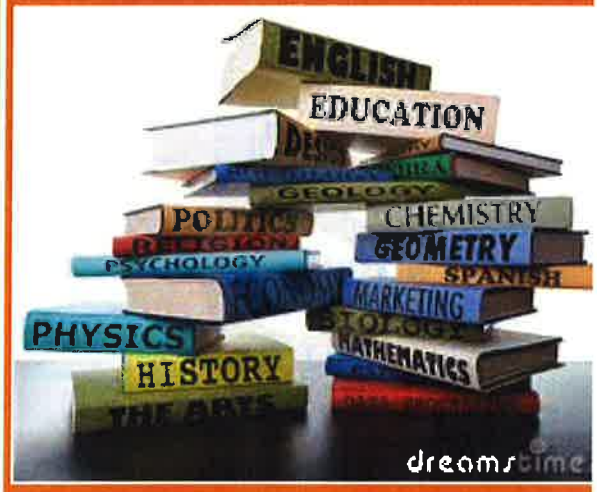

# 2015-2016

# TRS Compatibility Report




McCamey Independent School District

2015-2016

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# Section I

# Group Health Coverage Contract

BlueCross BlueShield of Texas

# STOP LOSS COVERAGE POLICY

between

**BLUE CROSS AND BLUE SHIELD OF TEXAS**
**A DIVISION OF HEALTH CARE SERVICE CORPORATION,**
**a Mutual Legal Reserve Company**

**Herein called "the Company"**
and

**The Policyholder**

The Application for Stop Loss Coverage (herein called the "Application") attached hereto and made a part of this Policy shall establish the Policyholder's Employer Group Name, Employer Group Number, the Effective Date of Policy, and the Policy Period.

In consideration of the Application attached hereto and in consideration of the payment made by the Policyholder of all premiums when due as hereinafter provided, the Company agrees to make the payments herein specified, subject to the provisions and conditions of this Policy.

All obligations, terms, definitions, conditions, promises, agreements and provisions of the Administrative Services Agreement between the Policyholder and the Company (herein called the "Agreement") shall apply equally to this Policy unless otherwise specified in this Policy or the Application.

**THIS IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. THE POLICYHOLDER DOES NOT BECOME A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM BY PURCHASING THIS POLICY, AND IF THE POLICYHOLDER IS A NON-SUBSCRIBER, THE POLICYHOLDER LOSES THOSE BENEFITS THAT WOULD OTHERWISE ACCRUE UNDER THE WORKERS' COMPENSATION LAWS. THE POLICYHOLDER MUST COMPLY WITH THE WORKERS' COMPENSATION LAW AS IT PERTAINS TO NON-SUBSCRIBERS AND THE REQUIRED NOTIFICATIONS THAT MUST BE FILED AND POSTED.**

ATTEST:

President of Blue Cross and Blue Shield of Texas

**WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY.**

The Policyholder understands the liability assumed under the portion of the self-funded employee health and welfare benefit plan (the Plan) which it is self-insuring and further understands that it is exempted from Chapter 101 of the *Texas Insurance Code* only if a qualified employee benefit plan has been filed and meets the requirements of Employee Retirement Income Security Act of 1974, as amended, (ERISA) unless the Policyholder is exempt from requirements of ERISA.

## SECTION I
## DEFINITIONS

Additional definitions applicable to this Policy are contained in the Agreement.

**"Application"** means the attached **APPLICATION FOR STOP LOSS COVERAGE** specifying the particulars of this Policy or any subsequent replacement Application supplied by the Company. The specifications or items of the Application shall be applicable for the Policy Period indicated on the Application, except that any item of the Application may be changed in accordance with the provisions described in this Policy.

"**Claim Liability"** means the total amount of Paid Claims that the Policyholder is responsible for paying each Policy Period. Claim Liability will be calculated for each Policy Period in accordance with the formula indicated in Item A.5. of the most current Application to this Policy.

"**Continuous Stay**" means an Inpatient stay spanning consecutive calendar days, beginning on the date of admission to the facility and ending on the date of discharge from the facility, even if the Provider submits claims in increments.

**"Covered Person"** means an individual Employee, dependent(s) of an Employee, a retired Employee, dependent(s) of a retired Employee, and certain continued persons and their dependents covered under a continuation of coverage provision, whose coverage has become effective in accordance with the terms of the Policyholder's Plan and whose Paid Claims are eligible for Stop Loss Coverage as indicated on the most current Application to this Policy.

**"Effective Date of Policy"** means the date specified on the Application.

**"Employee"** means an individual employee, retired employee, or continued person, whose coverage has become effective under the Policyholder's Plan and whose Paid Claims are eligible for Stop Loss Coverage as indicated on the most current Application to this Policy.

**"Final Policy Period"** means the period of time beginning on the first day of the Policy Period specified on the most current Application and ending on the date the Policy is terminated.

**"Month"** means each succeeding calendar Month period beginning on the first day of the Policy Period.

**"Paid Claims"** shall mean:

(a) The total amount of Claim Payments under and pursuant to the Agreement; and

(b) If applicable, the claim payments made by the Policyholder's prior claim administrator, as specified on the Application;

for the types of claims specified on the Application and in settlement of claims for any benefits under the Plan which are:

(a) In the case of new coverage: (i.) Incurred and paid during the Policy Period or (ii.) Incurred during the Stop Loss Coverage Period and paid during the Policy Period, as specified on the Application;

(b) In the case of a renewal of existing coverage, incurred on or after the original Effective Date of Policy and paid during the most current Policy Period, as specified on the Application.

(c) Paid Claims may also include Run-Off Paid Claims in accordance with the provisions of this Policy.

An Inpatient facility claim for a Continuous Stay is considered "incurred" on the first date of admission to such facility. All other claims, including but not limited to professional services claims for a Continuous Stay, are considered incurred on the date the service or supply is furnished. An Inter-Plan Program claim is considered "paid" on the date the Company receives notification from the Host Plan that payment has been sent to the Provider. All other claims are considered "paid" when the claim is both adjudicated and processed for payment.

**"Paid Claims"** shall not include:

(a) Claims incurred prior to the original Effective Date of Policy, except as specified on the Application; or

(b) Claims incurred after the termination date of this Policy; or

(c) Extra contractual damages of any nature, compensatory damages, or any similar damages however assessed, or any payments made as an exception to the Plan or as settlement of a lawsuit; or

(d) Any payments made at the specific written request of the Policyholder when not provided for as benefits under the Plan or which are limited or excluded under such document; or

(e) Any payments of benefits which are interpreted by the Policyholder as coming within the terms of the Plan if the Company notifies the Policyholder that it does not agree with that interpretation.

**"Plan"** shall mean the self-funded Group Health Plan of the Policyholder.

**"Point of Attachment"** means the dollar amount above which Stop Loss Insurance will apply as indicated in Items A.7. and/or B.4. of the most current Application to this Policy provided, however, that the Point of Attachment for Aggregate Stop Loss Insurance shall never be less than the minimum specified in Item A.7. of the most current Application.

**"Policy"** as used herein means this Stop Loss Coverage Policy.

**"Policy Period"** means the period of time beginning and ending on the dates shown on the most current Application.

**"Run-In Period"** means the period immediately prior to the initial Policy Period, if any, as specified in Items A.2. and/or B.2 of the Application.

**"Run-Off Paid Claims"** means those Paid Claims incurred on or after the original Effective Date of this Policy but prior to termination, which are paid in accordance with the Agreement during the Run-Off Period.

**"Run-Off Claims Liability"** means the amount to fund anticipated Run-Off Paid Claims. Settlements for Run-Off Paid Claims will be in accordance with the section entitled SETTLEMENTS, Run-Off Period Settlement subsection of this Policy.

**"Run-Off Period"** means the twelve-Month period immediately following the termination of this Policy.

**"Stop-Loss Claims"** means the amount of Paid Claims for which the Company assumes responsibility and risk.

(a) If the amount of Paid Claims that have accumulated during the Policy Period for any Covered Person exceeds the amount indicated in Item B.4. of the most current Application to this Policy, such excess, up to the maximum amounts indicated, if any, shall be referred to in this Policy as **Individual (Specific) Stop-Loss Claims.** A monthly review will occur to determine if such excess exists.

(b) Individual (Specific) Stop-Loss Insurance does not extend beyond the termination date of this Policy.

(c) If, during the current Policy Period, Paid Claims less Individual (Specific) Stop-Loss Claims, if any, exceed the Aggregate Point of Attachment indicated in Item A.7. of the most current Application to this Policy, such excess, if any, shall be referred to in this Policy as **Aggregate Stop-Loss Claims.**

(d) Stop Loss Claims may also include claims paid by the Policyholder's prior claim administrator as specified on the Application.

**"Stop Loss Coverage Period"** means the period specified in Items A.2. and/or B.2. of the most current Application.

**"Stop-Loss Premium"** means the Monthly or annual premium, calculated in accordance with the formulas indicated in Items A.8. and/or B.5. of the most current Application, that is required by the Company for the risk assumed for the Stop Loss Coverage indicated in Item A.7. and/or B.4. of the most current Application. The Policyholder shall pay to the Company the Stop Loss Premium within ten (10) calendar days of receipt of a billing.

The Stop-Loss Premium shall be subject to change by the Company as follows:

(a) At the end of the Policy Period shown in the most current Application, provided that sixty (60) days prior written notice is given by the Company;

(b) On the implementation date of any changes or benefit variances in the Policyholder's Plan, its administration, or the level of benefit valuation which would increase the Company's risk;

(c) On any date changes imposed by governmental entities increase expenses incurred by the Company provided that such increases shall be limited to an amount sufficient to recover such increase in expenses; or

(d) On any date that the number of Covered Persons enrolled changes by an amount equal to 10% or more of total enrollment over a one-Month period or 25% or more of total enrollment over a three-Month period.

## SECTION II
## POLICY PROVISIONS

**INDEMNIFICATION OF RISK.** The Company hereby agrees to indemnify the Policyholder as specified in the section of this Policy entitled SETTLEMENTS against the amount paid pursuant to the Plan during the Policy Period which is in excess of the Point of Attachment specified in Items A.7. and/or B.4. of the most current Application. The Company shall not be liable for, nor shall the indemnification be extended to, any claim or liability for extra–contractual or punitive damages, including interest, statutory penalties and attorney fees or any claims in excess of any lifetime or individual maximums specified in A.7. and B.4.

**ENTIRETY.** This Policy, the most current Application and any attachments shall constitute the entire Policy between the parties for the purposes of this Policy and shall supersede any and all prior or contemporaneous Policies or understandings, either oral or in writing, between the parties with respect to the subject matter herein. This Policy shall not create any right or legal obligation between the Company and the Covered Person under the Plan.

**MODIFICATION.** Except for the Application to this Policy, which may be changed at any time in accordance with the provisions of this Policy by notifying the Policyholder in writing of such change, no modification, amendment, change, or waiver of any provision of this Policy shall be valid unless agreed to by an officer of Company and an authorized representative of the Policyholder.

## SECTION III
## PREMIUM PROVISIONS

**PREMIUM PAYMENT.** The premium(s) to be paid to the Company as consideration for the insurance provided hereunder and the method of premium payment (monthly or annual) shall be as specified on the Application. Monthly premium is due on the first day of each Month beginning on the first day of the Policy Period through the end of the Policy Period. Annual Premium is due on the first day of the Policy Period. Premium is based on the current membership specified on the Application.

**REMITTANCE.** The Company shall bill the Policyholder in advance for the Stop-Loss Premium amount due and the Policyholder shall remit payment within ten (10) calendar days of receipt of a billing. A remittance will be considered received when actually delivered into the possession or control of the Company.

**DAILY CHARGE.** A daily charge shall be assessed for the late remittance of any amount(s) due and payable to the Company by the Policyholder. This charge shall be an amount equal to the amount resulting from multiplying the amount due times the lesser of:

(a) The rate of .0329% per day (which equates to an amount of 12.0% per annum); or

(b) The maximum rate permitted by state law.

**NOTICE AND PROOF OF LOSS.** The Company shall reimburse the Policyholder as specified in the section of this Policy entitled SETTLEMENTS. Payment to the Policyholder in settlement of claims hereunder shall not be construed as a waiver of, or prohibition against, the Company's right to adjudicate or make further adjustments to such settlements.

Any amount which the Policyholder recovers from a third party, whether by subrogation, reimbursement or otherwise, in connection with a claim under the Policyholder's Plan shall not be eligible to satisfy the Point(s) of Attachment applicable to the Policyholder as specified on the Application nor will the Company pay any benefit hereunder with respect to any such recovered amount. Any such recovery shall be applied first to refund to the Company any benefit paid hereunder with respect to such claim and the Policyholder shall pay such refund to the Company within thirty-one (31) days after its receipt of such recovery, whether or not this Policy is still in force at that time.

No action at law or in equity shall be brought to recover on this Policy more than three (3) years from expiration of this Policy.

If any time limitation of this section of the Policy is less than that permitted by the state of Texas at the time this Policy is issued, such limitation is hereby extended to agree with the minimum permitted by such law.

The books and records of the Policyholder which pertain to the Plan shall be open to the Company and its representatives at all times during the usual business hours for inspection.

## SECTION IV.
## DISPUTE RESOLUTION

Any dispute arising out of or relating to this Policy may be resolved in accordance with the procedures specified in this Section IV. All negotiations pursuant to this Section IV. are confidential and shall be treated as compromise and settlement negotiations for purposes of applicable rules of evidence.

- Arbitration, in all instances, must be entered into on a voluntary basis.
- Both parties to the contract must mutually agree to the arbitration procedure.

(a) **Arbitration**

In the event the parties fail to agree with respect to any matter covered herein, the question in dispute may be submitted for arbitration in Dallas, Texas. The arbitrator shall be selected as follows:

1. Upon declaration by one of the parties hereto that a deadlock exists, the parties shall select an arbitrator;
2. If no appointment is made within thirty (30) days after the deadlock is declared and the amount in contest is in excess of $200, the American Arbitration Association shall recommend an arbitrator; or
3. If no appointment is made within thirty (30) days after the deadlock is declared and the amount in question is $200 or less, the Company shall select an independent third party to be the arbitrator.

The arbitrator will submit a decision within thirty (30) days after appointment or as soon as reasonably feasible and such decision shall be binding on the parties hereto. Arbitration expenses will be shared by the parties. All other expenses (legal, incidental, etc.) shall be borne by the losing party or, if both parties prevail, be apportioned by the arbitrator to each party. Arbitration proceedings will be governed by the Rules of the American Arbitration Association then in effect.

(b) **Obligation to Continue Performance**

Except as provided otherwise in this Policy, each party is required to continue to perform its obligations under this Policy pending final resolution of any dispute arising out of or relating to this Policy.

## SECTION V
## SETTLEMENTS

**INDIVIDUAL (SPECIFIC) STOP LOSS SETTLEMENT.** For any Individual (Specific) Stop Loss Claims, the claim settlement shall be provided to the Policyholder by the Company within ninety (90) days after the end of each Policy Period during which this Policy is in effect. The Company reserves the right to deduct any amount(s) owed the Company by the Policyholder from any payment due the Policyholder as a result of the claim settlement.

If this Policy is terminated prior to the expiration of the Policy Period, claim settlements for Individual (Specific) Stop Loss Claims will be made, as specified herein, for only those full Months of the Policy Period immediately preceding Policy termination. Individual Stop-Loss Coverage shall not extend beyond the termination date of this Policy.

**AGGREGATE STOP LOSS SETTLEMENT OR ACCOUNTING.**

For any Aggregate Stop Loss Claims, the claim settlement shall be provided to the Policyholder by the Company within ninety (90) days after the end of each Policy Period during which this Policy is in effect. The Company reserves the right to deduct any amount(s) owed the Company by the Policyholder from any payment due the Policyholder as a result of the claim settlement. Aggregate Stop Loss Insurance shall not exceed the maximum indicated in Item A.7. of the most current Application to this Policy in any Policy Period or any Final Policy Period.

If the settlement reflects that Paid Claims for the Policy Period exceed the Point of Attachment for that Policy Period, then Aggregate Stop Loss Claims, minus any Individual (Specific) Stop Loss Claims, to the extent funded by the Policyholder, shall be the responsibility of the Company. If the Aggregate Point of Attachment exceeds the Paid Claims, then no Aggregate Stop-Loss benefit shall be payable to the Policyholder.

**RUN-OFF PERIOD SETTLEMENT.** In the event of termination of this Policy on the last day of the Policy Period, the Run-Off Period immediately following termination will be combined with the Final Policy Period and this shall be termed a **Final Settlement Period.** Within ninety (90) days following the end of the Run-Off Period, a final settlement will reflect the following:

(a) **Final Settlement Paid Claims:**

(1) The sum of the Paid Claims during the Final Policy Period and the Run-Off Paid Claims, minus

(2) Any Individual (Specific) Stop-Loss Claims during the Final Policy Period, if applicable.

(b) **Final Settlement Point of Attachment:**

(1) The sum of the Policyholder's Claims Liability for the Final Policy Period, plus

(2) The Policyholder's Run-Off Claim Liability

If the Final Settlement Paid Claims exceed the Final Settlement Point of Attachment, then Aggregate Stop-Loss benefits shall be payable to the Policyholder to the extent funded by the Policyholder.

If the Final Settlement Point of Attachment exceeds the Final Settlement Paid Claims, then no Aggregate Stop-Loss benefits shall be payable to the Policyholder

## SECTION VI
## GENERAL PROVISIONS

**LIMITATION OF LIABILITY.** Liability for any errors or omissions by the Company (or its officers, directors, employees, agents, or independent contractors) in the administration of this Policy, or in the performance of any duty of responsibility contemplated by this Policy, shall be limited to the maximum benefits which should have been paid under the Policy had the errors or omissions not occurred (including the Company's share of any arbitration expenses incurred under the Policy), unless any such errors or omissions are adjudged to be the result of intentional misconduct, gross negligence, or intentional breach of a duty under this Policy by the Company.

**TERM AND TERMINATION.** This Policy shall continue in full force and effect from year to year unless terminated as provided herein.

This Policy may be terminated as follows:

(a) By either party at the end of any Policy Period following thirty (30) days prior written notice to the other;

(b) By both parties on any date mutually agreed to in writing.

(c) This Policy will terminate automatically:

(1) On the date the most current Application terminates as specified on the Application, unless a replacement Application for the period immediately following is executed by the Company and the Policyholder;

(2) Upon failure of the Policyholder to pay Stop Loss Premium in accordance with the provisions of this Policy;

(3) On the date the Plan terminates; or

(4) On the date the Agreement terminates. The Policyholder shall notify the Company in writing of a change in claim administrator from the Company to another carrier or administrator no later than thirty (30) days in advance of the date of change.

In the event of termination of this Policy for any reason prior to the expiration of a Policy Period, no Aggregate Stop Loss Insurance will exist for the Final Policy Period or Run-Off Period. The Policyholder will be required to fund all claims during the Final Policy Period and Run-Off Period. The Company shall have no obligation to determine a claim settlement for the period during which coverage was in effect nor shall the Company refund any portion of the premium(s) to the Policyholder.

**ASSIGNMENT.** No part of this Policy, or any rights, duties, or obligations described herein, shall be assigned or delegated without the prior express written consent of both parties. Any such attempted assignment shall be null and void. The Company's standing contractual arrangements for the acquisition and use of facilities, services, supplies, equipment, and personnel from other parties shall not constitute an assignment under this Policy.

**GOVERNING LAW.** This Policy shall be governed by, and shall be construed in accordance with, the laws of the State of Texas without regard to any state choice-of-law statutes, and any applicable federal law. All obligations created hereunder are performable in Dallas, Texas and all disputes arising out of this Policy will be resolved in Dallas, Texas.

**NO WAIVER.** The failure of either the Policyholder or the Company to insist upon strict performance of any of the terms of this Policy shall not be construed as a waiver of its respective rights to remedies with respect to any subsequent breach or default in any of the terms of this Policy.

**SEVERABILITY.** In case any one or more of the provisions contained in this Policy shall, for any reason, be held to be invalid, illegal, or unenforceable in any respect, such invalidity, illegality, or unenforceability shall not affect any other provisions of this Policy, but this Policy shall be construed as if such invalid, illegal, or unenforceable provision had never been contained herein.

**TAXES.** Any premium amounts due under this Policy will automatically be increased by the amount of any taxes imposed, increased, or adjudged due by any lawful authority on or after the Effective Date of this Policy, which directly pertain to this Policy and which the Company is required to pay or remit, whether relating to fees, services, benefits, payments, or any other aspect of this Policy or the Plan.

**INSOLVENCY.** The insolvency, bankruptcy, financial impairment, receivership, voluntary plan of arrangement with creditors, or dissolution of the Policyholder or its Claim Administrator will not impose on the Company any liability other than the liability defined this Policy. The insolvency of the Policyholder will not make the Company liable to the creditors of the Policyholder, particularly the Covered Persons under the Plan.

**RIGHT OF RECOVERY**. The Company will not seek recovery of any excess or erroneous payment made under this Policy more than twenty-four (24) months after the payment is made, unless:

(a) The payment was made because of fraud committed by the Policyholder, the Covered Person or the provider; or

(b) The Policyholder, Covered Person or provider has otherwise agreed to make a refund to the Company for overpayment of a claim.

# Section II

# Summary of Benefits

# McCamey ISD – Buy Up Plan

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period: 09/01/2015 – 08/31/2016**
**Coverage for:** All | **Plan Type:** PPO

**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bcbstx.com or by calling 1-800-521-2227.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | For In- and Out-of-Network providers<br>**$1,000** Individual/**$2,000** Family<br>Doesn't apply to prescription drugs, services that charge a copay, and In-Network preventive care, home health, skilled nursing, hospice, and diagnostic tests.<br>Copays do not count toward the deductible. | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. |
| **Are there other deductibles for specific services?** | No. There are no other specific deductibles. | You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| **Is there an out-of-pocket limit on my expenses?** | Yes. For In-Network providers<br>**$4,500** Individual/**$6,000** Family<br>For Out-of-Network providers<br>**$6,500** Individual/**$10,000** Family | The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| **What is not included in the out-of-pocket limit?** | Premiums, preauthorization penalties, balance-billed charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. |
| **Does this plan use a network of providers?** | Yes. See www.bcbstx.com or call 1-800-810-2583 for a list of In-Network providers. | If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**. |
| **Do I need a referral to see a specialist?** | No. You don't need a referral to see a specialist. | You can see the **specialist** you choose without permission from this plan. |
| **Are there services this plan doesn't cover?** | Yes. | Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**. |

**Questions:** Call 1-800-521-2227 or visit us at www.bcbstx.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-855-756-4448 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an Out-of-Network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an Out-of-Network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use In-Network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $40 copay/visit | 40% coinsurance | ---none--- |
| | Specialist visit | $50 copay/visit | 40% coinsurance | |
| | Other practitioner office visit | $40 copay PCP/ $50 copay SPC | 40% coinsurance | Limited to 35 visits per calendar year. |
| | Preventive care/screening/immunization | No Charge | 40% coinsurance | Deductible waived In-Network. No Charge for child immunizations Out-of-Network through the 6th birthday. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No Charge | 40% coinsurance | Deductible waived In-Network. No charge with office visit copay. |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 40% coinsurance | ---none--- |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need drugs to treat your illness or condition**<br>More information about **prescription drug coverage** is available at www.bcbstx.com | Generic drugs | $10 retail and mail order copay/ prescription | $10 copay/ prescription plus 20% coinsurance | Retail and mail order cover a 30 day supply.<br>Non-Participating mail order is not covered.<br>For Non-Participating pharmacy, member must file claim. |
| | Preferred brand drugs | $40 retail and mail order copay/ prescription | $40 copay/ prescription plus 20% coinsurance | |
| | Non-preferred brand drugs | $60 retail and mail order copay/ prescription | $60 copay/ prescription plus 20% coinsurance | |
| | Specialty drugs | 20% of cost | 20% of cost plus 20% coinsurance | Available at any retail pharmacy.<br>Mail order is not covered.<br>For Non-Participating pharmacy, member must file claim. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 40% coinsurance | ---none--- |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | |
| **If you need immediate medical attention** | Emergency room services | $100 copay/visit plus 20% coinsurance | $100 copay/visit plus 20% coinsurance | Emergency room copay waived if admitted. |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | Ground and air transportation covered. |
| | Urgent care | $40 copay PCP/ $50 copay SPC | 40% coinsurance | ---none--- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 40% coinsurance | Preauthorization is required; $250 penalty if services are not preauthorized Out-of-Network. |
| | Physician/surgeon fee | 20% coinsurance | 40% coinsurance | ---none--- |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | $40 copay PCP/ $50 copay SPC | 40% coinsurance | Certain services must be preauthorized, refer to benefits booklet for details. |
| | Mental/Behavioral health inpatient services | 20% coinsurance | 40% coinsurance | All services must be preauthorized. $250 penalty if services are not preauthorized Out-of-Network. |
| | Substance use disorder outpatient services | $40 copay PCP/ $50 copay SPC | 40% coinsurance | Certain services must be preauthorized, refer to benefits booklet for details. |
| | Substance use disorder inpatient services | 20% coinsurance | 40% coinsurance | All services must be preauthorized. $250 penalty if services are not preauthorized Out-of-Network. |
| **If you are pregnant** | Prenatal and postnatal care | $40 copay PCP | 40% coinsurance | Copay applies to first prenatal visit, per pregnancy. After initial visit, 20% coinsurance applies. |
| | Delivery and all inpatient services | 20% coinsurance | 40% coinsurance | Preauthorization is required; $250 penalty if services are not preauthorized Out-of-Network. |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need help recovering or have other special health needs** | Home health care | No Charge | 40% coinsurance | Deductible waived In-Network.<br>Preauthorization is required.<br>Limited to 60 visits per calendar year. |
| | Rehabilitation services | 20% coinsurance | 40% coinsurance | Limited to 35 visits per calendar year. |
| | Habilitation services | 20% coinsurance | 40% coinsurance | |
| | Skilled nursing care | No Charge | 40% coinsurance | Deductible waived In-Network.<br>Preauthorization is required.<br>Limited to 25 days per calendar year. |
| | Durable medical equipment | 20% coinsurance | 40% coinsurance | ---none--- |
| | Hospice service | No Charge | 40% coinsurance | Deductible waived In-Network.<br>Preauthorization is required. |
| **If your child needs dental or eye care** | Eye exam | $40 copay PCP/<br>$50 copay SPC | 40% coinsurance | ---none--- |
| | Glasses | Not Covered | Not Covered | |
| | Dental check-up | Not Covered | Not Covered | |

## Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S
- Private-duty nursing
- Routine foot care
- Weight loss programs

**Questions:** Call 1-800-521-2227 or visit us at www.bcbstx.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-855-756-4448 to request a copy.

**Other Covered Services** **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Chiropractic care
- Hearing aids (limited to 1 new aid per ear per 36-month period)
- Routine eye care (Adult)

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at 1-800-521-2227. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact BlueCross BlueShield of Texas at 1-800-521-2227 or visit www.bcbstx.com, or contact U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your **appeal**. Contact the Texas Department of Insurance's Consumer Health Assistance Program at (855) 839-2427 or visit www.texashealthoptions.com.

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-521-2227.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-521-2227.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-800-521-2227.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-521-2227.

*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

**Questions:** Call 1-800-521-2227 or visit us at www.bcbstx.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-855-756-4448 to request a copy.

## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,220
- **Patient pays** $2,320

**Sample care costs:**

| | |
|---|---|
| Hospital charges (mother) | $2,700 |
| Routine obstetric care | $2,100 |
| Hospital charges (baby) | $900 |
| Anesthesia | $900 |
| Laboratory tests | $500 |
| Prescriptions | $200 |
| Radiology | $200 |
| Vaccines, other preventive | $40 |
| **Total** | **$7,540** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $1,000 |
| Copays | $20 |
| Coinsurance | $1,150 |
| Limits or exclusions | $150 |
| **Total** | **$2,320** |

### Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,540
- **Patient pays** $1,860

**Sample care costs:**

| | |
|---|---|
| Prescriptions | $2,900 |
| Medical Equipment and Supplies | $1,300 |
| Office Visits and Procedures | $700 |
| Education | $300 |
| Laboratory tests | $100 |
| Vaccines, other preventive | $100 |
| **Total** | **$5,400** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $1,000 |
| Copays | $600 |
| Coinsurance | $180 |
| Limits or exclusions | $80 |
| **Total** | **$1,860** |

# Questions and answers about the Coverage Examples:

## What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from Out-of-Network **providers**, costs would have been higher.

## What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

## Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

## Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

## Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

## Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.bcbstx.com or by calling 1-800-521-2227.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | For In- and Out-of-Network providers **$1,500** Individual/**$3,000** Family<br>Doesn't apply to In-Network diagnostic tests and preventive care. | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. |
| **Are there other deductibles for specific services?** | No. There are no other specific deductibles. | You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| **Is there an out-of-pocket limit on my expenses?** | Yes. For In-Network providers **$5,000** Individual/**$8,000** Family<br>For Out-of-Network providers **$6,000** Individual/**$10,000** Family | The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| **What is not included in the out-of-pocket limit?** | Premiums, preauthorization penalties, balance-billed charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. |
| **Does this plan use a network of providers?** | Yes. See www.bcbstx.com or call 1-800-810-2583 for a list of In-Network providers. | If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**. |
| **Do I need a referral to see a specialist?** | No. You don't need a referral to see a specialist. | You can see the **specialist** you choose without permission from this plan. |
| **Are there services this plan doesn't cover?** | Yes. | Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**. |

**Questions:** Call 1-800-521-2227 or visit us at www.bcbstx.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-855-756-4448 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an Out-of-Network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an Out-of-Network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use In-Network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | 20% coinsurance | 40% coinsurance | ---none--- |
| | Specialist visit | 20% coinsurance | 40% coinsurance | |
| | Other practitioner office visit | 20% coinsurance | 40% coinsurance | Chiropractic services are limited to 35 visits per calendar year. |
| | Preventive care/screening/immunization | No Charge | 40% coinsurance | Deductible waived In-Network<br>No Charge for child immunizations Out-of-Network through the 6th birthday. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance | 40% coinsurance | ---none--- |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 40% coinsurance | |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need drugs to treat your illness or condition**<br>More information about **prescription drug coverage** is available at www.bcbstx.com | Generic drugs | 20% coinsurance | 20% coinsurance | Non-Participating mail order is not covered.<br>For Non-Participating pharmacy, member must file claim. |
| | Preferred brand drugs | 20% coinsurance | 20% coinsurance | |
| | Non-preferred brand drugs | 20% coinsurance | 20% coinsurance | |
| | Specialty drugs | 20% coinsurance | 20% coinsurance | Available at any retail pharmacy.<br>Mail order is not covered.<br>For Non-Participating pharmacy, member must file claim. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 40% coinsurance | ---none--- |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | |
| **If you need immediate medical attention** | Emergency room services | 20% coinsurance | 20% coinsurance | ---none--- |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | |
| | Urgent care | 20% coinsurance | 40% coinsurance | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 40% coinsurance | Preauthorization is required; $250 penalty if services are not preauthorized Out-of-Network. |
| | Physician/surgeon fee | 20% coinsurance | 40% coinsurance | ---none--- |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | 20% coinsurance | 40% coinsurance | Certain services must be preauthorized; refer to benefits booklet for details. |
| | Mental/Behavioral health inpatient services | 20% coinsurance | 40% coinsurance | All services must be preauthorized; $250 penalty if services are not preauthorized Out-of-Network. |
| | Substance use disorder outpatient services | 20% coinsurance | 40% coinsurance | Certain services must be preauthorized; refer to benefits booklet for details. |
| | Substance use disorder inpatient services | 20% coinsurance | 40% coinsurance | All services must be preauthorized; $250 penalty if services are not preauthorized Out-of-Network. |
| **If you are pregnant** | Prenatal and postnatal care | 20% coinsurance | 40% coinsurance | ---none--- |
| | Delivery and all inpatient services | 20% coinsurance | 40% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 40% coinsurance | Limited to 60 visits per calendar year. Preauthorization is required. |
| | Rehabilitation services | 20% coinsurance | 40% coinsurance | ---none--- |
| | Habilitation services | 20% coinsurance | 40% coinsurance | |
| | Skilled nursing care | 20% coinsurance | 40% coinsurance | Limited to 25 days per calendar year. Preauthorization is required. |
| | Durable medical equipment | 20% coinsurance | 40% coinsurance | ---none--- |
| | Hospice service | 20% coinsurance | 40% coinsurance | Preauthorization is required. |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If your child needs dental or eye care** | Eye exam | 20% coinsurance | 40% coinsurance | ---none--- |
| | Glasses | Not Covered | Not Covered | |
| | Dental check-up | Not Covered | Not Covered | |

## Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care (with the exception of person with diagnosis of diabetes)
- Weight loss programs

**Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Chiropractic care
- Hearing aids (limited to 1 new aid per ear per 36-month period)
- Routine eye care (Adult)

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at 1-800-521-2227. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

**Questions:** Call 1-800-521-2227 or visit us at www.bcbstx.com.
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## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact BlueCross BlueShield of Texas at 1-800-521-2227 or visit www.bcbstx.com, or contact U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your **appeal**. Contact the Texas Department of Insurance's Consumer Health Assistance Program at (855) 839-2427 or visit www.texashealthoptions.com.

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-521-2227.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-521-2227.
Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-800-521-2227.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-521-2227.

*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

# About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

## Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,840
- **Patient pays** $2,700

**Sample care costs:**

| | |
|---|---|
| Hospital charges (mother) | $2,700 |
| Routine obstetric care | $2,100 |
| Hospital charges (baby) | $900 |
| Anesthesia | $900 |
| Laboratory tests | $500 |
| Prescriptions | $200 |
| Radiology | $200 |
| Vaccines, other preventive | $40 |
| **Total** | **$7,540** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $1,500 |
| Copays | $0 |
| Coinsurance | $1,050 |
| Limits or exclusions | $150 |
| **Total** | **$2,700** |

## Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,090
- **Patient pays** $2,310

**Sample care costs:**

| | |
|---|---|
| Prescriptions | $2,900 |
| Medical Equipment and Supplies | $1,300 |
| Office Visits and Procedures | $700 |
| Education | $300 |
| Laboratory tests | $100 |
| Vaccines, other preventive | $100 |
| **Total** | **$5,400** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $1,500 |
| Copays | $0 |
| Coinsurance | $730 |
| Limits or exclusions | $80 |
| **Total** | **$2,310** |

# Questions and answers about the Coverage Examples:

## What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from Out-of-Network **providers**, costs would have been higher.

## What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

## Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

## Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

## Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

## Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

# Section III

# Premium Rate Sheet

# BUY-UP PPO PLAN

| Tier | Premium | District Contribution | Employee Contribution |
|---|---|---|---|
| Employee Only | $625.00 | $400.00 | $225.00 |
| Employee & Child(ren) | $892.00 | $400.00 | $492.00 |
| Employee & Spouse | $1,075.00 | $400.00 | $675.00 |
| Employee & Family | $1,401.00 | $400.00 | $1,001.00 |

# STANDARD PPO PLAN

| Tier | Premium | District Contribution | Employee Contribution |
|---|---|---|---|
| Employee Only | $ 400.00 | $400.00 | $ 0.00 |
| Employee & Child(ren) | $ 727.00 | $400.00 | $327.00 |
| Employee & Spouse | $ 945.00 | $400.00 | $545.00 |
| Employee & Family | $1,050.00 | $400.00 | $650.00 |

# Section IV

# Enrollment Data

**Medical Enrollment by Month**

**Run Date:** 10/15/2015

**Metrics:** (Medical Member Months, Medical Subscriber Months)
**Rows:** (Enrollment Month)
**Columns:** (Metrics)
**Enrollment Month:** (Sep 2014, Oct 2014, Nov 2014, Dec 2014, Jan 2015, Feb 2015, Mar 2015, Apr 2015, May 2015, Jun 2015, Jul 2015, Aug 2015)
**Database:** (MCCAMEY INDEPENDENT SCHOOL DISTRICT: ALL)

| Enrollment Month | Medical Member Months | Medical Subscriber Months |
|---|---|---|
| Sep 2014 | 135 | 83 |
| Oct 2014 | 137 | 85 |
| Nov 2014 | 137 | 85 |
| Dec 2014 | 135 | 86 |
| Jan 2015 | 136 | 86 |
| Feb 2015 | 141 | 87 |
| Mar 2015 | 140 | 87 |
| Apr 2015 | 140 | 87 |
| May 2015 | 142 | 87 |
| Jun 2015 | 143 | 87 |
| Jul 2015 | 143 | 87 |
| Aug 2015 | 141 | 88 |
| **Total: Selected Filter(s)** | 1,670 | 1,035 |

# Section V

# Comparability Report Form

**TEACHER RETIREMENT SYSTEM OF TEXAS**
**1000 Red River Street, Austin, Texas 78701-2698**
**Telephone (512) 542-6446 or (800) 223-8778 Ext. 6446**
**www.trs.texas.gov**

# Comparability Report Form

**Please complete and mail, no later than March 1 of each even-numbered year, to:**

Ms. Marisa Campuzano
TRS-ActiveCare - Comparability Report
Teacher Retirement System of Texas
1000 Red River Street
Austin, TX 78701-2698

---

TRS District Number: 0880

District Name: McCamey ISD

Does your district offer employee health coverage that is comparable to HealthSelect? Yes X No ____

Is your district in compliance with all other requirements of Section 22.004 of the Education Code? Yes X No ____

---

*I certify that, based on my personal knowledge, the information provided above is true and accurate.*

Janet Hunt
*Signature of School Official*

5-5-16
*Date*

Janet Hunt
*Name of School Official (Print or Type)*

Superintendent
*Title (Print or Type)*

432-652-3666 Ext. 302
*Phone number*

Note: **This form is the only documentation that should be submitted by your district to TRS.** Do **not** provide any additional documentation such as the district's contract for group health coverage, schedule of benefits, premium rate sheet, etc.

For questions concerning this Comparability Report Form, please contact Marisa Campuzano at (512) 542-6396.

# Section VI

# Compliance Statement

MCCAMEY INDEPENDENT SCHOOL DISTRICT

Janet Hunt, Superintendent
PO Box 1069
McCamey, Texas 79752
432-652-3666 Ext. 302
Fax: 432-652-4219

Date: March 1, 2016
From: Superintendent Janet Hunt

Compliance Statement
Regarding Comparability of Healthcare

McCamey Independent School District (MCISD) offers health insurance coverage to eligible employees. MCISD has a partially self-funded plan instead of TRS-Active Care Plan. MCISD covers approximately 100 employees with the health care coverage plan options currently in place.

We are required to send a report to the Teacher Retirement System of Texas every two years to confirm that MCISD medical coverage is comparable to the HealthSelect Plan. This report is called the Comparability Report Form.

MCISD completed a comparison of the two plans using the available information from HealthSelect as of September 1, 2015. The MCISD In-Network plan for employees is comparable to HealthSelect in side-by-side comparison and is in compliance with other requirements of Section 22.004 of the Education Code.

**McCamey Independent School District**
**2015 TRS COMPARISON OPTIONS**

| BENEFITS | | MCISD HIGH MEDICAL PLAN | | MCISD LOW MEDICAL PLAN | | HealthSelect | | TRS ACTIVE CARE 2 |
|---|---|---|---|---|---|---|---|---|
| DEDUCTIBLE CAL/YR | | $1,000 IN / OON Combined | | $1,500 IN / OON Combined | | $0 IN / $500 OON | | $1,000 IN / $2,000 OON |
| COSHARE STOP LOSS | | $4,500 IN / $6,500 OON | | $5,000 IN / $6,000 OON | | $2000 IN / $7,000 OON | | $6,600 IN / None OON |
| LIFETIME MAXIMUM | | Unlimited | | Unlimited | | Unlimited | | Unlimited |
| PRIMARY CARE PHYSICIAN REQUIRED? | | No | | No | | Yes IN / No OON | | No |
| IN-PATIENT HOSPITAL | *** | 80% IN / 60% OON After CYD | *** | 80% IN / 60% OON after CYD | *** | 80% IN / 60% OON After Copay | *** | 80% IN / 60% OON after CYD |
| DEDUCTIBLE PER ADM. | | None | | None | | $150/day + Coin ($750 max/admit) | | $150/day + Coins ($750 max/admit) |
| OUTPATIENT SURGERY | | 80% IN / 60% OON After CYD | | 80% IN / 60% OON after CYD | | 80% IN / 60% OON After Copay | | 80% IN / 60% OON after CYD |
| DEDUCTIBLE PER ADM. | | None | | None | | $100 Copay + Coins | | $150 Copay/visit + Coins |
| HIGH TECH RADIOLOGY | | 80% IN / 60% OON After CYD | | 80% IN / 60% OON after CYD | ** | 80% IN / 60% OON After Copay | | 80% IN / 60% OON after CYD |
| COPAY | | | | None | | $100 Copay | | $100 Copay |
| MEDICAL/SURGICAL | | | | | | | | |
| OFFICE VISIT - PRIMARY | | $40 / 100% | | 80% IN / 60% OON after CYD | | $25 Copay / 100% | | $30 Copay/ 100% |
| OFFICE VISIT - SPECIALIST | | $50 / 100% | | 80% IN / 60% OON after CYD | | $40 Copay / 100% | | $50 Copay/ 100% |
| IN-PATIENT VISIT | *** | 80% IN / 60% OON After CYD | *** | 80% IN / 60% OON after CYD | *** | 80% IN / 60% OON After Copay | *** | 80% IN / 60% OON after CYD |
| SURGERY | | 80% IN / 60% OON After CYD | | 80% IN / 60% OON after CYD | | 80% IN / 60% OON After Copay | | 80% IN / 60% OON after CYD |
| CHEMICAL DEPENDENCY | *** | 80% IN / 60% OON After CYD | *** | 80% IN / 60% OON after CYD | *** | $150/day + Coin ($750 max/admit) | *** | $150/day + Coins ($750 max/admit) |
| SERIOUS MENTAL ILLNESS | | 80% after CYD | | 80% IN / 60% OON after CYD | | $150/day + Coin ($750 max/admit) | | $150/day + Coins ($750 max/admit) |
| MENTAL HEALTH CARE | *** | 80% after CYD | *** | 80% IN / 60% OON after CYD | *** | $150/day + Coin ($750 max/admit) | *** | $150/day + Coins ($750 max/admit) |
| EMERGENCY ROOM COPAY | | $100 Copay | | 80% IN / 60% OON after CYD | | $150 Copay | | $150 Copay |
| EMERGENCY CARE | | | | | | | | |
| ACCIDENT & MEDICAL | | 80% after CYD | | 80% IN / 60% OON after CYD | | 80% After CYD | | 80% after CYD |
| HOSPITAL | | 80% after $100 Copay | | 80% IN / 60% OON after CYD | | $150/day + Coin ($750 max/admit) | | $150/day + Coins ($750 max/admit) |
| PHYSICIAN | | 80% after CYD | | 80% IN / 60% OON after CYD | | 80% After CYD | | 80% after CYD |
| AMBULANCE | | 80% after CYD | | 80% IN / 60% OON after CYD | | 80% After CYD | | 80% after CYD |
| PREVENTIVE CARE | * | 100% | * | 100% | * | 100% | * | 100% |
| CHIROPRACTIC SERVICES | | 35 Visits Per Yr | | 35 Visits Per Yr | | 30 Visits Per Yr | | 35 Visits Per Yr |
| OFFICE VISIT | | 100% after $40/50 Copay | | 80% IN / 60% OON after CYD | | 100% After $40 Copay | | 100% after $50 Copay |
| OTHER OUTPATIENT SERVICES | | 80% after CYD | | 80% IN / 60% OON after CYD | | 80% After CYD | | 80% after CYD |
| PHYSICAL MEDICINE | | | | | | | | |
| OFFICE VISITS | | 100% after $40/50 Copay | | 80% IN / 60% OON after CYD | | 80% After $40 Copay | | 100% after $50 Copay |
| ALL OTHER SERVICES | | 80% after CYD | | 80% IN / 60% OON after CYD | | 80% After CYD | | 80% after CYD |
| PRESCRIPTION DRUG | | | | | | | | |
| DEDUCTIBLE | | None | | None | | None | | $200 per person (toward Brand only) |
| GENERIC | | $10 | | 80% after CYD | **** | $15 / $20 | | $20 / $25 / $45 |
| BRAND PREFERRED | | $40 | | 80% after CYD | **** | $35 / $45 | | $40 / $50 / $105 |
| BRAND NON PREFERRED | | $60 | | 80% after CYD | **** | $60 / $75 | | $65 / $80 / $180 |
| SPECIALTY DRUGS | | 20% Copayment Amount | | 80% after CYD | | N/A | | $200 per fill (30-day)/ $450 per fill (32-90 days) |
| 30 Day Supply | | 1 Copay | | 1 Copay | | 1 Copay | | see above |
| 60 Day Supply | | 1 Copay | | 1 Copay | | 2 Copays | | see above |
| 90 Day Supply | | 1 Copay | | 1 Copay | | 3 Copays | | see above |
| MAIL ORDER REQUIRED | | No | | No | | No | | No |
| | | | | | | | | |
| RATES | | **9/1/2015** | | **9/1/2015** | | **9/1/2015** | | **9/1/2015** |
| Employee Only | | $625.00 | | $400.00 | | $576.54 | | $614.00 |
| Employee & Child(ren) | | $892.00 | | $727.00 | | $1,018.78 | | $992.00 |
| Employee & Spouse | | $1,075.00 | | $945.00 | | $1,237.02 | | $1,478.00 |
| Employee & Family | | $1,401.00 | | $1,050.00 | | $1,679.29 | | $1,521.00 |

** Under the Affordable Care Act, certain perventive health services are paid at 100% conditioned upon physician billing and diagnosis. In some cases, you will still be responsible for payment on some services.*
*** No copay if high-tech radiology performed during ER Visit or inpatient admission.*
**** Preauthorization required.*
***** $15/$35/$60 Copayments for non-maintenance drugs and $20/$45/$75 Copayments for Maintenance Drugs*