BENEFIT	AETNA-PFFS	AETNA-PPO		KELSEYCARE ADVANTAGE POS		BLUE CROSS BLUE SHIELD PPO	
Coverage		Network	Non-Network	Network	Non-Network	Network	Non-Network
SERVICE AREA	Nationwide	Bexar, Brazoria, Chambers, Collin, Comal, Dallas, Denton, El Paso, Fort Bend, Galveston, Grayson, Harris, Jefferson, Johnson, Kaufman, Kendall, Liberty, Montgomery, Nueces, Orange, Rock Wall, Tarrant, Travis, Williamson		Brazoria, Chambers, Ft. Bend, Galveston zip codes - 77510,77511, 77517, 77518, 77539, 77546, 77549, 77563, 77565, 77568, 77573, 77574, 77590, 77591, 77592, Harris, Liberty, Montgomery and Waller		All 50 states are in the service area. A reduced benefit and higher deductibles apply for services obtained out-of-network. To identify participating providers outside of Texas, call 1-800-810-2583 or use your zip code to find a provider at www.bcbstx.com.	
ANNUAL DEDUCTIBLES	None	None	None	None		Individual: $200 Family: $600	Individual: $400 Family: $1,200
MAXIMUM ANNUAL Out-of-Pocket Costs	None	None	$3,500 for certain services	$1500 for certain services		Individual: $3,000 Family: $6,000	Individual: $5,000 Family: $10,000
LIFETIME MAXIMUM	None	None	None	None		$1,500,000 per participant. Lifetime maximum does not apply to coverage or services for AIDS or human immunodeficiency virus infection.	
PCP	$15 copayment	$15 copayment	15% coinsurance	$0 copayment	No coverage	$35 copayment	40% after annual deductible
Specialist	$15 copayment	$15 copayment	15% coinsurance	$15 copayment	20% of Medicare approved fee	$55 copayment	40% after annual deductible
Chiropractic	$15 copayment	$15 copayment	15% coinsurance	$15 copayment	20% of Medicare approved fee	$55 copayment plus 20% after deductible	40% after deductible
Podiatry	$15 copayment	$15 copayment	15% coinsurance	$15 copayment	20% of Medicare approved fee	$55 copayment	40% after deductible
Inpatient Hospital	$0 copayment	$0 copayment	15% coinsurance	$300 copayment	$1,000 days 1-60 $250/day - days 61-90 $500/day - days 91-150	20% after $500 copayment	40% after $1,000 copayment
Emergency Room	$50 copayment	$50 copayment	$50 copayment	$50 copayment		$150 copayment plus 20% (within 48 hours of medical emergency)	$150 copayment plus 40% (within 48 hours of medical emergency)
Ambulance	$15 copayment	$15 copayment	15% coinsurance	$100 copayment for emergency and non-emergency	$100 copayment	20% after deductible	40% after deductible
Urgent Care Center	$15 copayment	$15 copayment	$15 copayment	$50 copayment	No coverage	$60 copayment	40% after deductible
Lab & X-Ray	$15 copayment	$15 copayment	15% coinsurance	$0 copayment	20% of Medicare approved fees	$0 copayment with office visit.	40% after deductible
Therapeutic Radiology (treatment of cancer and other diseases with radiation)	$15 copayment	$15 copayment	15% coinsurance	$15 copayment	20% of Medicare approved fees	$35 copayment plus 20% after deductible - PCP office $55 copayment plus 20% after deductible - Specialist office	40% after deductible
Physical Therapy	$15 copayment	$15 copayment	15% coinsurance	$15 copayment	No coverage	$35 copayment-PCP office $55 copayment -Specialist office	40% after deductible
Occupational Therapy	$15 copayment	$15 copayment	15% coinsurance	$15 copayment	No coverage	$35 copayment-PCP office $55 copayment -Specialist office	40% after deductible
Immunizations	$0 copayment	$0 copayment	15% coinsurance	$0 copayment	No coverage	$0 copayment to age 6. $35 copayment after age 6-PCP office.	$0 copayment to age 6. 20% after deductible- after age 6.
Home Health	$0 copayment	$0 copayment	15% coinsurance	$0 copayment	No coverage	20% after deductible. 60 visits per calendar year.	40% after deductible. 60 visits per calendar year.

City of Houston Medicare PPO, POS and PFFS Plans Comparison for Retirees

Medicare-covered members may enroll in AETNA PFFS, AETNA PPO and the KelseyCare Advantage POS plans.
All members may enroll in the BlueCross BlueShield PPO.

Plan Comparison Worksheet

This worksheet is to help you compare features that are important to you. See the enrollment guide to find the contribution rates for the plan you elect. Use the Monthly Contribution Calculation Worksheet to calculate your monthly rates.

Monthly Contribution Calculation Worksheet

1. Select and enter rates for desired coverage				
Medicare plans	**Retiree**	**Spouse**	**Dependent**	**Total**
PPO and POS				
Aetna PPO				
KelseyCare POS				
Network-free				
Aetna PFFS				
BCBSTX plans	**Retiree**	**Retiree + 1**	**Retiree + family**	**Total**
BCBSTX PPO				
2. Add $25 if any BCBSTX PPO members use tobacco products				
3. Total monthly contribution				

1. Select and enter rates for desired coverage.
2. Total the rows and add row totals to get your total monthly contribution amount.

The worksheet below lets you easily decide which plan covers your prescriptions. Just write your prescriptions in the column on the left and put a √ under each plan that covers them.

Prescription Drugs

Prescription name	Which plan covers your prescriptions		
	Aetna PPO and PFFS	KelseyCare Advantage POS	BCBSTX PPO

Your choice of doctor is important. In the box below fill in the doctor you prefer to go to and put a √ under each plan that covers that doctor.

Doctor

Doctor name	Which plan covers the doctor you prefer		
	Aetna PPO and PFFS	KelseyCare Advantage POS	BCBSTX PPO

City of Houston PPO, POS and PFFS Plans Comparison For Retirees

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All members may enroll in the BlueCross BlueShield PPO.

BENEFIT	AETNA-PFFS	AETNA-PPO		KELSEYCARE ADVANTAGE POS		BLUE CROSS BLUE SHIELD PPO	
Coverage		**Network**	**Non-Network**	**Network**	**Non-Network**	**Network**	**Non-Network**
Skilled Nursing	$0/day - days 1-10 $25/day - days 11-20 $50/day - days 21-100 100 days maximum each benefit year	$0/day - days 1-10 $25/day - days 11-20 $50/day - days 21-100 100 days maximum each benefit year	15% coinsurance	$0/day - days 1-20 $100/day - days 21-100 100 days maximum each benefit year	No coverage	20% after $500 copayment per admission -Inpatient Maximum of 60 days per calendar year	$1,000 copayment and 40%- Inpatient Maximum of 60 days per calendar year
Renal Dialysis	$15 copayment per session	$15 copayment per session	$15 copayment per session	$50 copayment per session	No coverage	20% after deductible	40% after deductible
Durable Medical Equipment	15% coinsurance	15% coinsurance	15% coinsurance	10% coinsurance	No coverage	20% after deductible	40% after deductible
Prosthetic Devices	15% coinsurance	15% coinsurance	15% coinsurance	20% coinsurance	No coverage	20% after deductible	40% after deductible
Diabetic Equipment	$0 copayment	$0 copayment	15% coinsurance	20% coinsurance	No coverage	20% after $35 copayment	40% after deductible
Diabetic Supplies	$0 copayment	$0 copayment	15% coinsurance	20% coinsurance	No coverage	Same as prescription drug benefit	
Diabetic Monitoring / Training	$0 copayment	$0 copayment	15% coinsurance	$0 copayment	No coverage	20% after $35 copayment-PCP office 20% after $55 copayment-Specialist office	40% after deductible
Diabetic - Injectable Insulin (30-day supply)	See prescription drug benefit	See prescription drug benefit	See prescription drug benefit	See prescription drug benefit		See prescription drug benefit	See prescription drug benefit
Colorectal Screening	$0 copayment	$0 copayment	15% coinsurance	$0 copayment	No coverage	$0 copayment	40% after deductible
Hospice	Covered by Medicare at Medicare certified facility	Covered by Medicare at Medicare certified facility	Covered by Medicare at Medicare certified facility	Covered by Medicare at Medicare certified facility		$500 copayment and 20% -Inpatient $35 copayment per visit - Outpatient	$1,000 copayment and 40% -Inpatient 40% after deductible - Outpatient
Well Woman Exam	$0 copayment	$0 copayment	15% coinsurance	$0 copayment	No coverage	$0 copayment	40% after deductible
Well Man Exam	$0 copayment	$0 copayment	15% coinsurance	$0 copayment	No coverage	$0 copayment	40% after deductible
Outpatient Surgery							
Hospital	$0 copayment	$0 copayment	15% coinsurance	$175 copayment	20% of Medicare approved fees	20% after deductible	40% after deductible
Ambulatory	$0 copayment	$0 copayment	15% coinsurance	$150 copayment	20% of Medicare approved fees	20% after deductible	40% after deductible
Mental Health							
Inpatient	$0 copayment	$0 copayment	15% coinsurance	$300	No coverage	20% after $500 copayment	40% after $1,000
Outpatient	$25 copayment	$15 copayment	15% coinsurance	$35 copayment	No coverage	20% after $35 or $55 copayment	40% after deductible
Substance Abuse & Chemical Dependency							
Inpatient	$0 copayment	$15 copayment	15% coinsurance	$300	No coverage	20% after $500 copayment	40% after $1,000 copayment
Outpatient	$25 copayment	$15 copayment	15% coinsurance	$35 copayment	No coverage	Specialist office - $55 copayment plus 20% PCP office - $35 copayment plus 20% Emergency room $150 copayment plus 20% after deductible Hospital outpatient - 20% after deductible	40% after deductible
Prescriptions - Contact your plan administrator (see page 1 in the Retiree Enrollment Guide)							
Retail							
Generic	$10 copayment	$10 copayment	$10 copayment	$10 copayment		$10 copayment	$10 copayment
Preferred Brand	$30 copayment	$30 copayment	$30 copayment	$30 copayment		$35 copayment	$35 copayment
Non-Preferred Brand	$45 copayment	$45 copayment	$45 copayment	$45 copayment		$50 copayment	$50 copayment
Specialty Drugs	$45 copayment	$45 copayment	$45 copayment	$45 copayment		30-day supply at $35 or $50 copayment through Triessent only	30-day supply at $35 or $50 copayment through Triessent only
Mail Order							
Generic	$20 copayment	$20 copayment	$20 copayment	$20 copayment		$20 copayment	$20 copayment
Preferred Brand	$60 copayment	$60 copayment	$60 copayment	$60 copayment		$70 copayment	$70 copayment
Non-Preferred Brand	$90 copayment	$90 copayment	$90 copayment	$90 copayment		$100 copayment	$100 copayment
Specialty Drugs	$90 copayment	$90 copayment	$90 copayment	N/A		30-day supply at $35 or $50 copayment through Triessent only	30-day supply at $35 or $50 copayment through Triessent only
Medicare Part B Drugs	100% covered - no copayment	100% covered - no copayment	15% until annual out of pocket max = $3,500 then 100%	15% until annual out of pocket max = $1,500 then 100%		Covered under drug benefit.	Covered under drug benefit.
Additional Benefits - Contact your plan administrator (see page 1 in the Retiree Enrollment Guide)							
Dental	Discounts	Discounts	Discounts	$0 for Medicare covered benefits	No coverage	N/A	N/A
Vision (routine)	$0 copayment - 1 exam per year $15 diagnostic vision exam	$0 copayment	15% coinsurance	$15 copayment- annual exam	No coverage	**Members under age 18:** $35 PCP vision screenings $55 Specialist vision screenings **For all members:** Davis Vision Value offers an Added Discount Program.	40% after deductible for eligible expenses when performed by a physician **For all members:** Davis Vision Value offers an Added Discount Program.
Eyewear	Discounts (also on Lasik)	$70 every 24 months	$70 every 24 months	$50 max per year	No coverage		
Hearing (routine)	$0 - 1 exam per year	$0 copayment	15% coinsurance	$15 copayment per annual exam	No coverage	**Members under age 18:** $35 PCP hearing screenings $55 Specialist hearing screenings	40% after deductible
Hearing aids	$500 every 36 months	$500 every 36 months	$500 every 36 months	Discount up to 20% per year	No coverage	$1000 benefit per 36 month period	

If there exists a conflict between this Comparison Chart and the official plan documents for each plan, the official plans documents will prevail. The city of Houston reserves the right to change, modify, increase or terminate any benefits.