

Blue Cross Blue Shield of Texas - Current/Renewal

City of Los Fresnos

Carrier: Plan Type: Network:	Blue Cross Blue Shield PPO BlueChoice Current	Blue Cross Blue Shield PPO BlueChoice Renewal
IN-NETWORK BENEFITS	MTBCP507	MTBCP567
Deductible - Calendar Year	\$1250 Ind/\$3750 Fam	\$1250 Ind/\$3750 Fam
Coinsurance	100%	100%
Annual Coinsurance Limit-Single/Family	\$3750/\$11250	\$3750/\$11250
Annual Coinsurance Limit-Single/Family	\$3750/\$11250	\$3750/\$11250
Office Visit Copay	\$35 PCP \$70 Specialist Lab & X-Ray: No Charge	\$35 PCP \$70 Specialist Lab & X-Ray: No Charge
Professional Services: IN-PATIENT also includes: surgery, anesthesia, x-ray, lab and imaging	100% after Deductible	100% after Deductible
Preventive Care <i>Babies/Children:</i> exam, immunization and necessary lab work	100%	100%
<i>Adults:</i> routine pap smears & mammograms for women and routine PSA's for men	100%	100%
Maternity	Included	Included
Home Health Care Services	100% after Deductible (60 visits)	100% after Deductible (60 visits)
Spinal Manipulation Therapy	100% after Deductible	100% after Deductible
Emergency Room Care If applicable no ER Copay if confined	\$500 Copay	\$750 Copay
Prescription Drug Benefit	\$0/\$10/\$50/\$100/\$150/\$250 NP: \$10/\$20/\$70/\$120/\$150/\$250	\$0/\$10/\$50/\$100/\$150/\$250 NP: \$10/\$20/\$70/\$120/\$150/\$250
Serious Mental Illness ★Required for Public Entities ★	Included	Included
OUT OF NETWORK BENEFITS	MTBCP507	MTBCP567
Deductible - Calendar Year	\$10000 Ind/\$20000 Fam	\$10000 Ind/\$20000 Fam
Coinsurance	50%	50%
Annual Coinsurance Limit-Single/Family	Unlimited	Unlimited
Professional Services: IN-PATIENT also includes: surgery, anesthesia, x-ray, lab and imaging	50% after Deductible	50% after Deductible
Lifetime Maximum	Unlimited	Unlimited
COST OF INSURANCE	MTBCP507	MTBCP567
EO: Employee Only	\$746.06	\$1,074.96
ES: Employee+Spouse	\$746.06+\$969.87= \$1715.93	\$1074.96+\$1397.36= \$2472.32
EC: Employee + Child(ren)	\$746.06+\$662.51= \$1408.57	\$1074.96+\$954.57= \$2029.53
EF: Employee + Family	\$746.06+\$1632.37= \$2378.43	\$1074.96+\$2351.93= \$3426.89
TOTAL GROUP EMPLOYEE COST	\$43,271.48	\$62,347.68
TOTAL DEPENDENT COST	\$2,294.88	\$3,306.50
TOTAL GROUP COST	\$45,566.36	\$65,654.18

Based on 58 FT Employees: EO=56; ES=0, EC=1, EF=1

Blue Cross Blue Shield of Texas - Mid-Mkt Alternate Plan Options

City of Los Fresnos

Carrier: Plan Type: Network:	Blue Cross Blue Shield PPO BlueChoice MTBCP631	Blue Cross Blue Shield PPO (Basic) BlueChoice MTBCB626	Blue Cross Blue Shield HSA BlueChoice MTBCP006H
IN-NETWORK BENEFITS			
Deductible - Calendar Year	\$3500 Ind/\$10500 Fam	\$3000 Ind/\$9000 Fam	\$4000 Ind/\$8000 Fam
Coinsurance	80%	70%	100%
Annual Coinsurance Limit-Single/Family	\$8750/\$17500	\$9000/\$18000	\$4000/\$8000
Office Visit Copay	\$40 PCP \$80 Specialist Lab & X-Ray: No Charge	\$55 PCP \$110 Specialist Lab & X-Ray: Ded+Coins	100% after Deductible
Professional Services: IN-PATIENT <i>also includes: surgery, anesthesia, x-ray, lab and imaging</i>	80% after Deductible	70% after Deductible	100% after Deductible
Preventive Care <i>Babies/Children: exam, immunization and necessary lab work</i>	100%	100%	100%
<i>Adults: routine pap smears & mammograms for women and routine PSA's for men</i>	100%	100%	100%
Maternity	Included	Included	Included
Home Health Care Services	80% after Deductible (60 visits)	70% after Deductible (60 visits)	100% after Deductible (60 visits)
Emergency Room Care <i>If applicable no ER Copay if confined</i>	80% after Deductible Plus \$750 Copay per visit	70% after Deductible Plus \$750 Copay per visit	100% after Deductible
Prescription Drug Benefit	\$0/\$10/\$50/\$100/\$150/\$250 <i>NP:\$10/\$20/\$70/\$120/\$150/\$250</i>	\$0/\$10/\$50/\$100/\$150/\$250 <i>NP:\$10/\$20/\$70/\$120/\$150/\$250</i>	100% after Deductible
Serious Mental Illness ★Required for Public Entities★	Included	Included	Included
OUT OF NETWORK BENEFITS			
Deductible - Calendar Year	\$10000 Ind/\$20000 Fam	\$6000 Ind/\$18000 Fam	\$8000 Ind/\$16000 Fam
Coinsurance	50%	50%	70%
Annual Coinsurance Limit-Single/Family	Unlimited	Unlimited	Unlimited
Professional Services: IN-PATIENT <i>also includes: surgery, anesthesia, x-ray, lab and imaging</i>	60% after Deductible	50% after Deductible	70% after Deductible
Lifetime Maximum	Unlimited	Unlimited	Unlimited
COST OF INSURANCE	MTBCP631	MTBCB626	MTBCP006H
EO: Employee Only	\$886.69	\$785.48	\$784.39
ES: Employee+Spouse	\$886.69+\$1152.58= \$2039.27	\$785.48+\$1021.05= \$1806.53	\$784.39+\$1019.61= \$1804.00
EC: Employee + Child(ren)	\$886.69+\$787.36= \$1674.05	\$785.48+\$697.51= \$1482.99	\$784.39+\$696.52= \$1480.91
EF: Employee + Family	\$886.69+\$1939.97= \$2826.66	\$785.48+\$1718.55= \$2504.93	\$784.39+\$1716.14= \$2500.53
TOTAL GROUP EMPLOYEE COST	\$51,428.02	\$45,557.84	\$45,494.62
TOTAL DEPENDENT COST	\$2,727.33	\$2,416.06	\$2,412.66
TOTAL GROUP COST	\$54,155.35	\$47,973.90	\$47,907.28

Based on 58 FT Employees: EO=56; ES=0, EC=1, EF=1

United HealthCare - Fully Insured
The City of Los Fresnos

Carrier: Plan Type: Network:	United HealthCare PPO Premier ChoicePlus	United HealthCare PPO ChoicePlus	United HealthCare PPO/HSA ChoicePlus
IN-NETWORK BENEFITS	ETRM (Rx KU)	ETP4 (Rx KU)	ETMG (Rx MM)
Deductible - Calendar Year	\$1500 Ind/\$3000 Fam	\$5000 Ind/\$10000 Fam	\$3500 Ind/\$7000 Fam
Coinsurance	80%	80%	100%
Annual Out of Pocket Max-Single/Family	\$5500/\$11000	\$7150/\$14300	\$4000/\$8000
Office Visit Copay	\$35 PCP \$35/\$70 Specialist <i>(Child less than 19: \$0 Copay)</i> Virtual Visits: \$0 Copay Lab & X-Ray: No Copay	\$15 PCP \$50/\$100 Specialist <i>(Child less than 19: \$0 Copay)</i> Virtual Visits: \$0 Copay Lab & X-Ray: Ded+Coins	100% after Ded
Professional Services: IN-PATIENT <i>also includes: surgery, anesthesia, x-ray, lab and imaging</i>	80% after Deductible	80% after Deductible	100% after Deductible
Preventive Care Babies/Children: exam, immunization and necessary lab work	100%	100%	100%
Adults: routine pap smears & mammograms for women and routine PSA's for men	100%	100%	100%
Maternity	Included	Included	Included
Home Health Care Services	80% after Deductible <i>(60 visits)</i>	80% after Deductible <i>(60 visits)</i>	100% after Deductible <i>(60 visits)</i>
Emergency Room Care <i>If applicable no ER Copay if confined</i>	\$500 Copay + Ded/Coins	\$300 Copay + Ded/Coins	100% after Deductible
Prescription Drug Benefit	\$20 / \$45 / \$80	\$20 / \$45 / \$80	\$10 / \$35 / \$60
Serious Mental Illness ★Required for Public Entities★	Included	Included	Included
OUT OF NETWORK BENEFITS	ETRM (Rx KU)	ETP4 (Rx KU)	ETMG (Rx MM)
Deductible - Calendar Year	\$5000 Ind/\$10000 Fam	\$10000 Ind/\$20000 Fam	\$5000 Ind/\$10000 Fam
Coinsurance	50%	50%	70%
Annual Coinsurance Limit-Single/Family	\$10000/\$20000	\$20000/\$40000	\$10000/\$20000
Professional Services: IN-PATIENT <i>also includes: surgery, anesthesia, x-ray, lab</i>	50% after Deductible	50% after Deductible	70% after Deductible
Lifetime Maximum	Unlimited	Unlimited	Unlimited
COST OF INSURANCE	ETRM (Rx KU)	ETP4 (Rx KU)	ETMG (Rx MM)
EO: Employee Only	\$882.67	\$730.84	\$777.70
ES: Employee+Spouse	\$882.67+\$1147.40= \$2030.07	\$730.84+\$950.03= \$1680.87	\$777.70+\$1010.95= \$1788.65
EC: Employee + Child(ren)	\$882.67+\$783.82= \$1666.49	\$730.84+\$648.99= \$1379.83	\$777.70+\$690.60= \$1468.30
EF: Employee + Family	\$882.67+\$1931.21= \$2813.88	\$730.84+\$1599.02= \$2329.86	\$777.70+\$1701.55= \$2479.25
TOTAL GROUP EMPLOYEE COST	\$51,194.86	\$42,388.72	\$45,106.60
TOTAL DEPENDENT COST	\$2,715.03	\$2,248.01	\$2,392.15
TOTAL GROUP COST	\$53,909.89	\$44,636.73	\$47,498.75

Based on 58 FT Employees: EO=56; ES=0, EC=1, EF=1