month period beginning on the effective date of group coverage. Changes in enrollment and contribution will be addressed as stated in the Benefit Program Application (BPA)

Group Executive Name and Title (Please type or print)	Signature	Date
Agent of Record Name (Please print or type)	Signature	Date
BCBSTX Representative Name (Please print or type)	Signature	Date

PPO Insured/Cost Basic with Network Deductible, Split Copays

BlueCross BlueShield of Texas

BENEFIT HIGHLIGHTS *Prepared for*
City of Marshall Employee Benefits Trust - Retiree
Funding: ☒ Fully Insured
Effective Date: 01/01/2019
BA# 0004

BlueChoice Network

This is a general summary of your benefits. *Please refer to your Summary of Benefits and Coverage (SBC), or you may request a copy of the policy or plan document for additional details and a description of the plan requirements and benefit design. This plan does not cover all health care expenses. Please carefully review the plan's limitations and exclusions.*

Overall Payment Provisions	In-Network Benefits	Out-of-Network Benefits
Deductibles		
Per-admission Deductible	None	$250
Calendar Year Deductible	$1,000 Individual / $3,000 Family	$1,500 Individual / $4,500 Family
Applies to all Eligible Expenses, unless otherwise indicated, except Inpatient Hospital Expenses		
Three-month Deductible carryover applies***	Yes	Yes
Deductible credit from prior carrier (applied on initial group enrollment only)	Yes	Yes
Out-of-Pocket Maximum		
Standard (2014 forward)	$3,500 Individual / $10,500 Family	$7,000 Individual / $21,000 Family
Deductible applies to Out-of-Pocket	Yes – no option	Yes**
Copayment applies to Out-of-Pocket	Yes – no option	Yes**
** Copayment amounts and per are admission deductibles applied but will continue to be required after the benefit percentage increases to 100%.	Network Deductible & Out-of-Pocket **will only** apply toward Network Deductible & Out-of-Pocket Maximum	Out-of-Network Deductible & Out-of Network Out-of-Pocket **will only** apply toward Out-of-Network Deductible & Out-of-Network Out-of-Pocket Maximum
Credit for Out-of-Pocket Maximum from prior carrier (applied on initial group enrollment only)	Yes	Yes
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	$30 Primary Care Copayment	
Specialty Care Copayment Amount for office visit/consultation when services rendered by a Specialty Care Provider	$50 Specialty Care Copayment	
Refer to Medical/Surgical Expenses section for more information		
Urgent Care center visit	$50 Copayment Amount	
Refer to Urgent Care Services section for more information		
Outpatient Hospital Emergency Room/Treatment Room visit	$250 Copayment Amount	$250 Copayment Amount
Refer to Emergency Room/Treatment Room section for more information		
Maximum Lifetime Benefits		
Per Participant	Unlimited	

Inpatient Hospital Expenses		
Inpatient Hospital Expenses		
All services must be preauthorized		
All usual services and supplies, including semiprivate room, intensive care, and coronary care units.	80% of Allowable Amount after Calendar year Deductible	60% of Allowable Amount after per-admission Deductible and Calendar Year
Penalty for failure to preauthorize For Inpatient Facility Services, Blue Cross Blue Shield of TX or the Host Blue's Participating Provider is required to obtain preauthorization. If preauthorization is not obtained, the Participating Provider will be sanctioned	None	$250

BENEFIT HIGHLIGHTS *Prepared for*
City of Marshall Employee Benefits Trust - Retiree
Funding: ☒ Fully Insured
Effective Date: 01/01/2019
BA# 0004

BlueChoice Network

based on Blue Cross Blue Shield of TX or the Host Blue's contractual agreement with the Provider, therefore the member will be held harmless for the Provider sanction		

Medical/Surgical Expenses

Medical / Surgical Expenses

Services performed during the office visit/consultation when rendered by a Primary Care Provider *(does not include lab & x-ray, Certain Diagnostic Procedures and surgical services)*	*100% of Allowable Amount after $30 Primary Care Copayment***	*60% of Allowable Amount after Calendar Year Deductible*
Services performed during the office visit/consultation when services rendered by a Specialty Care Provider *(does not include lab & x-ray, Certain Diagnostic Procedures and surgical services)*	*100% of Allowable Amount after $50 Specialty Care Copayment*	*60% of Allowable Amount after Calendar Year Deductible*
-Lab & x-ray in Physician office or any outpatient facility (excluding Certain Diagnostic Procedures)	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*

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

PPO Insured/Cost Basic with Network Deductible, Split Copays

BlueCross BlueShield of Texas

Medical / Surgical Expenses, cont.	In-Network Benefits	Out-of-Network Benefits
-Certain Diagnostic Procedures; such as Bone Scan, Cardiac Stress Test, CT Scan (with or without contrast), MRI, Myelogram, PET Scan.	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
-Physician surgical services performed in any setting	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
-Physician inpatient hospital visits	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
-Home Infusion Therapy *(Services must be preauthorized)*	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
-All other outpatient services and supplies	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
In Vitro Fertilization Services	*Not Covered*	
Virtual Visit MDLIVE (standard offering) **Note:** Must mirror PCP office visit benefit Medical & Behavioral Health **Medical**	*100% of Allowable Amount after $30 Copayment Amount*	*60% of Allowable Amount after Calendar Year Deductible*
Note: Behavioral Health benefit must mirror benefit under Mental Health and Substance Use Disorder **Behavioral Health**	*100% of Allowable Amount after $30 Copayment Amount*	*60% of Allowable Amount after Calendar Year Deductible*
Note: Behavioral Health Virtual Visit applies to MHP		

Extended Care Expenses

Extended Care Expenses *All services must be preauthorized*	*100% of Allowable Amount*	*60% of Allowable Amount after Calendar Year Deductible*
Skilled Nursing Facility	*Limited to 25 day maximum each Year**	
Home Health Care	*Limited to 60 visit maximum each Year**	
Hospice Care	*Unlimited*	

Special Provisions Expenses

Mental Health (Serious Mental Illness (SMI) included) and Chemical Dependency (Substance Use Disorder) **Inpatient Services** *Inpatient Chemical Dependency treatment must be provided in a Chemical Dependency/Residential Treatment Center (RTC)*		
-Hospital services (facility)	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after per-admission Deductible and Calendar Year Deductible*
-Physician services	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
Penalty for failure to preauthorize *Preauthorization required for inpatient, residential treatment centers (RTC), partial hospital program admissions, and certain outpatient professional services*	*None*	*$250*
Outpatient Services		
-Services performed during office visit/consultation when rendered by Primary Care Provider (does not include psychological testing)	*100% of Allowable Amount after $30 Primary Care Copayment Amount*	*60% of Allowable Amount after Calendar Year Deductible*
-All outpatient services, lab & x-ray and psychological testing	*80% of Allowable Amount after Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
Emergency Room/Treatment Room **Accidental Injury & Emergency Care**		
-Facility charges	*80% of Allowable Amount after $250 Copayment Amount (Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply)*	
-Physician charges	*80% of Allowable Amount after Calendar Year Deductible*	
Non-Emergency Care		
-Facility charges	*80% of Allowable Amount after $250 Copayment Amount (Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply)*	*60% of Allowable Amount after $250 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*	*60% of Allowable Amount after Calendar Year Deductible*
Urgent Care Services		
Urgent Care center visit services *(does not include lab & x-ray, Certain Diagnostic Procedures and surgical services)*	*100% of Allowable Amount after $50 Copayment Amount*	*60% of Allowable Amount after Calendar Year Deductible*
Lab & x-ray, Certain Diagnostic Procedures; such as Bone Scan, Cardiac Stress Test, CT Scan (with or without contrast), MRI, Myelogram, PET Scan, and surgical procedures	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*

* 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***
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*	*60% 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*	*60% of Allowable Amount after Calendar Year Deductible*
Hearing Aid Maximum	*Hearing aids are subject to 1 per ear per 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*
Physical Medicine Services		
Physical Medicine Services (includes, but is not limit to physical, occupational, and manipulative therapy)	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
Maximum	*Limited to 35 visits each Year**	

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

PPO Insured/Cost Basic with Network Deductible, Split Copays

BlueCross BlueShield of Texas

Pharmacy Benefits	Participating Pharmacy*	Non-Participating Pharmacy (member files claim)
Drug List**	*Enhanced* *Broad Advantage Network*	
Compound Drugs	*Not Covered*	
Non-sedating antihistamine (NSA) drugs and combination medications containing a non-sedating antihistamine and decongestant	*Exclude Prescription Strength NSA's*	
Proton Pump Inhibitors NOTE: For the Performance drug list, coverage will be based on the drug list. Customization is not allowed.	*Generics coverage only*	
Prescribed over-the-counter (OTC) medications	*Not covered* *Exclude prescription orders for which there is an OTC product available with the same active ingredient(s) in the same strength (standard exclusion).* *Cover Omeprazole 20 mg Yes*	
Prescription Drug Deductible***	☒ *None*	
Prescription Drug Out-of-Pocket Maximum	☒ *Separate Prescription Drug Out-of-Pocket Maximum applies: $1500 Combined (per family) Retail & Mail Service Pharmacy Out of Pocket Maximum per Calendar Year*	
Vaccinations obtained through Pharmacies**	*Yes, all ACA vaccines, including flu, covered at pharmacies participating in Prime's Vaccination Network only:* *Zero Copayment* ***Deductible does not apply*** ***(No OON Benefits)***	
Retail Pharmacy (Copayment amounts are based on a 30-day supply. With appropriate prescription order, up to a 90-day supply is available. Copayment amounts apply to Out-of-Pocket Maximum.)		
Generic Drug	*$10 Copayment Amount*	*80% of Allowable Amount minus Copayment Amount*
Preferred Name Brand	*$35 Copayment Amount*	*80% of Allowable Amount minus Copayment Amount*
Non-Preferred Brand Name	*$50 Copayment Amount*	*80% of Allowable Amount minus Copayment Amount*
Specialty Drugs†	*Mandatory Specialty applies (standard): Available at in-network benefit level through specialty pharmacy network provider only. All other pharmacies will be payable at the non-participating pharmacy benefit level.*	
Mail Order Program (Copayment amounts are based on a 30-day supply. With appropriate prescription order, up to a 90-day supply is available. Copayment amounts apply to Out-of-Pocket Maximum.)	*Yes*	
Generic Drug	*$10 Copayment Amount*	
Preferred Brand Name Drug	*$35 Copayment Amount*	
Non-Preferred Brand Name Drug	*$50 Copayment Amount*	

MAC 3 - Generic Incentive (Standard)- *Members electing to purchase brand name drugs when a generic equivalent is available, will be required to pay the difference between the cost of the generic and brand name drug, plus the applicable copay.*

** To locate a preferred/participating pharmacy in your area, go to myprime.com or contact customer service at the phone number on the back of your identification card.*

***The drug lists are available at: bcbstx.com/member/rx_drugs.html*

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

*****Select Participating Pharmacies have been contracted to provide vaccination services. Each pharmacy may have age, scheduling, or other requirements that will apply. Members are encouraged to contact the store in advance.* ***Benefit does not include childhood immunizations, subject to state regulations.***

†*For more information on the specialty drug program, call (877)627-6337.*

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.

Standard UM Programs (prior authorization and step therapy) and exclusions apply, including auto updates and FastPath.

***Note:** To confirm standard benefits, refer to the Pharmacy page on Product Central on FYIBlue.*

EMPLOYER INFORMATION

RATES

Plan I – Four Rate Structure

Employee Only	$671.54
Employee + Child(ren)	$1,216.93
Employee + Spouse	$1,496.28
Employee + Family	$2,041.70

The above proposed rates are projected to be effective for the 12-month period beginning on the effective date of group coverage. Changes in enrollment and contribution will be addressed as stated in the Benefit Program Application (BPA)

Group Executive Name and Title (Please type or print)	Signature	Date
Agent of Record Name (Please print or type)	Signature	Date
BCBSTX Representative Name (Please print or type)	Signature	Date