

benefit summary

CITY OF SPRINGDALE



**Arkansas
BlueCross BlueShield**

An Independent Licensee of the Blue Cross and Blue Shield Association

benefit summary

CITY OF SPRINGDALE

Effective Date:
01/01/2014



welcome

Arkansas Blue Cross and Blue Shield is pleased to be your health insurance company. This Benefit Summary gives you an overview of

your health coverage and provides some of the most commonly requested information regarding your health insurance policy. This summary

is not a policy. You will receive a Benefit Certificate that describes, in detail, your complete health insurance policy benefit features.

important details about your health insurance policy

Most of us are interested in saving money, and when the services of In-network Providers are utilized, you will pay less money out of pocket. Please take a moment to review this important information about your coverage.

Provider: Throughout this document, you will see the term health-care "provider." Providers are doctors, hospitals and others who offer medical services, including labs or radiology clinics.

In-network providers: These health-care providers are part of a group of participants who have agreed to bill according to our processes and have agreed to participate in our negotiated discounts for medical services. We pass these savings on to

you, resulting in lower out-of-pocket expenses. When in doubt, please check to see that your health-care provider is in your health plan's network.

Out-of-network providers: These health-care providers may not offer discounted services to our members and may follow their own billing rules for services. Your out-of-pocket expenses may be greater when you use an out-of-network provider. Your health insurance policy is set up with a higher coinsurance percentage for an out-of-network provider.

Remember, always check the network status of any health-care provider that your doctor may refer you to for additional care. If you are referred to an out-of-network provider by an

in-network provider, you still may have to pay higher costs.

Medical emergency: In a medical emergency, go directly to the nearest hospital. We do not subject you to additional charges for using an out-of-network hospital for yourself or a covered family member, although hospitals outside of our network may have higher total charges than an in-network hospital. This can result in higher out-of-pocket costs. Some examples of a medical emergency include a suspected heart attack, stroke or poisoning.

At Arkansas Blue Cross, your continued good health is our main concern.

how to find an in-network provider

In Arkansas

For a list of in-network providers, visit us on the Web at: arkansasbluecross.com
Your Provider Network is: True Blue
or call Customer Service at:
479-527-2310 or 1-800-817-7726

Important Note: For your protection, we want you to know that some doctors and hospitals may require up-front payment of your anticipated portion of the deductible and coinsurance fees.

Outside of Arkansas

On the Web, visit the Blue Cross and Blue Shield Association site at: bcbs.com/healthtravel/finder.html

Or call the Blue Cross and Blue Shield Association at:
1-800-810-BLUE

Note: For some health policies, out-of-state providers may not be included at in-network rates. Check your Benefit Certificate for your policy details.

Your older, dependent children can be covered by your health insurance plan until they reach 26 years of age.

Important Disclaimer from Arkansas Blue Cross and Blue Shield

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Individual Deductible: The total amount of covered medical expenses that you incur before your health insurance policy begins to pay.

\$575
(combination of both in network and out of network)

Family Deductible — Accumulated: The total amount of covered medical expenses your family incurs before your health insurance policy begins to pay. You pay a new deductible each calendar year.

\$1,150
(combination of both in network and out of network)

Coinsurance: The percentage of the allowable charge for a medical service that becomes your responsibility to pay after your deductible has been satisfied.

Copayment: The dollar amount you pay for a doctor's office visit, calendar-year coinsurance maximum:

lifetime maximum:

	in-network	out-of-network
individual	\$200	\$0
family	\$400	\$0

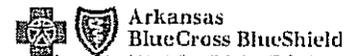
No Lifetime Limitation

service type	your cost in-network coinsurance	your cost out-of-network coinsurance
professional services primary care physician visit copayment amount \$35	0%	30%
specialty physician visit (Coinsurance may apply to additional services)	10%	30%
preventive services (adult wellness and routine physical)	0%	20%
children's preventive services (immunizations covered 100%)	0%	20%
professional fees for inpatient surgical and medical services	10%	30%
professional fees for outpatient surgical and medical services	10%	30%
hospital and other medical facility services		
hospital visit (inpatient)	10%	30%
hospital (outpatient) includes surgery, diagnostics and therapeutic care	10%	30%
emergency room visit	10%	30%
maternity and obstetrics	10%	30%
other services		
durable medical equipment	10%	30%
diabetic supplies	10%	30%
mental health	10%	30%
therapeutic services — physical and occupational copayment amount \$35	10%	30%
— chiropractic	10%	30%
speech copayment amount \$35	10%	30%
ambulance services — ground: up to \$1,000 per trip	10%	10%
— air: up to \$5,000 (limit one air ambulance trip per year.)	10%	10%

* Additional fees may apply. Please check your Benefit Certificate.

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your retail drug coverage

A pharmacy benefit is an important component of your overall health insurance coverage. Your drug card allows you to obtain medications at discounted prices. The different copayment levels shown on your ID

card are called "tiers." When referring to these tiers, you'll notice that **tier one** (generic drugs) and **tier two** (brand-name drugs) require lower copayments than **tier three** brand-name drugs. You may want to ask your doctor if there

is an alternative for a prescription that falls into the more expensive tier three category. Selecting lower-cost drugs (such as generics) is an important way to save money on your overall health-care expenses.

copayments by tier

	tier one	tier two	tier three
retail	\$15.00	\$35.00	\$55.00
mail order*	\$30.00	\$70.00	\$110.00

*One copayment per 90-day supply

additional benefits / riders

Maternity
Mental Health Parity
Primary Physician Copayment Only - \$35
Check your Benefit Certificate for details on any additional benefits or riders.

messages

Your policy features a deductible carry over feature. Check Benefit Certificate for details and restrictions.

HealthConnect Blue — a free health program from Arkansas Blue Cross — provides you with a variety of resources to help you reach your health goals; available through "Health Resources" on My Blueprint.

My Blueprint — your personal online self-service center — allows you access to a wealth of information and can be accessed from the home page of our Web site at arkansasbluecross.com.

questions?

We hope you will call us with any questions or concerns you have. Our office hours are Monday through Friday from 8 a.m. to 4:30 p.m. (Central Time).

Customer Service Number: 479-527-2310 or 1-800-817-7726

More information can be found at our Web site at: arkansasbluecross.com

Regional Address: Arkansas Blue Cross and Blue Shield
516 E. Millsap Road
Suite 103
Fayetteville, AR 72703

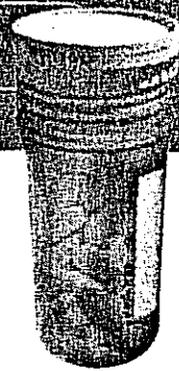


PLAN #PPO

MPI #637 BS_ABCBS_IN-OUT B/10

value formulary

member



Introduction

The Value Formulary is a tiered list of medications covered by your health plan that emphasizes the use of generic drugs as the first line of prescribing. It also includes select brands in specific therapeutic classes.

Generic drugs are commonly prescribed, safe and effective for treating a given condition, and are typically less expensive than brand-name drugs. Select brand-name drugs are not covered in the Value Formulary unless you *have complications using a generic alternative*.

The Value Formulary uses four drug tiers and includes a process called "step therapy."

The four Value Formulary tiers are:

Tier 1 — Includes all generics covered.

Tier 2 — Includes a limited number of brand-name products with a low copayment. Together, Tier 1 and Tier 2 provide low-cost medications for most conditions.

Tier 3 — Includes medications available only from a single pharmaceutical company or manufacturer. Because these drugs are more expensive, single-source brands are covered at a higher copayment.

Tier 4 — Includes all drugs otherwise not covered. Members pay 100 percent of the copayment, but benefit from the network discount available through the drug card.

step therapy

Step therapy helps members treat medical conditions with prescription medications by first using generic drugs to treat the condition and moving to brand-name or higher-cost medication only if the generic medication is not effective.

In the Value Formulary, it is necessary to try step therapy in selected drug classes before a brand-name drug is covered. A list of those products and an explanation of the step therapy requirement follows. The Value Formulary is evaluated periodically to consider new brand products and recently launched generics.

Step therapy ensures that you receive clinically appropriate drugs in a cost-effective manner. Step therapy protocols are based on current medical findings, U.S. Food and Drug Administration (FDA)-approved drug labeling and drug costs. (continued on back)



Drugs Not Covered

Certain classes of drugs are not covered in the Value Formulary when over-the-counter (OTC) options are available. OTC products typically are less expensive than prescription products. Prescription products are on Tier 4. Multisource brand products are those that have a generic equivalent; these products also are on Tier 4.

Drug classes that are subject to **Step Therapy** and **No Plan Coverage** in the Value Formulary are in the table below.

THERAPEUTIC CLASS	DESCRIPTION
Blood Pressure Medications (ACE-Inhibitors / ARBs)	Step Therapy. Step through generic ACE-Inhibitor before ARBs or Tekturna. Step through generic ACE-Inhibitor/diuretic combination before ARB/diuretic or Tekturna/diuretic combinations.
Cholesterol Medications (Statins)	Step Therapy. Step through generic statin before single-source brands and single-source brand combination products.
NSAIDs	Step Therapy. Step through one generic NSAID before Celebrex; however, Celebrex is allowed if Plavix, warfarin or oral corticosteroid is in current drug profile.
Osteoporosis	Step Therapy. Step through generic bisphosphonate before single-source brand products.
Antidepressants (SSRI, SNRI)	Step Therapy. Step through generic SSRI or SNRI before single-source brands.
Proton Pump Inhibitors (PPIs)	No Plan Coverage. All prescription products are on Tier 4. OTC options are available.
Antihistamines	No Plan Coverage. All prescription products are on Tier 4. OTC options are available.
Anti-Migraine Medications (Triptans)	Step Therapy. Step through a generic triptan before a brand product is covered.
Nasal Steroids	Step Therapy. Step through a generic nasal steroid before a brand product is covered.
Sedative-Hypnotics, Nonbenzodiazepine	Step Therapy. Step through a generic product before a brand product is covered.



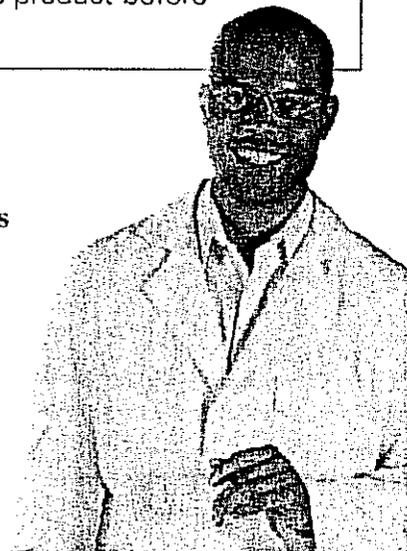
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Health Advantage
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Blue Advantage
Administrators of Arkansas
An Independent Licensee of the Blue Cross and Blue Shield Association



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Effective Date

01/01/2017

description	in network	out of network
Individual Deductible: The total amount of covered medical expenses that you incur before your health insurance policy begins to pay.	\$2,500	\$5,000
Family Deductible — Accumulated: The total amount of covered medical expenses your family incurs before your health insurance policy begins to pay. Any individual within a family may satisfy an individual deductible separately from the family deductible. When an individual within a family meets his or her deductible, the health plan begins to pay for that individual only. You pay a new deductible each calendar year.*	\$5,000	\$10,000

Coinsurance: The percentage of the allowable charge for a medical service that becomes your responsibility to pay after your deductible has been satisfied.

Dependent Benefits: Your older dependent children can be covered by your health insurance until they reach 26 years of age, unless they can be covered by their employer.

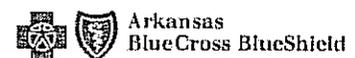
* The family deductible adds together expenses from family members in any combination to satisfy the deductible. **Family Example:** With a \$5,000 deductible for family contracts, four people can have \$1,250 in expenses and satisfy the deductible. Or one individual can have \$5,000 in expenses, and all persons in the family will be considered to have satisfied the deductible. **Individuals Within Families:** One individual can have \$2,500 in expenses and satisfy their own deductible.

	calendar-year coinsurance maximum:		lifetime maximum:
	in network	out of network	
individual	N/A	Unlimited	No Lifetime Limitation
family	N/A	Unlimited	

Service Type**	Your Cost	
	in network coinsurance	out of network coinsurance
professional services		
primary care physician visit	0%	20%
specialty physician visit	0%	20%
adult preventive health services (deductible does not apply in network)	0%	20%
children's preventive health services (deductible does not apply in network) immunizations covered 100%	0%	20%
professional fees for inpatient surgical and medical services	0%	20%
professional fees for outpatient surgical and medical services	0%	20%
hospital and other medical facility services		
hospital visit (inpatient)	0%	20%
hospital (outpatient) includes surgery, diagnostics and therapeutic care	0%	20%
emergency room visit	0%	20%
maternity and obstetrics	0%	20%
other services		
durable medical equipment	0%	20%
diabetic supplies	0%	20%
mental health **	0%	20%
therapeutic services — physical and occupational **	0%	20%
— chiropractic	0%	20%
speech **	0%	20%
ambulance services — ground: up to \$1,000 per trip	0%	0%
— air: up to \$5,000 (limit one air ambulance trip per year.)	0%	0%
retail pharmacy — standard formulary	0%	non-covered

**Visit limitations may apply to some service types. Please check your Benefit Certificate.

MPI 695 HSA 618-E PPACA 11/10



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Consumer Directed Health Plan

YOU are in control ... backed by the power of Blue!
for members

A Consumer Directed Health Plan combines four components into one health program

Personal Spending Account

- Your employer will allocate money to a Personal Spending Account (PSA) for you and your family. Your employer has chosen to use a Health Savings Account as your personal spending account. This means that you can make additional deposits to the account if you choose (up to the regulatory limits). Interest earned on account balances also is tax free.
- You can use PSA dollars to pay for medical care without paying any deductibles or copayments first.
- You can visit any doctor you choose. If you want to get the biggest discounts off retail, choose a Preferred Provider Organization (PPO) provider.
- If you don't spend all your PSA dollars, unused amounts roll over from year to year. You can save these dollars to reduce the amount you pay out of your own pocket in future years.

Traditional Health Coverage

- Sometimes, despite your best effort, your health care cost may exceed your PSA balance. A Consumer Directed Health Plan provides the extra security of knowing you are protected from major health expenses.
- There is a limit on the total amount you'll have to pay out of your pocket each year. After you spend your PSA and meet any remaining deductible balance, a traditional PPO health insurance plan pays your covered health care expenses.

Remaining Deductible

- Sometimes you may have large expenses that exceed the money in your PSA. When this happens, you will be responsible for a limited out-of-pocket amount before traditional health coverage begins.
- Your health plan deductible minus your PSA balance equals the remaining deductible.
- After you've been in the program for a year or more, you may have enough money saved in your PSA to cover some or all of your remaining deductible.

Tools

- Backed by the power of Blue, you will have the knowledge you need to work with your doctor to make informed health care choices. You will have easy access to health care education, treatment and drug cost information, along with facts to help you choose the doctors and hospitals that are right for you.
- A Consumer Directed Health Plan's simple, online money management tools allow you to keep track of expenses and balances in your PSA.



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Consumer Directed Health Plan

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EE-ABCBS-HSA/Employer Contribution-2013
MPI 1140

Consumer Directed Health Plan

Health Savings Account FAQs for employees

The following are the answers to some frequently asked questions about Health Savings Accounts.

1. Who owns my HSA account?	You do. Just like any other checking account, this account is held by a bank in your name.
2. Who can make deposits to my HSA?	You, your employer or both.
3. How much can be contributed to my HSA each year?	If you are covered by a qualified plan, you and your employer can contribute up to the statutory maximum amounts. For 2013, these are \$3,250 single / \$6,450 family.
4. Can the account earn interest?	Interest can accrue on account balances tax free.
5. Who can have an HSA?	Anyone covered by a qualified high-deductible health insurance plan who has no other health coverage (some exceptions apply).
6. What is a qualified high-deductible health plan?	Federal law defines qualified health plans by specifying minimum deductibles and maximum out-of-pocket amounts. All covered services apply to this deductible except preventive care.
7. What if I change jobs?	This is your account ... you own it. Changing employers does not impact your health savings account.
8. How do I make a deposit?	Your employer may allow you to payroll deduct your deposits or you may make deposits directly to your account.
9. How do I access my money?	You make withdrawals using a check or debit card, just like you do from any other checking account.
10. How can HSA dollars be used?	You can use your HSA to cover the cost of most medical services, such as, office visits, prescription drugs and lab tests.



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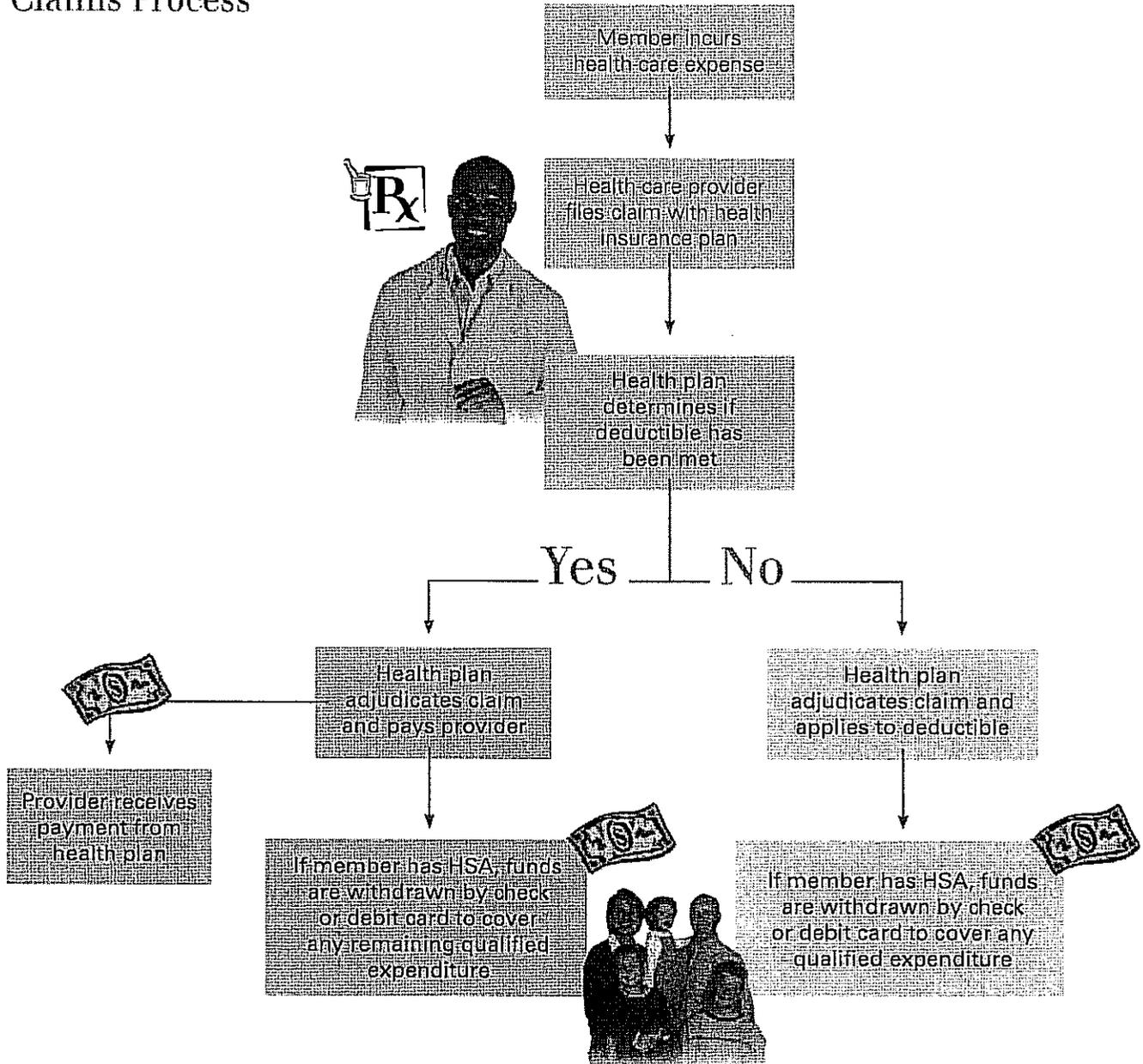
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CDHP-ABCBS-HSA-Employees-FAQ-Claims-2013
MPI 1145

Consumer Directed Health Plan

Consumer Directed Health Plan Health Savings Account (HSA) Claims Process



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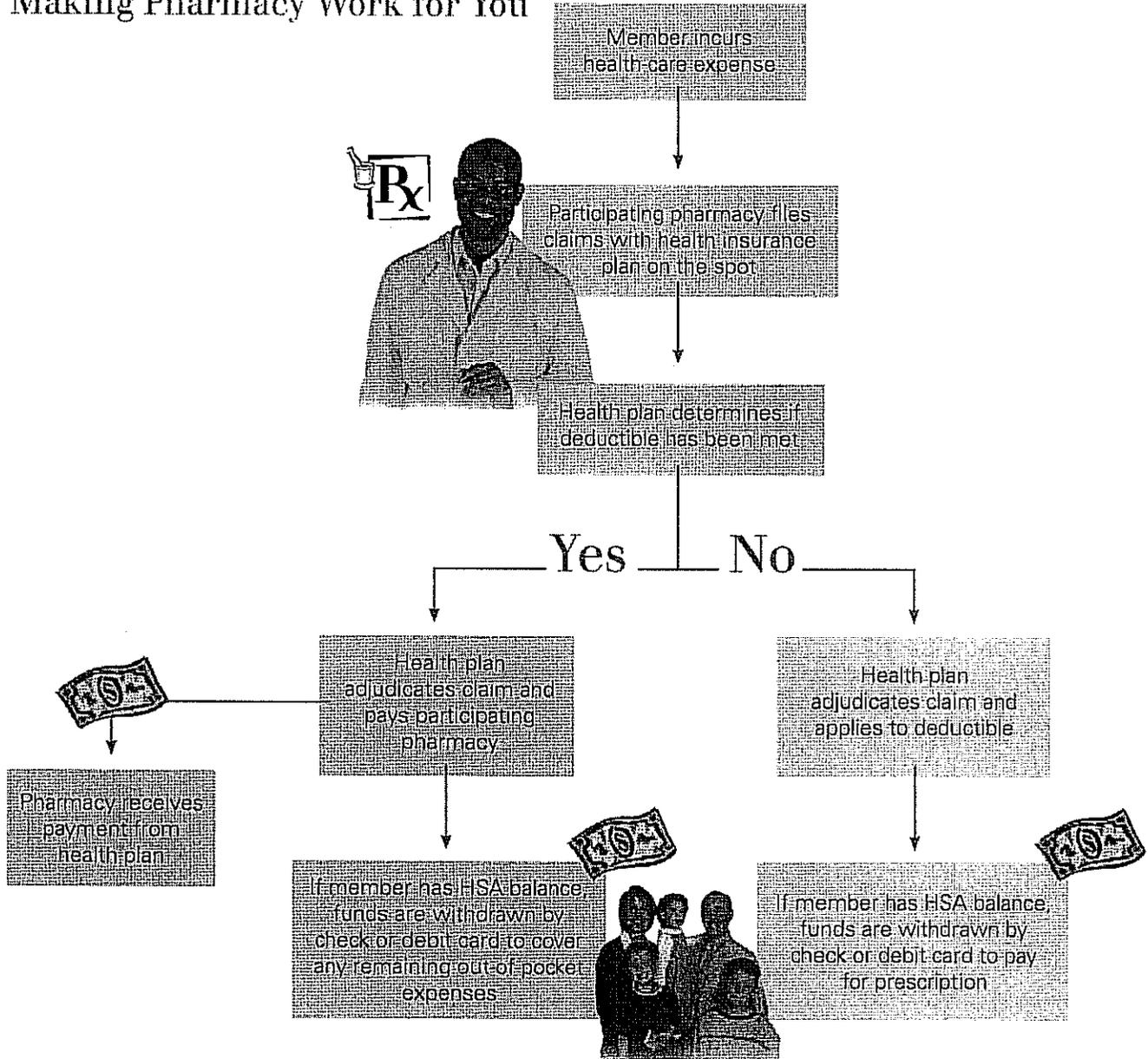
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Consumer Directed Health Plan

Consumer Directed Health Plan Health Savings Account (HSA)

Making Pharmacy Work for You



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CDHP-ABCBS-HSA-Pharmacy-2013

MPI 1144