BlueCross BlueShield of Texas

BENEFIT HIGHLIGHTS *Prepared for* United ISD #21673 High Plan Effective 9/01/2011

BlueChoice Network

This is a general summary of your benefits. Please refer to your benefit booklet for additional details and a description of the plan requirements and benefit design. This plan does not cover all health care expenses. Upon receipt of your benefit booklet, carefully review the plan's limitations and exclusions.

Overall Payment Provisions	In-Network Benefits	Out-of-Network Benefits
Deductibles		
Per-admission Deductible	*$0*	*$ 500*
Calendar Year Deductible *Applies to all Eligible Expenses, unless otherwise indicated, except Inpatient Hospital Expenses*	*$500 Individual / $1,500 Family*	*$1,000 Individual / $3,000 Family*
Three-month Deductible carryover applies	☒ *Yes*	☒ *Yes*
Out-of-Pocket Maximum		
Deductibles are not applied to the Out-of-Pocket Maximum. Copayment Amounts are applied but will continue to be required after the benefit percentages increase to 100%. Your benefit booklet will provide more details.	*$5,000 Individual / $15,000 Family* *Network Deductible & Out-of-Pocket maximum **will only** apply toward Network Deductible & Out-of-Pocket Maximum*	*$10,000 Individual / $30,000 Family* *Out-of-Network Deductible & Out-of-Pocket maximum **will also** apply toward Network Deductible & Out-of-Pocket Maximum*
Copayment Amounts Required		
Physician office visit/consultation *Refer to Medical/Surgical Expenses section for more information*	*$25 Copayment Amount*	
Urgent Care center visit *Refer to Urgent Care section for more information*	*$40 Copayment Amount*	
Outpatient Hospital Emergency Room/Treatment Room visit *Refer to Emergency Room/Treatment Room section for more information*	*$500 Copayment Amount*	*$500 Copayment Amount*
Maximum Lifetime Benefits		
Per Participant	*Unlimited*	

Inpatient Hospital Expenses		
Inpatient Hospital Expenses *All services must be preauthorized*		
All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units	*80% of Allowable Amount*	*80% of Allowable Amount after per-admission Deductible*
Penalty for failure to preauthorize services	*None*	*$250*

Medical/Surgical Expenses		
Medical / Surgical Expenses		
Services performed during the Physician office visit/consultation, including lab & x-ray *(does not include Certain Diagnostic Procedures and surgical services)*	*100% of Allowable Amount after $25 Copayment Amount*	*70% of Allowable Amount after Calendar Year Deductible*
Lab & x-ray in other outpatient facilities (excluding Certain Diagnostic Procedures)	*100% of Allowable Amount*	*70% of Allowable Amount after Calendar Year Deductible*
-Physician surgical services performed in any setting	*80% of Allowable Amount after Calendar Year Deductible*	*80% of Allowable Amount after Calendar Year Deductible*
-Physician inpatient hospital visits	*80% of Allowable Amount after Calendar Year Deductible*	*80% of Allowable Amount after Calendar Year Deductible*
-Certain Diagnostic Procedures; such as Bone Scan, Cardiac Stress Test, CT Scan (with or without contrast), Ultrasound, MRI, Myelogram, PET Scan	*80% of Allowable Amount*	*80% of Allowable Amount after Calendar Year Deductible*
-Home Infusion Therapy *(Services must be preauthorized)*	*80% of Allowable Amount after Calendar Year Deductible*	*80% of Allowable Amount after Calendar Year Deductible*
-All other outpatient services and supplies	*80% of Allowable Amount after Calendar Year Deductible*	*80% of Allowable Amount after Calendar Year Deductible*
In Vitro Fertilization Services	☒ *Decline*	

Extended Care Expenses	In-Network Benefits	Out-of-Network Benefits
Extended Care Expenses *All services must be preauthorized*	*100% of Allowable Amount*	*70% of Allowable Amount after Calendar Year Deductible*
Skilled Nursing Facility	*Limited to 25 day maximum each Calendar Year**	
Home Health Care	*Limited to 60 visit maximum each Calendar Year**	
Hospice Care	*Unlimited*	

Special Provisions Expenses

	In-Network Benefits	Out-of-Network Benefits
Serious mental Illness ***Mental Health Care*** ***Treatment of Chemical Dependency***		
Inpatient Services (All services must be preauthorized)		
-Hospital services (facility) (Inpatient Chemical Dependency treatment must be provided in a Chemical Dependency Treatment Center)	*80% of Allowable Amount after per-admission Deductible*	*60% of Allowable Amount after per-admission Deductible*
-Physician services	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
Outpatient Services (All services must be preauthorized)		
-Services performed during Physician office visit *(does not include psychological testing)*	*100% of Allowable Amount after $25 Copayment Amount*	*60% of Allowable Amount after Calendar Year Deductible*
-All outpatient services and psychological testing	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
Emergency Room/Treatment Room		
Accidental Injury & Emergency Care		
-Facility charges	*80% of Allowable Amount after $500 Copayment Amount (Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply)*	
-Physician charges	*80% of Allowable Amount after Calendar Year Deductible*	
Non-Emergency Care		
-Facility charges	*80% of Allowable Amount after $500 Copayment Amount (Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply)*	*60% of Allowable Amount after $500 Copayment Amount & Calendar Year Deductible (Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply)*
-Physician charges	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
Urgent Care Services		
Urgent Care center visit, including lab & x-ray services *(does not include Certain Diagnostic Procedures and surgical services)*	*100% of Allowable Amount after $40 Copayment Amount*	*70% of Allowable Amount after Calendar Year Deductible*
Certain Diagnostic Procedures: Bone Scan, Cardiac Stress Test, CT Scan (with or without contrast), Ultrasound, MRI, Myelogram, PET Scan, surgical procedures and all other services and supplies	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
Ground and Air Ambulance Services	*80% of Allowable Amount after Calendar Year Deductible*	

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

Special Provisions Expenses, cont.	In-Network Benefits	Out-of-Network Benefits
Preventive Care		
Routine annual physical examinations, well-baby care exams, immunizations 6 years of age & over, and any other preventive health services as determined by USPSTF	*100% of Allowable Amount*	*70% of Allowable Amount after Calendar Year Deductible*
Immunizations for Dependent children through the date of the child's 6th birthday	*100% of Allowable Amount*	*100% of Allowable Amount*
Speech and Hearing Services		
Services to restore loss of or correct an impaired speech or hearing function	*Covered same as any other sickness*	*Covered same as any other sickness*
Hearing Aids	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
Hearing Aid Maximum	*Hearing aids are subject to a $1,000 maximum amount each 36-month period**	
Organ and Tissue Transplant Services		
	Covered same as any other sickness Refer to benefit booklet for details	*Covered same as any other sickness Refer to benefit booklet for details*
Physical Medicine Services		
Physical Medicine Services (includes, but is not limited to physical, occupational, and manipulative therapy)	*80% of Allowable Amount after Calendar Year Deductible*	*60% of Allowable Amount after Calendar Year Deductible*
Calendar Year Maximum	*Limited to 35 visits each Calendar Year**	

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

Pharmacy Benefits*	Participating Pharmacy	Non-Participating Pharmacy (member files claim)
Vaccinations obtained through Pharmacies* **	☒ *Yes* *Flu vaccination- $0 Copayment* *If yes, flu vaccine covered; copayment and deductibles do not apply*	
Retail Pharmacy (All Copayment Amounts are per 30-day supply and will not apply to Coshare Stoploss Maximum)		
Generic Drug	*$5 Copayment Amount*	*80% of Allowable Amount minus Copayment Amount*
Preferred Brand Name Drug	*$40 Copayment Amount*	*80% of Allowable Amount minus Copayment Amount*
Non-Preferred Brand Name Drug	*$60 Copayment Amount*	*80% of Allowable Amount minus Copayment Amount*
Mail Order Program (All Copayment Amounts are per 90-day supply and will not apply to Coshare Stoploss Maximum)	☒ *Yes*	
Generic Drug	*$10 Copayment Amount*	
Preferred Brand Name Drug	*$80 Copayment Amount*	
Non-Preferred Brand Name Drug	*$120 Copayment Amount*	

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

Rx Enhanced-*Members electing to purchase Preferred/Non-Preferred Brand Name Drugs when "Brand Medically Necessary" is not indicated and a Generic equivalent is available, will be required to pay the difference between the cost of the Generic and Preferred/Non-Preferred Brand Name Drug, plus the Preferred Brand Name Copayment Amount. If "Brand Medically Necessary" is indicated on the prescription, the member will pay the Preferred or Non-Preferred Brand Name Copayment Amount.*

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

**** Each Participating Pharmacy that has contracted to provide vaccination services may have age, scheduling, or other requirements that will apply. You are encouraged to contact the store in advance. Childhood immunizations subject to state regulations are not available under this pharmacy benefit. Refer to your BCBSTX medical coverage for benefits available for childhood immunizations.*

Diabetes Supplies are available under the Prescription Drug benefits of your plan. Diabetic Supplies include insulin and insulin analog preparations, insulin syringes necessary for self-administration, prescriptive and non-prescriptive oral agents, all required test strips and tablets which test for glucose, ketones, and protein, lancets and lancet devices, biohazard disposable containers, glucagon emergency kits, and other injection aids. All provisions of this portion of the plan will apply including Copayment Amounts and any pricing differences that may apply to the items dispensed.

EMPLOYEE INFORMATION

The following benefits apply to dependent coverage:

- Dependent children are covered for maternity benefits.
- Dependent children are covered to age 26.
- Automatic coverage for newborns for the first 31 days following birth. Infants not enrolled for coverage within the first 31 days after birth will not be eligible for coverage until the following open enrollment period or special enrollment event.

Payments: Network providers agree to accept amounts negotiated with BCBSTX and are paid according to this BCBSTX-determined Allowable Amount. Covered individuals are responsible for any required Deductibles, Coinsurance Amounts, and Copayments. Plan benefits paid to Out-of-Network providers are also based on the BCBSTX-determined Allowable Amount. Covered individuals will be responsible for charges in excess of the Allowable Amount in addition to any applicable Deductibles, Coinsurance Amounts, and Copayments. For cost savings information, refer to the section on ParPlan Providers and the definition of Allowable Amount in the benefit booklet.

Preexisting conditions Provision: Benefits for Eligible Expenses incurred for treatment of a Preexisting Condition will not be available during the twelve-month period following the individual's initial Effective Date, or if a Waiting Period applies, the first day of the Waiting Period. In accordance with state and federal law, certain conditions will not be considered Preexisting Conditions and the Preexisting Condition exclusion will not apply to certain individuals. Details are provided in the benefit booklet.

Replacement of Medical Coverage: In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Texas State law, the following provisions apply to each eligible participant who has health coverage under the employer's plan immediately prior to the effective date of the health contract between the employer and BCBSTX (the contract date):

- Benefits for eligible expenses incurred for any service or supplies prior to the contract date, are not covered under the contract.
- Eligible expenses for services or supplies incurred on or after the effective date will be considered for benefits subject to all applicable contract provisions.

Members residing in other states may use that state's network through the BlueCard program. To locate a participating provider in your state, please contact 1-800-810-BLUE or visit our web site at www.bcbstx.com to use our Provider Finder® tool.

This benefit plan design includes provisions mandated by the Affordable Care Act of 2010, and is subject to change upon direction by federal and state agencies.

EMPLOYER INFORMATION

Employee Only	$371.12
Employee + Child(ren)	$576.35
Employee + Spouse	$703.04
Employee + Family	$970.04

The above proposed rates are projected to be effective for the 12-month period beginning on the effective date of group coverage and are contingent upon the provisions shown below. Final rates may vary based on actual enrollment results.

- An effective date of September 1, 2011.
- A minimum enrollment of 4935 or 90% of the eligible employees, but in any event not less than 4,113.
- The employer contributing 75% of the Employee Only cost plus 0% of the Dependent cost.
- No additional taxes will be imposed and no increase in existing taxes until the next Anniversary Date.
- Rates do not include any future mandated benefit changes.
- All employees must enroll in BCBSTX coverages; no other carrier allowed.
- Standard BCBSTX Managed Care programs with standard membership, eligibility, administration, claims processing, and standard network. Standard Master Contract provisions and definitions apply. Any costs associated with special services or custom materials provided by BCBSTX will be supplemental billed separate and apart from the rates outlined on this confirmation page.
- Annual open enrollment.

This proposal assumes the group contract will be issued in Texas. In addition to the benefits stated herein, benefits for covered persons who reside outside of Texas will conform to all Extraterritorial requirements of those states.

This proposal is made on the condition you are not a Small Employer as defined in the Texas Insurance Code. A proposal to a Small Employer would have to contain specific contractual elements and mandated insurance plans not contained in this proposal. Should it be determined you were a Small Employer, this proposal and any health insurance contract issued to you, shall be null and void.

Robert Chapa, Director of Risk Management

7/27/11

Group Executive Name and Title (Please type or print) | Signature | Date

Robert J. Laurel

7-27-11

Agent of Record Name (Please print or type) | Signature | Date

Donald Coronado, Account Executive

July 26, 2011

BCBSTX Representative Name (Please print or type) | Signature | Date