Value Added Services

Aetna

EyeMed Vision Services
- Discount vision services and eye care
- Reduced fees for eyeglass frames and lens
- 15 percent off contact lens
- 15 percent off Lasik Procedure

Informed Healthline
- 24 hour informed Healthline staffed with registerd nurses

Alternative Health Care Programs
Access special rates on alternative therapies, products, and services, including:
1. Natural alternatives
   - Acupuncture
   - Massage
   - Chiropractic services (Consider using plan benefits first.)
2. Vitamin Advantage

Pay discounts for:
   - Over-the-counter vitamins
   - Nutritional supplements
3. Natural Care Products

TexanPlus

HearPO Hearing Discount Services:
- 30% discount on hearing exams and services.
- Up to 62% savings on hearing aids at a participating provider.
- Discounts on repairs and batteries.
- Access to newest digital technology.
- Locate a hearing provider at 1-800-456-6801

Hearing Aid:
- TexanPlus will pay a one-time $500 cash payment per covered member for the purchase of a hearing aid.
- You may use any hearing aid provider; however, you can receive up to a 62 percent discount if you go to HearPO. To receive your reimbursement, submit a copy of the receipt for your hearing aid to TexanPlus, and they will send a check to you for up to $500.

EyeMed Vision Services:
- Discounted vision services and eye care.
- This includes a $25 copayment for an annual eye exam and discounts on frames and lenses.
- Look in your provider directory for a list of network eye doctors.

Careington Dental Discount Services:
- Receive 20% - 50% off most dental procedures.
- Up to 20% discount on specialty services.
- Cosmetic dentistry and teeth whitening included.
- 24,000 participating providers.
- Locate a dental provider at 1-800-290-0523

ElderCare Services - NurseNavigator:
- Works with you to identify elder- care needs.
- Evaluate options, put solutions in place.
- Provide on-going support needed to maintain independence and quality of life.
- Wellness assessments, care planning tools.
- 24-hour Nurse Navigator elder-care advisor.
- Significant discounts on senior housing alternatives & additional care services.

Texas HealthSpring

Fitness Benefit: Members may enroll in Silver Sneakers Fitness program that allows them access to health clubs and participate in classes specifically designed for Seniors.
- Upon enrollment the member will be provided with numerous fitness and health centers in the local area.
- Full use of amenities including free weights, tread mills, aerobic classes, as well as fitness programs specifically tailored for the needs of seniors.
- A customer service department ready to answer any questions regarding the program and to assist with enrollment.

Careington Dental Discount Services:
- Receive 20% - 50% off most dental procedures.
- Up to 20% discount on specialty services.
- Cosmetic dentistry and teeth whitening included.
- 24,000 participating providers.
- Locate a dental provider at 1-800-290-0523.

Free Rides:
- Free rides are provided to plan-approved health facilities, such as doctor's appointments, hospitals, and pharmacies. Up to 30 one-way trips or 15 round trips per calendar year.

Discount Hearing Aids:
- Discount hearing services provide up to 30%.
- Discount for hearing aids from selected providers.

PAL–Personal Assistant Liaison:
- PALs proactively engage members in THS' benefits plan. PALs will "reach out" to members and encourage them to use plan benefits, educate them about programs and services, and resolve members' problems.

Contribution Rates

Use the chart below to find the contribution for the coverage you elect. First, look for the category in the left-hand column that fits your situation, then select the corresponding rate for the plans of your choice. If you have family members who remain in the HMO or PPO, select the rate based on the age of the oldest family member keeping the HMO or PPO plan. Your total monthly contribution is the sum of the rate for HMO or PPO, plus the rate for Aetna, TexanPlus or Texas HealthSpring.

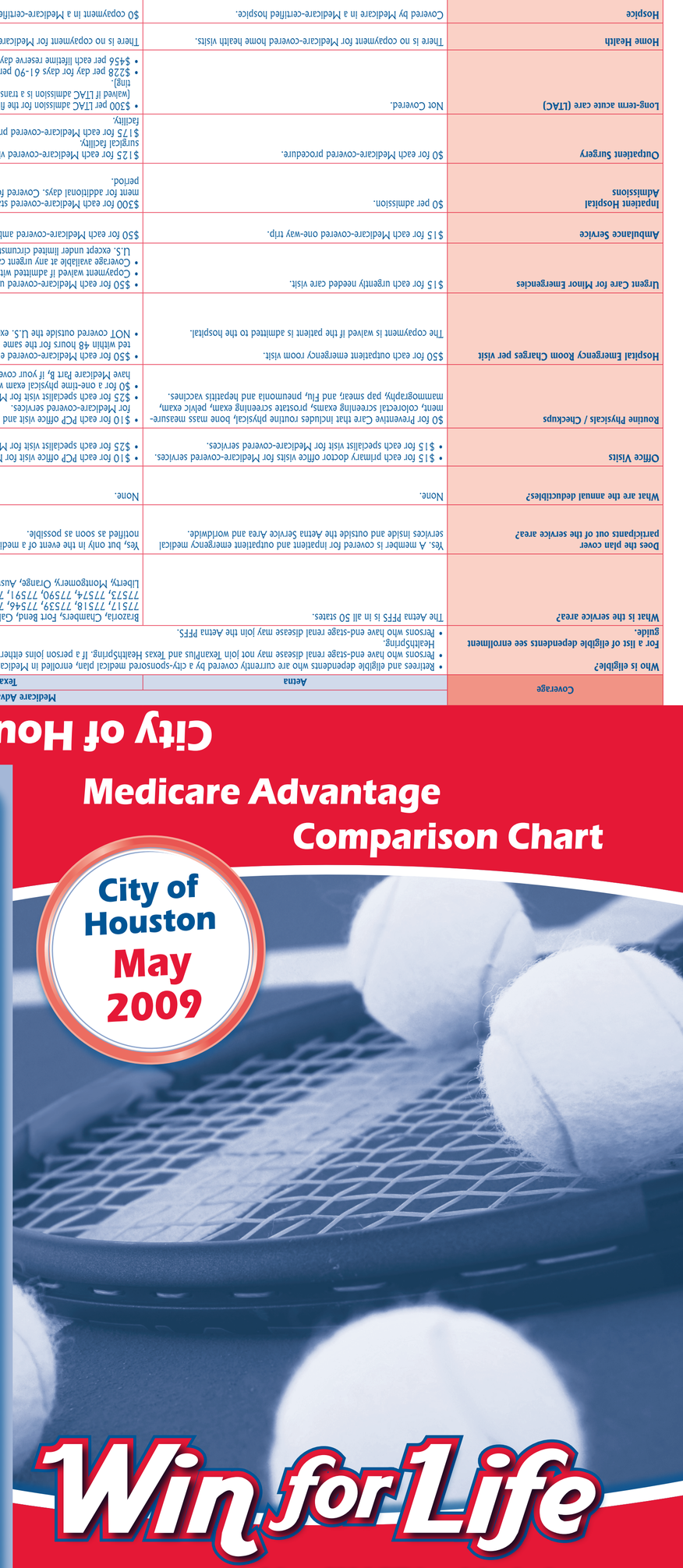
Contribution chart for May 2009

Family Coverage Category	Monthly Retiree Contributions				
	Aetna	TexanPlus	Texas Health-Spring	HMO*	PPO*
Retiree Only (Has Medicare)				**$166.18**	**$506.60**
1 Retiree elects an MA plan	$61	$9.76	$18	–	–
Retiree + One (Both have Medicare)				**$324.12**	**$713.14**
2 Both elect the same MA plan	$122	$19.52	$36	–	–
3 Each elects a seperate plan	$61	$9.76	$18	$166.18	$506.60
Retiree + One (Only one has Medicare)				**$332.46**	**$1,089.78**
4 One elects an MA plan / one keeps city plan (less than 65)	$61	$9.76	$18	$185.36	$580.40
5 One elects an MA plan / one keeps city plan (age 65+)	$61	$9.76	$18	$503.62	$816.36
Retiree + Family (Two have Medicare)				**$515.28**	**$1,326.02**
6 Two elect the same MA plan / one keeps city plan (less than 65)	$122	$19.52	$36	$185.36	$580.40
7 Two elect the same MA plan / two keep city plan (both are less than 65)	$122	$19.52	$36	$546.98	$1,499.42
8 Two elect the same MA plan / two+ keep city plan (all are less than 65)	$122	$19.52	$36	$853.00	$2,105.54
9 One elects an MA plan / two keep city plan (1 is 65+, 1 is less than 65)	$61	$9.76	$18	$332.46	$1,089.78
10 One elects an MA plan / two+ keep city plan (1 is 65+, 2 are less than 65)	$61	$9.76	$18	$565.14	$1,451.32
Retiree + Family (Two with Medicare + one 65+ w/o Medicare)				**$515.28**	**$1,326.02**
11 Two elect the same MA plan / one keeps city plan (age 65+)	$122	$19.52	$36	$503.62	$816.36
12 Two elect the same MA plan / two keep city plan (1 is 65+, 1 is less than 65)	$122	$19.52	$36	$1,057.62	$1,731.38
Retiree + Family (Three w/ Medicare)				**$515.28**	**$1,326.02**
13 Three elect an MA plan	$183	$29.28	$54	–	–
14 Three elect the same MA plan / one keeps city plan (1 is less than 65)	$183	$29.28	$54	$185.36	$580.40
15 Three elect the same MA plan / two keep city plan (both are less than 65)	$183	$29.28	$54	$546.98	$1,499.42
16 Three elect the same MA plan / two+ keep city plan (all are less than 65)	$183	$29.28	$54	$853.00	$2,105.54
17 Two elect the same MA plan / one keeps city plan (age 65+)	$122	$19.52	$36	$166.18	$506.60
18 Two elect the same MA plan / two keep city plan (1 is 65+, 1 is less than 65)	$122	$19.52	$36	$332.46	$1,089.78
19 Two elect the same MA plan / two + keep city plan (1 is 65+, 2 are less than 65)	$122	$19.52	$36	$565.14	$1,451.32
20 One elects an MA plan / two keep city plan (2 are 65+)	$61	$9.76	$18	$324.12	$713.14
21 One elects an MA plan / two+ keep city plan (2 are 65+, 1 is less than 65)	$61	$9.76	$18	$515.28	$1,326.02
Retiree + Family (Only one has Medicare)				**$565.14**	**$1,451.32**
22 One elects an MA plan / two keep city plan (both are less than 65)	$61	$9.76	$18	$546.98	$1,499.42
23 One elects an MA plan / two+ keep city plan (all are less than 65)	$61	$9.76	$18	$853.00	$2,105.54
24 One elects an MA plan / two keep city plan (1 is 65+, 1 is less than 65)	$61	$9.76	$18	$1,057.62	$1,731.38
25 One elects an MA plan / two+ keep city plan (1 is 65+, 2 are less than 65)	$61	$9.76	$18	$1,813.04	$2,154.98

* Rates displayed for the HMO and PPO are for participants who do not use tobacco products. If the participant or a family member uses tobacco products, the rate is $25 higher per month. This additional amount does not apply to TexanPlus, Texas HealthSpring, or Aetna PFFS.

Medicare Advantage Comparison Chart

City of Houston
May 2009



Win for Life

Making SMART health choices

City of Houston Medicare Advantage Plan Comparison

Coverage	Medicare Advantage Plans			HMO Plan	Preferred Provider Organization	
	Aetna	TexanPlus	Texas HealthSpring		In-Network	Out-of-Network
Who is eligible? **For a list of eligible dependents see enrollment guide.**			• Retirees and eligible dependents who are currently covered by a city-sponsored medical plan, enrolled in Medicare Part A and Part B, and live in the service area. • Persons who have end-stage renal disease may join Texan Plus and Texas HealthSpring. If a person joins either plan and later develops end-stage renal disease, the member may remain a member of TexanPlus or Texas HealthSpring. • Persons who have end-stage renal disease may not join TexanPlus or HealthSpring.		Retirees and eligible dependents who are currently enrolled in a city-sponsored medical plan, enrolled in Medicare Part A and Part B, and live in HMO Blue Texas or Blue Cross Blue Shield Service Area.		
What is the service area?	The Aetna PFFS is in all 50 states.	Brazoria, Chambers, Fort Bend, Galveston zip codes: 77510, 77511, 77511?, 77513, 77518, 77539, 77546, 77549, 77563, 77565, 77568, 77573, 77574, 77590, 77591, 77592, Harris, Hardin, Jefferson, Liberty, Montgomery, Orange, Austin, Dallas, Rockwall, Tarrant, Waller	Angelina, Brazoria, Cameron, Chambers, Fort Bend, Galveston zip codes: 77510, 77511, 77517, 77518, 77539, 77546, 77549, 77563, 77565, 77568, 77573, 77574, 77590, 77591, 77592, Harris, Hardin, Hidalgo, Jasper, Jefferson, Liberty, Montgomery, Nacogdoches, Newton, Orange, Polk, Sabine, San Augustine, San Jacinto, Shelby, Tyler, Walker, Waller, Willacy	Plan covers all but 34 counties in Texas. See the HMO directory for a list of counties in the service area, or visit the Web site at www.bcbstx.com.	All 50 states are in the service area. A reduced benefit and higher deductibles apply for services obtained out-of-network. To identify participating providers outside of Texas, call 1-800-810-2583 or use your zip code to find a provider at www.bcbstx.com.	
Does the plan cover participants out of the service area?	Yes. A member is covered for inpatient and outpatient emergency medical services inside and outside the Aetna Service Area and worldwide.	Yes, but only in the event of a medical emergency. TexanPlus must be notified as soon as possible.	Yes, but only in the event of a medical emergency. Texas HealthSpring must be notified as soon as possible.	Yes, in the event of a medical emergency notify HMO Blue Texas within 48 hours of initial treatment. Seek services within 12 hours after the onset of an illness or within 48 hours after an accident.	Yes, participants are covered at home or away 24-hours a day, using their choice of physicians. A reduced benefit and higher deductibles apply for services obtained out-of-network. There is emergency care coverage outside of the Continental United Sates. To identify participating providers outside of Texas, call 1-800-810-2583.	
What are the annual deductibles?	None.	None.	None.	None.	**Individual:** $200 **Family:** $600	**Individual:** $400 **Family:** $1,200
Office Visits	• $15 for each primary doctor office visits for Medicare-covered services. • $15 for each specialist visit for Medicare-covered services.	• $10 for each PCP office visit for Medicare-covered services. • $25 for each specialist visit for Medicare-covered services.	• $10 for each PCP office visit for Medicare-covered services. • $25 for each specialist office visit for Medicare-covered services.	$20 copayment for primary care physician. $45 copayment for specialist.	$30 copayment for primary care physician. $50 copayment for specialist.	40% after annual deductible.
Routine Physicals / Checkups	$0 for Preventive Care that includes routine physical, bone mass measurement, colorectal screening exams, prostate screening exam, pelvic exam, mammography, pap smear, and Flu, pneumonia and hepatitis vaccines.	• $10 for each PCP office visit and one routine physical exam annually for Medicare-covered services. • $25 for each specialist visit for Medicare-covered services. • $0 for a one-time physical exam within the first 6 months that you have Medicare Part B, if your coverage began on or after 1/1/07.	• $10 for each PCP office visit and one routine physical exam annually for Medicare-covered services. • $25 for each specialist office visit for Medicare-covered services.	$0 copayment. One well woman and one well man exam per 12 months.	$0 copayment. One well woman and one well man exam per 12 months.	40% after annual deductible.
Hospital Emergency Room Charges per visit	$50 for each outpatient emergency room visit. The copayment is waived if the patient is admitted to the hospital.	• $50 for each Medicare-covered emergency room visit, waived if admitted within 48 hours for the same condition. • NOT covered outside the U.S. except under limited circumstances.	• $50 for each Medicare-covered emergency room visit; waived if admitted within 3 days for the same condition. • Worldwide emergency care. If you get inpatient care at a non-plan hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a plan hospital with plan authorization.	$150 per visit (waived if admitted to the hospital). You must notify your PCP or RCBS within 48 hours. Physician's office after hours: $20 per visit.	$150 copayment plus 20% for emergency within 48 hours of accident/medical emergency. Illness anytime. Copayment waived if admitted to hospital.	$150 copayment plus 40% after deductible for emergency after 48 hours of the accident/medical emergency. Copayment waived if admitted to hospital.
Urgent Care for Minor Emergencies	$15 for each urgently needed care visit.	• $50 for each Medicare-covered urgently needed care visit. • Copayment waived if admitted within 24 hours for the same condition. • Coverage available at any urgent care facility. NOT covered outside the U.S. except under limited circumstances.	• $40 for each Medicare-covered urgently needed care visit. • Copayment waived if admitted within 3 day(s) for the same condition. • World-wide coverage.	**Office Visits:** $20 copayment. **Urgent Care Center:** $40 copayment.	**Office Visits:** $30 copayment. **Urgent Care Center:** $60 copayment. St. Luke's Community Emergency Center requires $150 Emergency Room copayment.	**Office Visits:** 40% after annual deductible. **Urgent Care Center:** 40% after annual deductible.
Ambulance Service	$15 for each Medicare-covered one-way trip.	$50 for each Medicare-covered ambulance one-way service.	$100 for each Medicare-covered one-way ambulance service; you do not pay this amount if you are admitted to the hospital.	$100 Copayment	Eligible expenses at 20% after annual deductible.	Eligible expenses at 40% after annual deductible is met.
Inpatient Hospital Admissions	$0 per admission.	$300 for each Medicare-covered stay in a network hospital. No copayment for additional days. Covered for unlimited days each benefit period.	• $275 for each Medicare-covered stay in a network hospital. No copayment for additional days. Covered for unlimited days each benefit period. • If you are readmitted to the hospital within 3 days for the same diagnosis your copayment will be waived.	$500 copayment per hospital admission. Pre-authorization required.	20% after $500 copayment per admission. Pre-authorization required.	40% after $1,000 copayment per admission. Pre-authorization required. $250 copayment for failure to get pre-authorization.
Outpatient Surgery	$0 for each Medicare-covered procedure.	$125 for each Medicare-covered visit or procedure in an ambulatory surgical facility. $175 for each Medicare-covered procedure in an outpatient hospital facility.	$200 for each Medicare-covered visit or procedure in an ambulatory surgical center or outpatient hospital facility.	$200 copayment for each procedure. Pre-authorization is required.	20% after annual deductible for each procedure.	40% after annual deductible for each procedure.
Long-term acute care (LTAC)	Not Covered.	• $300 per LTAC admission for the first 60 days of the LTAC admission. (waived if LTAC admission is a transfer from an inpatient acute care setting). • $228 per day for days 61-90 per benefit period. • $456 per each lifetime reserve day (maximum 60 lifetime reserve days).	• $0 for 1-15 days • $50 for 16+ days	N/A	N/A	N/A
Home Health	There is no copayment for Medicare-covered home health visits.	There is no copayment for Medicare-covered home health visits.	There is no copayment for Medicare-covered home health visits.	$20 copayment for each visit. Pre-authorization required.	Skilled, non-custodial home health care services are 20% after annual deductible. Limited to 60 visits per calendar year. Pre-authorization required.	Skilled, non-custodial home health care services are 40% after annual deductible. Limited to 60 visits per calendar year. Pre-authorization required.
Hospice	Covered by Medicare in a Medicare-certified hospice.	$0 copayment in a Medicare-certified hospice facility.	$0 copayment in a Medicare-certified hospice facility.	$0 copayment. Pre-authorization required. Maximum calendar year benefit is $20,000.	**Inpatient:** Eligible expenses subject to $500 hospital inpatient copayment and 20%. **Outpatient:** Eligible expenses, $50 copayment per visit. Services other than those provided by hospice facility, such as attending physician's services, are subject to 20% after the plan deductible.	**Inpatient:** Eligible expenses subject to $1,000 hospital inpatient copayment and 40%. **Outpatient:** Eligible expenses, 40% after deductible. Services other than those provided by hospice facility, such as attending physician's services, are subject to 40% after plan deductible.

Note: If there exists a conflict between this Medical Plans Comparison and the Official plans documents for each plan, the Official plans documents will prevail. In all matters of coverage, only eligible expenses will be covered and paid according to plans provision. If pre-authorizations are required for medical services, penalties will apply if those services are received without authorization.
The City of Houston reserves the right to change or modify benefits provided under these plans without consent, authorization or prior notice to covered members. Aetna, SelectCare of Texas (TexanPlus), and Texas HealthSpring provide additional benefits. For a complete listing of all benefits and services, please refer to the Evidence of Coverage for the plan that you select.

Coverage	Medicare Advantage Plans			HMO Plan	Preferred Provider Organization	
	Aetna	TexanPlus	Texas HealthSpring		In-Network	Out-of-Network
Skilled Nursing Facility	• $0 per day for days 1-10 • $25 per day for days 11 – 20 • $50 per day for days 21 – 100 • A prior hospital confinement is not required. You are covered for 100 days each benefit period.	• $0/day for day(s) 1 – 20 with immediate prior inpatient acute care. • $300/day for day(s) 1 – 20 No prior hospital stay is required. • $100/day for day(s) 21-100 You are covered for 100 days each benefit period.	• $25/day for day(s) 1-100 for a stay in a skilled nursing facility • No prior hospital stay is required. You are covered for 100 days each benefit period.	$25 per day. (Maximum of 60 days per calendar year.)	Eligible facility expenses subject to $500 hospital inpatient copayment: 20% thereafter. Copayment waived for transfer from inpatient hospital level of care to a skilled nursing level of care. Services other than those provided by skilled nursing facility, such as attending physician's services, are subject to 20% coinsurance after the deductible. Coverage is limited to the following conditions: If participant is not admitted to a skilled nursing facility and acute care hospitalization would be needed, the attending physician must order the care and the administrator must pre-authorize it. Coverage is also limited to a maximum of 60 days per calendar year. Custodial care or care for persistent illnesses and disorders that, in the administrator's opinion, cannot be relieved or improved by medical treatment are not covered.	Eligible facility expenses subject to $1,000 hospital inpatient copayment; 40% thereafter. Copayment waived for transfer from inpatient hospital level of care to a skilled nursing level of care. Services other than those provided by skilled nursing facility, such as attending physician's services, are subject to 40% coinsurance after the deductible.
Chiropractic Services	$15 for each Medicare-covered visit (manual manipulation of the spine)	$25 for each Medicare-covered visit (manual manipulation of the spine to correct subluxation).	$25 for each Medicare-covered visit (manual manipulation of the spine to correct subluxation).	$45 specialist copayment. No maximum amount.	**Specialist Visit:** 20% after $50 copayment. **Other Services:** 20% after annual deductible in outpatient setting. Combined annual limit is $1,000 per calendar year, including all X-rays, lab, medicines, etc.	**Office Visit:** 20% after annual deductible. **Other Services:** 40% after annual deductible in outpatient setting.
Inpatient Mental Health Services	$0 per admission. Combined maximum of 190 days per lifetime for all inpatient mental health. Detoxification and rehabilitation for substance abuse treatment in a Medicare-certified psychiatric hospital. (Inpatient services in a general hospital have no maximum day limit.)	$300 for each Medicare-covered stay in a network hospital. There is a 190-day lifetime limit in a psychiatric hospital. The benefit days used under the Original Medicare program will count towards the 190-day lifetime reserve days when enrolling in TexanPlus.	$275 for each Medicare-covered stay in a network hospital. There is a 190-day lifetime limit in a psychiatric hospital. The benefit days used under the Original Medicare program will count towards the 190-day lifetime reserve days when enrolling in Texas HealthSpring.	If admission is deemed medically necessary, 100% after 20% copayment per admission. 30 days maximum per calendar year. Pre-authorization required.	20% after $500 copayment per admission; 30 days maximum per calendar year. Pre-authorization required.	40% after $1,000 copayment per admission; 15 days maximum per calendar year. Pre-authorization required.
Outpatient Mental Health Services Note: Emergency Room visits will require Emergency Room Copayment.	$25 for each Medicare-covered mental health visit	For Medicare-covered mental health services, you pay $35/individual per visit and $20/group per therapy visit.	For Medicare-covered mental health services, you pay $25/individual per visit and $25/group per therapy visit.	**Office Visit**: $25 copayment per session. Maximum of 20 sessions per calendar year.	**PCP Visit**: 20% after $30 copayment. 30 visits maximum per calendar year, includes outpatient visits.	**Office Visit:** 40% after annual deductible. 30 visits maximum per calendar year, includes outpatient visits.
Chemical Dependency Services/Substance Abuse	**Emergency Room:** $50 for each Medicare-covered emergency room visit. The Copayment is waived if the patient is admitted to the hospital. **Office Visit:** $15 for each Medicare-covered visit **Inpatient:** $0 per admission Combined maximum of 190 days per lifetime for all inpatient mental health and detoxification and rehabilitation substance abuse treatment in a Medicare-certified psychiatric hospital. (Inpatient services in a general hospital have no maximum day limit.)	**Emergency Room:** $50 for each Medicare-covered emergency room visit; waived if admitted within 48 hours. NOT covered outside the U.S. except under limited circumstances. **Office Visit:** $35 per individual visit and $20 per group therapy visit for Medicare-covered services. **Inpatient:** $300 for each Medicare-covered stay in a network hospital. No copayment for additional days. Covered for unlimited days each benefit period.	**Emergency Room:** $50 for Medicare-covered emergency room visit; waived if admitted within 3 days. Worldwide Emergency Care. **Office Visit:** $25 for each individual/group therapy visit. **Inpatient:** $275 for each Medicare-covered stay in a network hospital. Covered for unlimited days each benefit period. If readmitted to the hospital within 3 days for the same diagnosis, copayment will be waived.	**Emergency Room:** $150 copayment. Copayment waived if admitted. **Office Visit:** $20 copayment. **Specialist Visit:** $45 copayment **Inpatient:** $500 copayment for each admission. Limited to 3 series of treatments per lifetime of individual. Pre-authorization required.	**Emergency Room:** 20% after $150 copayment. Copayment waived if admitted. **Primary Physician Visit:** 20% after $30 copayment. **Specialist Visit:** 20% after $50 copayment **Inpatient:** 20% after $500 copayment for each admission. Limited to 3 series of treatments per lifetime of individual.	**Emergency Room:** 40% after $150 copayment and after deductible. Copayment waived if admitted. **Office Visit:** 40% after annual deductible. **Inpatient:** 40% after $1,000 copayment for each admission. Limited to 3 series of treatments per lifetime of individual. Pre-authorization required.
Physical Therapy/Outpatient Rehabilitation	$15 for each Medicare-covered visit. Services include outpatient physical therapy, occupational therapy, speech and language therapy	$25 for each Medicare-covered Occupational Therapy visit. $25 for each Medicare-covered Physical Therapy and/or Speech/Language Therapy visit.	$25 for each Medicare-covered Occupational Therapy visit. $25 for each Medicare-covered Physical Therapy and/or Speech/Language Therapy and cardiac rehabilitation visits.	$45 specialist copayment per visit. Unlimited physical therapy visits that continue to meet or exceed treatment goals set by physician. For physically disabled persons, treatment goals may include maintaining function or preventing or slowing further deterioration. Pre-authorization required.	**Specialist visit:** 20% after $50 copayment. **Outpatient:** 20% after deductible Unlimited physical therapy visits that continue to meet or exceed treatment goals set by physician. For physically disabled persons, treatment goals may include maintaining function or preventing or slowing further deterioration. Pre-authorization required.	40% after deductible. Unlimited physical therapy visits that continue to meet or exceed treatment goals set by physician. For physically disabled persons, treatment goals may include maintaining function or preventing or slowing further deterioration. Pre-authorization required.
Durable Medical Equipment	15% of the cost for each Medicare-covered item	10% of the cost for each Medicare- covered item.	10% of the cost for each Medicare-covered item.	Eligible expenses covered with 20% copayment for rental or purchase (initial placement only) of such equipment when pre-authorized and determined to be medically necessary by BCBS. Rental or purchase is determined by BCBS. Coverage is limited to equipment listed in the Health Care Finance Administration Coverages Issue Manual. Covers hearing aid benefit of $1,000 per 36-month period.	Eligible expenses are 20% after annual deductible for rental or purchase (initial placement only) of such equipment when pre-authorized and determined to be medically necessary by BCBS. Coverage is limited to equipment listed in the Health Care Finance Administration Coverages Issue Manual. Covers hearing aid benefit of $1,000 per 36-month period.	Eligible expenses are 40% after annual deductible for rental or purchase (initial placement only) of such equipment when pre-authorized and determined to be medically necessary by BCBS. Coverage is limited to equipment listed in the Health Care Finance Administration Coverages Issue Manual. Covers hearing aid benefit of $1,000 per 36-month period.
Diabetic Equipment, Self-Monitoring and Training Supplies	**Diabetic self-monitoring training:** $0 copayment **Diabetic equipment:** $0 of eligible charges **Diabetic supplies:** $0 copayment for each covered item including **Injectable insulin (31-day supply):** • $10 generic • $30 brand	**Diabetic self-monitoring training:** $0 copayment **Diabetic equipment:** 10% of eligible charges **Diabetic supplies:** 10% of the cost for each covered item **Injectable insulin (31-day supply):** • $10 generic • $30 brand	**Diabetic self-monitoring training:** $0 copayment **Diabetic equipment:** 20% of eligible charges **Diabetic supplies:** 20% of the cost for each covered item **Injectable insulin (30-day supply):** • $10 generic • $30 brand	**Diabetic equipment:** 20% of eligible charges **Diabetic supplies:** same as prescription drug coverage **Diabetes Self-Management Training Programs:** $0 copayment **Injectable insulin (30-day supply):** See prescription drug benefit.	Eligible expenses at 20% after $30 copayment. Diabetic equipment, self-management training and supplies are covered on the same basis as benefits are provided for treatment of other similar chronic medical conditions. Also covered: disposable or consumable outpatient diabetic supplies, equipment and supplies that do not require a prescription under state law, and injectable insulin. **Injectable Insulin (30-day supply):** See prescription drug benefit.	Eligible expenses at 40% after deductible is met. Diabetic equipment, self-management training and supplies are covered on the same basis as benefits are provided for treatment of other analogous chronic medical conditions. Also covered: disposable or consumable outpatient diabetic supplies, equipment and supplies that do not require a prescription under state law, and injectable insulin. **Injectable Insulin (30-day supply):** See prescription drug benefit.
Lab & X-rays	• $15 per visit for diagnostic laboratory, X-Ray, and nuclear testing • $15 for each PET Scan • $15 for each CAT Scan • $15 for each MRI • $15 for each visit for outpatient chemotherapy, dialysis and radiation	• $0 for specimen drawing or each covered laboratory service • $75 for each MRI, MRA, CT Scan • $100 for each IMRT • $150 for each PET Scan • $25 for each Medicare-covered radiation therapy • $0 for each Medicare-covered X-ray visit in the physician's office or freestanding facility	• $0 for specimen drawing, lab service • $25 for each Medicare-covered radiation therapy • $0 for each Medicare-covered X-ray visit in the physician's office or freestanding facility • $150 for each PET scan • $100 for each MRI, CT or cardiac nuclear medicine scan	$0 copayment. Included in physician's office visit.	**Office Visit:** $30 copayment Eligible expenses covered at 100% when associated with a physician office visit.	40% after annual deductible.
Bone Mass Measurement	$0 copayment	$0 copayment		$20 copayment - Primary Care Physician visit $45 copayment - Specialist visit	$30 copayment - Primary Care Physician visit $50 copayment - Specialist visit	40% after annual deductible is met.
Colorectal Cancer Screening (Includes fecal occult blood test, a flexible sigmoidoscopy and colonoscopy)	$0 copayment	$0 copayment for age 50 and older: • Flexible sigmoidoscopy – every 48 months. • Fecal occult blood test-every 12 months. • Member with risk factors: Colonoscopy every 24 months. • Member with low risk factors: Colonoscopy every 10 years.		$0 copayment for age 50 and older or members with risk factors: • Fecal occult blood test –every year • Flexible sigmoidoscopy -every 5 years. • Colonoscopy –every 10 years.	$0 copayment for age 50 and older or members with high risk factors: • Fecal occult blood test – every year. • Flexible sigmoidoscopy – every 5 years. • Colonoscopy –every 10 years.	40% after annual deductible for age 50 and older or members with high risk factors: • Fecal occult blood test – every year. • Flexible sigmoidoscopy –every 5 years. • Colonoscopy –every 10 years.
Routine Immunizations	$0 copayment for immunizations for flu, pneumonia, and Hepatitis B.	• $0 copayment for the Pneumonia and Flu vaccines. • No referral necessary for Pneumonia and Flu vaccines. • $0 copayment for the Hepatitis B vaccine.		$0 copayment if service provided during an office visit. Otherwise a $20 copayment applies.	$0 copayment to age 6. After age 6, $30 copayment.	$0 copayment to age 6. After age 6, 40% after annual deductible.
Well-Woman Exam (Includes clinical breast exams, mammogram, pelvic exam & pap smear)	$0 copayment	• $0 copayment for Medicare-covered screening: pap smear, breast exam or pelvic exam every 24 months. • Age 40 and older: Breast exam or mammogram every 12 months. • Members with high risk cervical cancer factors and are of childbearing age: Pap smear every 12 months. • No referral necessary for Medicare-covered screenings performed by a network provider.		$0 copayment (One exam per 12 months). Mammogram-over age 40 or family history of breast cancer exists.	$0 copayment. (One exam per 12 months). Mammogram-over age 40 or family history of breast cancer exists.	40% after annual deductible. (One exam per 12 months). Mammogram-over age 40 or family history of breast cancer exists.
Well-Man Exam – Prostate Cancer Screening for age 50 and older. (Includes prostate examination & prostate specific antigen test)	$0 copayment	$0 copayment for Medicare-covered exams once every 12 months.	$0 copayment for Medicare covered exams once every 12 months.	$0 copayment- one exam per 12 months. (Includes members age 40 with a family history of prostate cancer or prostate cancer risk factors)	$0 copayment-every 12 months. (includes members age 40 with a family history of prostate cancer or prostate cancer risk factors)	40% after annual deductible –every 12 months. (includes members age 40 with a family history of prostate cancer or prostate cancer risk factors)
Prescriptions If physician prescribes or allows a generic drug, but the patient requests brand, the copayment will be the difference between the cost of brand and generic plus the generic copayment. For all plans you must use a designated retail or mail-order pharmacy.	**RETAIL** **Copayment for a 31-day Supply** $10 – Generic $30 – Preferred Brand $45 – Non-preferred Brand $45 – Specialty Drugs **MAIL ORDER** **Copayment for a 90-day Supply** $20 – Generic $60 – Brand $90 – Non-preferred Brand $90 – Specialty Drugs After the member's copayments total $4,350 in the plan year, copayments become the greater of $2.40 or 5% for generic drugs and brand drugs treated as generic. For any other drugs, the copayments become the greater of $6 or 5%.	**RETAIL PARTICIPATING PHARMACY** **Copayment for a 31-day Supply** $10 – Generic $30 – Preferred Brand $45 – Non-preferred Brand $45 – Specialty Drugs **LOCAL PHARMACY (Must pick-up from pharmacy)** **Copayment for a 90-day Supply for a 2-month copay** $20 – Generic $60 – Preferred Brand $90 – Non-preferred Brand $90 – Specialty Drugs	**RETAIL PARTICIPATING PHARMACY** **Copayment for a 30-day Supply** $10 – Generic $30 – Preferred Brand N/A – Non-preferred Brand $45 – Specialty Drugs (Prior authorization required) **MAIL ORDER** **Copayment for a 90-day Supply** $20 – Generic $60 – Preferred Brand $0 – Non-Preferred Brand $90 – Specialty Drugs (Prior authorization required)	**RETAIL - Participating Pharmacy** **Copayment for a 30-day Supply** $10 – Generic $30 – Preferred Brand $45 – Non-preferred Brand $45 – Specialty Drugs (Prior authorization required) **RETAIL - Non-Participating Pharmacy** **Copayment for a 30-day Supply** Generic 50% after $20 copayment Preferred Brand 50% after $20 copayment Non-preferred Brand 50% after $20 copayment Specialty Drugs (Prior authorization required) 50% after $20 copayment **MAIL ORDER - Participating Pharmacy** **Copayment for a 90-day Supply** $20 – Generic $60 – Preferred Brand $90 – Non-Preferred Brand $90 – Specialty Drugs (Prior authorization required)		
Vision Services	• $0 for 1 routine exam per calendar year • $15 for each diagnostic vision exam • $0 for post-cataract surgery eyeglass lenses and/or contact lenses (Limited to the Medicare-allowable amount)	**Features:** • $25 for each routine eye exam, limited to 1 exam every year. • $25 for annual glaucoma screening for high-risk patients • $25 for symptomatic ophthalmologic services • $0 post-cataract surgery eyeglass lenses and/or contact lenses requiring intraocular lenses • $50 for eyeglass frames after each cataract surgery requiring intraocular lenses.	**Features:** • $0 copayment for Medicare-covered eye wear (one pair of eyeglasses or contact lenses after each cataract surgery) • $25 for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye) • $25 for annual glaucoma screening for high-risk patients.	Vision screenings $0 copayment for Primary Care Physician - coverage for members under age 18. **Features for all HMO members:** • $3 copayment for routine eye exam every 12 months • Copayments for frames and lenses are based on fee schedule.	**Features:** • Vision screenings at $30 copayment when performed by primary physician or $50 when performed by a specialist for members under age 18.	**Features:** • Eligible expenses are 40% after annual deductible when performed by physician.
				Davis Vision Value - Added Discount Program is offered to all members. There are discounts on all vision services, a mail-order contact lens replacement program and discounts on laser vision correction.		
Hearing Services	$0 for 1 routine exam per calendar year $15 - for each diagnostic hearing exam **Hearing Aid** Aetna PFFS will reimburse $500 for hearing aids every 36 months.	• $25 for each Medicare-covered Specialty Care Physician hearing exam (diagnostic hearing exams). • Member pays pay 100% for routine hearing exam and hearing aids.	• $25 for each Medicare-covered hearing exam (diagnostic hearing exams). • Member pays 100% for routine hearing exams. • Up to a 30% discount for hearing aids from selected providers.	Hearing screenings $0 copayment for Primary Care Physician visit - coverage for members under age 18. One audiometric exam to determine type and extent of hearing loss once every 36 months. Plan pays $1,000 for hearing device once every 36 months.	Hearing screenings at $30 copayment when performed by primary physician for members under age 18. **Not covered:** Exams for hearing aids, hearing, speech, etc.	Eligible expenses at 40% after annual deductible when performed by physician. **Not covered:** Exams for hearing aids, hearing, speech, etc.
Transplants	$0 for each admission For all other transplant services (i.e. outpatient diagnostic, lab, X-ray, outpatient physician visits, etc.), the member's copayment is based on the type of service provided.	• $912 copayment per confinement then 100% coverage up to 60 days • $228 additional copayment per day then 100% coverage for 61-90 days • $456 additional copayment per each lifetime reserve day then 100% coverage for maximum 60 lifetime reserve days	• $952 copayment per confinement then 100% coverage up to 60 days • $238 additional copayment per day then 100% coverage for 61-90 days • $476 additional copayment per each lifetime reserve day (then 100% coverage for maximum 60 lifetime reserve days	**PCP office:** $20 copayment **Specialist:** $45 copayment **Outpatient facility:** $200 copayment **Inpatient facility:** $500 copayment	**Primary Doctor's office:** $30 copayment **Specialist:** $50 copayment **Outpatient facility:** 20% **Inpatient facility:** 20% after $500 copayment	**Doctor's office:** 40% after annual deductible **Outpatient facility:** 40% after annual deductible **Inpatient facility:** 40% after $1,000 copayment
What is the annual maximum out-of-pocket amount that I will pay? **What are the annual combined coinsurance/ deductible maximum for the PPO?** (Add all coinsurance, deductibles and eligible copayments) For Aetna PFFS, you will always pay the copayments listed in the chart.	No annual out-of-pocket maximum • Inpatient mental health care • Skilled nursing facility • Home health care • Chiropractic services • Podiatry services • Outpatient mental health care • Outpatient substance abuse care • Outpatient services • Ambulance services • Emergency services • Urgently needed care • Outpatient rehabilitation services • Durable medical equipment • Prosthetic devices • Cardiac rehabilitation services • Renal dialysis • Diabetic self-monitoring training and supplies • Comprehensive outpatient rehabilitation facility (CORF) • Partial hospitalization • Medicare Part B outpatient prescription drug copayments or coinsurance • Copayments for Primary Physicians • Outpatient prescription drugs • All other services not listed	**Individual:** $1,500 The following services apply: • Inpatient hospital care • Inpatient mental health care • Skilled nursing facility • Home health care • Chiropractic services • Podiatry services • Outpatient mental health care • Outpatient substance abuse care • Outpatient services • Ambulance services • Emergency services • Urgently needed care • Outpatient rehabilitation services • Durable medical equipment • Prosthetic devices • Cardiac rehabilitation services • Renal dialysis • Diabetic self-monitoring training and supplies • Comprehensive outpatient rehabilitation facility (CORF) • Partial hospitalization • Diagnostic test, X-rays, and lab services (Texas HealthSpring only) These out-of-pocket costs do not apply: • Medicare Part B outpatient prescription drug copayments or coinsurance • Copayments for PCPs and specialists • Outpatient prescription drugs • All other services not listed		**Individual:** $1,500 **Family:** $3,000 Excluding copays for prescription drugs, inpatient mental health and other supplemental riders (e.g. Vision care, prescription drug and durable medical equipment).	**Individual:** 3,000 **Family:** $6,000 Copayments are always payable.	**Individual:** $5,000 **Family:** $10,000 Copayments are always payable.
After I reach my annual out- of-pocket maximum, will I continue to pay any coinsurance or copayments?	Yes. You will always pay the listed copayments or coinsurance for medical services, prescription drugs, and equipment.	Yes. You will always pay the copayments or coinsurance for outpatient prescription drugs and PCP/specialist visits and any other services not listed above.	Yes. You will always pay the copayments or coinsurance for outpatient prescription drugs and PCP/specialist visits and any other services not listed above.	Yes. You will always pay the copayments or coinsurance for prescription drugs, vision care, durable medical equipment, inpatient hospital stays, urgent care and emergency room services, etc.	Yes. You will always pay the copayments for physician office visits, prescription drugs, inpatient hospital stays, urgent care and emergency room services. You will not pay coinsurance.	Yes. You will always pay the copayments for physician office visits, prescription drugs, inpatient hospital stays, urgent care and emergency room services. You will not pay coinsurance.
May plan participants select physicians, specialists, and hospitals of their choice?	Yes. You may receive services from any provider eligible to receive Medicare reimbursement and who accepts the Aetna Private Fee for Service plan. The plan recommends you select a primary physician to direct and coordinate your health care needs.	• You must go to network doctors, specialists, and hospitals. • You must choose a primary care physician (PCP). • All care must be coordinated by your PCP. • PCP must refer you to other providers and specialists who are in the same group. • Referral needed to go to network hospitals for non-emergency care and certain doctors, including specialists, for certain services. • You do not need a referral when you have a medical emergency. You should seek treatment at the nearest medical facility. • You may change your PCP at any time, the change will be effective the first of the month following your request to change.		Plan participants must choose primary care physicians (PCP) and pharmacies that are in the HMO network. All care must be coordinated by your PCP. The PCP must refer you to other providers and specialists who are in the same IPA as the PCP. Female plan members may self-refer to OB/GYN in the PCP's group for their annual well-woman examinations. Note: Changes in the selection of your PCP will be effective the first of the month after you request the change.	Plan participants may choose physicians, hospitals, pharmacies and other medical providers that are members of the PPO network. Contact BCBS for assistance in locating a provider or visit www.bcbstx.com. Participants may choose a provider out-of-network. The doctor may be a ParPlan provider contracted with BCBS to provide reduced or discounted fees.	Participants may select the provider, hospital or pharmacy of their choice. If the provider is not in the PPO network, the doctor may be a ParPlan provider contracted with BCBS to provide reduced or discounted fees.
Transportation	N/A	N / A	$0 copayment to recieve 30 one-way trips to plan-approved locations every year.	N / A	N / A	
What is the lifetime maximum benefit per person?	None	None	None	None	$1,500,000 per participant. Lifetime maximum does not apply to coverage or services for AIDS or human immunodeficiency virus infection	