



Angels of Care

2011 – 2012 BENEFITS GUIDE



www.angelsofcare.com



Angels of Care Pediatric Home Health
8001 S. U.S. Hwy 75 Sherman, TX 75090
P.O. Box 338 Howe, TX 75459
Phone 903-532-1400 Fax 903-532-1401
www.angelsincare.com

May 1, 2011

Dear Employee,

Thank you for choosing Angels of Care Pediatric Home Health as your preferred place of employment and welcome to our home health care family.

We look forward to serving you as you serve our community. This agency is dedicated to caring for and helping the families of special needs children and young adults.

Angels of Care has been in business since 2000 and consistently strives to be the very best Pediatric Home Health Agency in Texas. We offer a great benefits package as well as many additional employee incentives.

Enclosed, you will find Angels of Care employee benefits and incentives for your review. If you have any questions please feel free to contact our corporate office staff at 903-532-1400

Sincerely,

Bonnie West

Bonnie West
Administrator



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Employee Benefits & Incentives

Dear Employee,

Please review Angels of Care employee benefits & incentives below:

- Great Pay
- Stress Free Work Environment
- Health, Dental, Life Insurance and Vision Discount Program
- Free \$15,000 Life Insurance Policy
- AFLAC
- Prepaid Legal
- 40 Hours of Paid Vacation
- 401K
- Shift Differentials—for working nights, weekends, & holidays
- \$500 Employee of the Month Drawing
- \$500 Payday Drawing
- New Car Giveaway Every 6 Months
- Free Fitness Center Membership to all Nautilus Locations
- 24% off AT&T Wireless Bill
- 22% off Verizon Wireless Bill
- Apartment Discounts-Grayson County Only
 - 10% off plus special promotions for “The Bridges on Travis” in Sherman, Texas
 - 5% off plus special promotions for “Creek View, Rain Tree & Country Village” in Sherman, Texas
- CPR Classes for the low cost of \$4 for each employee
- Direct Deposit for your convenience

We have a Certified Respiratory Therapist on staff that is available to train you on medical equipment such as ventilators and tracheotomies. He is also a certified CPR instructor and teaches classes regularly.

If you have any questions, please feel free to contact our corporate office at 903-532-1400.

Cordially,

Angels of Care Staff



Explanation of Medical Plan Options And Dental Plan Choice for Angels of Care July 1, 2011 – July 1, 2012

As a valued employee of Angels of Care, we are pleased to provide you the following three Health Plan Options and Dental Plan Choice. This Benefits Guide contains your Health and Dental Benefit options and provides necessary forms for your enrollment. This year we have three options for you to choose from for your Healthcare. Health plans are summarized on the following page. The voluntary Dental Plan option is also summarized on the following page. **Below, you will find the highlights of the 3 plans and enrollment instructions for both Health and Dental plans.** To generalize the differences: An HSA plan is less expensive because it does not have co-pays for doctor and pharmacy visits. The PPO plans do include co-pays and we are offering two deductible options to choose from this year. As always, all deductibles are on a calendar year basis.

Option 1 Co-Pay Health Plan (RM-26 PPO) plan features:

- \$3,000 individual deductible & \$9,000 family deductible
- \$40 doctor office visit co-pay
- Prescription co-pay benefits, \$20 for Generic, \$40 for Preferred Brand and \$60 for Non-Preferred Brand prescriptions
- After deductible has been met the plan pays at 70% and you pay at 30%
- The Coinsurance maximum is \$5,000 individual & \$15,000 family (not including deductible)
- Maximum risk is \$8,000 individual & \$24,000 family

Option 2 Co-Pay Health Plan (RM-34 PPO) plan features:

- \$10,000 individual deductible & \$30,000 family deductible
- \$40 doctor office visit co-pay
- Prescription co-pay benefits, \$20 for Generic, \$40 for Preferred Brand and \$60 for Non-Preferred Brand prescriptions
- After deductible has been met the plan pays at 75% and you pay at 25%
- The Co-insurance maximum is \$5,000 individual & \$15,000 family (not including deductible)
- Maximum risk is \$15,000 individual & \$45,000 family

Option 3 HSA (Health Savings Account) Health Plan (RMH-3) features:

- \$5,000 individual deductible & \$10,000 family deductible for office visits, surgeries, prescriptions and in hospital stays. Annual preventative exams are covered at no cost to you.
- After the deductible has been met, the plan pays at 100%.
- Debit card can be set up to pay medical expenses that go towards deductible
- Maximum risk is only the deductible amount of \$5,000 for an individual and \$10,000 for a family

YOU NEED TO DO THE FOLLOWING:

1. Health Plan: Choose from Options 1 through 3 for your Health Plan. See Summary and detailed benefit highlights on the following pages.
2. Dental Plan: Decide whether you want to take the voluntary Dental Plan. See next page for a summary of the Dental Plan highlights.
3. Fill out the BCBS Enrollment Form in this booklet for both your Health and Dental plans. Turn it into your Safe Harbor Benefits Team May 12th or 13th or to your plan administrator.

If you have any questions related to your Health, Dental or Life Insurance benefits please call our Safe Harbor Benefits Team, (817) 226-3372 and they will be happy to help you.

ANGELS OF CARE Summary of 3 Health Insurance Options

Bryan Keathley, Julissa M. Chubbs, Lytia McGee, Agents
 Safe Harbor Benefits (817) 226-3372

Please call us for any questions & further explanation

<u>Health Insurance Options</u>	Option #1 PPO RM26 <u>Blue Cross</u>	Option #2 PPO RM34 <u>Blue Cross</u>	Option #3 HSA RMH3 <u>Blue Cross</u>
Employee Only (EE)	AOC Contribution \$325/ Month EE Per Paycheck \$112.03	AOC Contribution \$325/ Month EE Per Paycheck \$53.81	AOC Contribution \$325/ Month EE Per Paycheck \$61.83
Employee & Spouse	\$452.65	\$318.75	\$337.19
Employee & Child(ren)	\$321.65	\$216.84	\$231.29
Employee & Family	\$662.28	\$481.80	\$506.66
Website	hcbstx.com Choice Network		
<u>The insured pays:</u>	\$3,000 Individual Deductible \$9,000 Family Deductible 30% In-Network Coinsurance (after deductible) \$5,000 Individual Maximum Coinsurance \$15,000 Family Maximum Coinsurance \$8,000 Individual Maximum Risk \$24,000 Family Maximum Risk Hospital Admission 30% After Deductible Outpatient Surgery 30% After Deductible Dr. Office Co-Pay \$40 Rx Co-Pay \$20 Generic/ \$40 Preferred/ \$60 Non-Formulary	\$10,000 Individual Deductible \$30,000 Family Deductible 25% In-Network Coinsurance (after deductible) \$5,000 Individual Maximum Coinsurance \$15,000 Family Maximum Coinsurance \$15,000 Individual Maximum Risk \$45,000 Family Maximum Risk Hospital Admission 25% After Deductible Outpatient Surgery 25% After Deductible Dr. Office Co-Pay \$40 Rx Co-Pay \$20 Generic/ \$40 Preferred/ \$60 Non-Formulary	\$5,000 Individual Deductible \$10,000 Family Deductible 0% In-Network Coinsurance (after deductible) 0 Individual Maximum Coinsurance 0 Family Maximum Coinsurance \$5,000 Individual Maximum Risk \$10,000 Family Maximum Risk Hospital Admission 0% After Deductible Outpatient Surgery 0% After Deductible Dr. Office Discounted Price (Not A Co-pay) Rx Discounted Price (Not A Co-pay)

Note:

These benefit descriptions are for generalized comparison only, see Blue Cross Blue Shield Benefit Highlights for details. Call The Safe Harbor Benefits Team (817) 266-3372 for any questions related to the information provided on this summary page.

On all options Preventative Care is covered at 100% of the Blue Cross Allowable Amount.

\$15,000 term life insurance only on the employees with health insurance.

Medical plans include a vision discount program available through Davis Vision Network.

Find network providers at www.davisvision.com by clicking "members; and entering client code 2295

This presentation is confidential and proprietary for Angels of Care employees only.

ANGELS OF CARE Summary of Voluntary Dental Plan

Bryan Keathley, Julissa M. Chubbs, Lytia McGee, Agents
Safe Harbor Benefits (817) 226-3372

Please call us for any questions & further explanation

<u>Dental Plan</u>	Voluntary Dental <u>Blue Cross</u>	
	<i>EE Per Month</i>	<i>EE Per Paycheck</i>
Employee Only (EE)	\$22.40	\$10.34
Employee & Spouse	\$47.37	\$21.86
Employee & Child(ren)	\$46.16	\$21.30
Employee & Family	\$72.92	\$33.66
Website for Doctor etc.	bcbstx.com Choice Network	
<u>The insured Pays:</u>	<p>\$50 Individual Deductible \$150 Family Deductible</p> <p>100% Preventative Services Cleanings, X-rays, Deductible Waived</p> <p>80% Basic Services sealants, fillings, and/or extractions</p> <p>50% Major Services crowns, anesthesia, root canals</p> <p>No Waiting Periods</p> <p>No Ortho Coverage</p> <p>\$1000 Calendar Year Maximum Annual Benefit Per person</p>	

Note:

This benefit description is for generalized comparison only, see Blue Cross Blue Shield Benefit Highlights for details.

Call The Safe Harbor Benefits Teams (817) 266-3372 for any questions related to the information provided on this summary page.

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Effective 07/01/11

Preferred Provider Benefit Plan (PPO) – RM26

Extended Care Expenses		PPO (in-network)	Non-PPO (out-of-network)
Extended Care Expenses (must be preauthorized)		100% of Allowable Amount	70% of Allowable Amount after Calendar Year Deductible
Skilled Nursing Facility Home Health Care Hospice Care		Limited to 25 days maximum each Calendar Year* Limited to 60 visits each Calendar Year Unlimited	Calendar Year Deductible
Special Provisions Expenses			
Treatment of Chemical Dependency (must be preauthorized)			
Inpatient treatment must be provided in a Chemical Dependency Treatment Center		Covered as any other sickness	Covered as any other sickness
All other outpatient treatment		Covered as any other sickness	Covered as any other sickness
Serious Mental Illness (must be preauthorized)			
Inpatient Services Hospital services (facility)		70% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Physician services		70% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Outpatient Services Physician office visit/consultation, including lab & x-ray		100% of Allowable Amount after \$40 Copayment Amount	70% of Allowable Amount after Calendar Year Deductible
Other outpatient services, including psychological testing		70% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Mental Health Care (must be preauthorized)			
Inpatient Services Hospital services (facility)		70% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Physician services		70% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Outpatient Services Physician office visit/consultation, including lab & x-ray		100% of Allowable Amount after \$40 Copayment Amount	70% of Allowable Amount after Calendar Year Deductible
Other outpatient services, including psychological testing		70% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Emergency Care/Outpatient Hospital Emergency Room			
Accidental Injury & Medical Emergency Care Facility charges		70% of Allowable Amount after \$100 Copayment Amount (Copayment Amount waived if admitted)	70% of Allowable Amount after Calendar Year Deductible
Non-Emergency Situations Facility charges		70% of Allowable Amount after \$100 Copayment Amount (Copayment Amount waived if admitted)	50% of Allowable Amount after \$100 Copayment Amount & Calendar Year Deductible (Copayment Amount waived if admitted)
Physician charges		70% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible

* Benefits used In-Network and Out-of-Network will apply toward satisfying any day, visit, or Calendar Year Maximum amounts indicated

Preferred Provider Benefit Plan (PPO) – RM26

BENEFIT HIGHLIGHTS		BlueChoice Network	PPO (in-network)	Non-PPO (out-of-network)
Overall Payment Provisions				
Calendar Year Deductible (Combined)				
Applies to all Eligible Expenses (unless otherwise indicated)				
4 th quarter Deductible carryover applies				
Deductible credit from prior carrier (applied on initial group enrollment only)				
Copayment Amounts Required				
Physician office visit/consultation				
Urgent Care center visit		\$40 Copayment Amount		
Outpatient Hospital Emergency Room visit		\$65 Copayment Amount		
Outpatient Hospital Emergency Room visit		\$100 Copayment Amount		\$100 Copayment Amount
Coinsurance Stop-Loss Amount				
Deductibles are not applied to Coinsurance Stop-Loss Amount. Your benefit booklet will provide more details.				
Network Coinsurance Stop-Loss Amount		\$5,000 Individual / \$15,000 Family		\$10,000 Individual / \$30,000 Family
Out-of-Network Coinsurance Stop-Loss Amount will only apply toward Network Coinsurance Stop-Loss Amount				
Credit for Coinsurance Stop-Loss Amount from prior carrier (applied on initial group enrollment only)		Yes	Yes	Yes
Maximum Lifetime Benefits				
Per individual				
Unlimited				
Inpatient Hospital Expenses				
Inpatient Hospital Expenses (must be preauthorized)				
Inpatient Hospital Expenses		70% of Allowable Amount after Calendar Year Deductible		50% of Allowable Amount after Calendar Year Deductible
Penalty for failure to preauthorize		None		\$250
Medical/Surgical Expenses				
Medical / Surgical Expenses				
Physician office visit/consultation, including lab & x-ray		100% of Allowable Amount after \$40 Copayment Amount		70% of Allowable Amount after Calendar Year Deductible
Physician surgical services in any setting		70% of Allowable Amount after Calendar Year Deductible		50% 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
Certain Diagnostic Procedures: Bone Scan, Cardiac Stress Test, CT Scan (with or without contrast), Ultrasound, MRI, Myelogram, PET Scan		70% of Allowable Amount after Calendar Year Deductible		50% of Allowable Amount after Calendar Year Deductible
Home Infusion Therapy (must be preauthorized)		70% of Allowable Amount after Calendar Year Deductible		50% of Allowable Amount after Calendar Year Deductible
In Vitro Fertilization Services		Declined		Declined
All other outpatient services and supplies		70% of Allowable Amount after Calendar Year Deductible		50% of Allowable Amount after Calendar Year Deductible

Preferred Provider Benefit Plan (PPO) – RM26

EMPLOYEE INFORMATION

The following benefits apply to dependent coverage:

- Dependent children are covered for maternity benefits.
- 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 BCBSX and are paid according to this BCBSX-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 BCBSX-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 Out-of-Network 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 twelvemonth 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.

Renewal 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 BCBSX (the contract date).

- 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.bcbsx.com to use our Provider Finder tool.

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 Extrajurisdictional 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.

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

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

BCBSX Representative Name
(Please type or print) _____ Signature _____ Date _____

Preferred Provider Benefit Plan (PPO) – RM26

Special Provisions Expenses, cont.

	PPO (In-Network)	Non-PPO (Out-of-Network)
Urgent Care Services Urgent Care center visit, including all lab & x-ray services, except Certain Diagnostic Procedures	100% of Allowable Amount after \$65 Copayment Amount	70% of Allowable Amount after Calendar Year Deductible
Certain Diagnostic Procedures and all services and supplies	70% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Preventive Care Routine annual physicals, well-baby care, immunizations (after 6th birthday), and other preventive health services as determined by the USPSTF	100% of Allowable Amount	70% of Allowable Amount after Calendar Year Deductible
Immunizations (birth through the day of the 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 Hearing Aids	Covered same as any other sickness 70% of Allowable Amount after Calendar Year Deductible	Covered same as any other sickness 50% of Allowable Amount after Calendar Year Deductible
Hearing Aids Maximum Benefit	Hearing aids are subject to a \$1,000 maximum amount each 36-month period*	
Physical Medicine Services Physical Medicine services (includes but is not limited to physical, occupational, and manipulative therapy)	70% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Calendar Year (Maximum)	Limited to 35 visits each Calendar Year*	

* All benefit payments made for both In-Network and Out-of-Network services will apply toward any maximum amounts indicated.

Prescription Drug Program	Participating Pharmacy	Non-Participating Pharmacy (member pays claim)
Prescription Drugs		
Retail Prescription** (All Copayment Amounts are per 30-day supply and will not apply to Generic Stop-Loss Amount)		
Generic		80% of Allowable Amount minus Copayment Amount
Preferred Brand Name	\$20 Copayment Amount	80% of Allowable Amount minus Copayment Amount
Non-Preferred Brand Name	\$40 Copayment Amount	80% of Allowable Amount minus Copayment Amount
Mail Service Prescription** (All Copayment Amounts are per 30-day supply and will not apply to Generic Stop-Loss Amount)		
Generic	\$20 Copayment Amount	
Preferred Brand Name	\$40 Copayment Amount	
Non-Preferred Brand Name	\$60 Copayment Amount	

**Generic Incentive: Members electing to purchase Preferred/Non-Preferred Brand Name Drugs when 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.

Diabetes Supplies are available under the Prescription Drug Program portion of your plan. Diabetes 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, glucoagon 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.

Preferred Provider Benefit Plan (PPO) – RM34



BENEFIT HIGHLIGHTS
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.

	PPO (in-network)	Non-PPO (out-of-network)
Overall Payment Provisions		
Calendar Year Deductible (Combined) Applies to all Eligible Expenses (unless otherwise indicated).		\$100,000 Individual / \$300,000 Family
4 th quarter Deductible carryover applies Deductible credit from prior carrier (applied on initial group enrollment only)	Yes	Yes
Copayment Amounts Required Physician office visit/consultation	\$40 Copayment Amount	
Urgent Care center visit	\$65 Copayment Amount	
Outpatient Hospital Emergency Room visit	\$100 Copayment Amount	\$100 Copayment Amount
Coinsurance Stop-Loss Amount Deductibles are not applied to Coinsurance Stop-Loss Amount. Your benefit booklet will provide more details.	\$5,000 Individual / \$15,000 Family Network Coinsurance Stop-Loss Amount will only apply toward Network Coinsurance Stop-Loss Amount	\$10,000 Individual / \$30,000 Family Out-of-Network Coinsurance Stop-Loss Amount will also apply toward Network Coinsurance Stop-Loss Amount
Credit for Coinsurance Stop-Loss Amount from prior carrier (applied on initial group enrollment only)	Yes	Yes
Maximum Lifetime Benefits Per individual	Yes	Unlimited
Inpatient Hospital Expenses Inpatient Hospital Expenses	75% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Penalty for failure to preauthorize	None	\$250
Medical / Surgical Expenses Medical / Surgical Expenses	100% of Allowable Amount after Calendar Copayment Amount	70% of Allowable Amount after Calendar Year Deductible
Physician office visit/consultation, including lab & x-ray	75% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Physician surgical services in any setting	75% of Allowable Amount after Calendar Year Deductible	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
Certain Diagnostic Procedures: Bone Scan, Cardiac Stress Test, CT Scan (with or without contrast), Ultrasound, MRI, Myelogram, PET Scan	75% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Home Infusion Therapy (must be preauthorized)	75% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
In Vitro Fertilization Services	Declined	Declined
All other outpatient services and supplies	75% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible

Preferred Provider Benefit Plan (PPO) – RM34



Extended Care Expenses
(must be preauthorized)

	PPO (in-network)	Non-PPO (out-of-network)
Extended Care Expenses Skilled Nursing Facility Home Health Care Hospice Care	100% of Allowable Amount Limited to 25 days maximum each Calendar Year* Limited to 60 visits each Calendar Year Unlimited	70% of Allowable Amount after Calendar Year Deductible
Special Provisions Expenses		
Treatment of Chemical Dependency (must be preauthorized)	Covered as any other sickness	Covered as any other sickness
Inpatient treatment must be provided in a Chemical Dependency Treatment Center	Covered as any other sickness	Covered as any other sickness
All other outpatient treatment	Covered as any other sickness	Covered as any other sickness
Serious Mental Illness (must be preauthorized)		
Inpatient Services Hospital services (facility)	75% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Physician services	75% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Outpatient Services Physician office visit/consultation, including lab & x-ray	100% of Allowable Amount after \$40 Copayment Amount	70% of Allowable Amount after Calendar Year Deductible
Other outpatient services, including psychological testing	75% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Mental Health Care (must be preauthorized)		
Inpatient Services Hospital services (facility)	75% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Physician services	75% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Outpatient Services Physician office visit/consultation, including lab & x-ray	100% of Allowable Amount after \$40 Copayment Amount	70% of Allowable Amount after Calendar Year Deductible
Other outpatient services, including psychological testing	75% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Emergency Care/Outpatient Hospital Emergency Room Accidental Injury & Medical Emergency Care Facility charges	75% of Allowable Amount after \$100 Copayment Amount (Copayment Amount waived if admitted)	75% of Allowable Amount after Calendar Year Deductible
Physician charges	75% of Allowable Amount after \$100 Copayment Amount (Copayment Amount waived if admitted)	50% of Allowable Amount after \$100 Copayment Amount & Calendar Year Deductible (Copayment Amount waived if admitted)
Physician charges	75% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible

* Benefits used In-Network and Out-of-Network will apply toward satisfying any day, visit, or Calendar Year Maximum amounts indicated

Preferred Provider Benefit Plan (PPO) – RM34

EMPLOYEE INFORMATION

The following benefits apply to dependent coverage:

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- 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 BCBS TX and are paid according to this BCBS TX-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 BCBS TX-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 Plan/Plan 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.

Repealment 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 BCBS TX (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 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 Extrajurisdictional 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.

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

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

BCBS TX Representative Name
(Please type or print) _____ Signature _____ Date _____

Preferred Provider Benefit Plan (PPO) – RM34

Special Provisions Expenses, cont.

Urgent Care Services

	PPO (In-Network)	Non-PPO (Out-of-Network)
Urgent Care center visit, including all lab & x-ray services, except Certain Diagnostic Procedures	100% of Allowable Amount after Copayment Amount	70% of Allowable Amount after Calendar Year Deductible
Certain Diagnostic Procedures and all services and supplies	75% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Preventive Care Routine annual physicals, well-baby care, immunizations (after 6th birthday), and other preventive health services as determined by the USPSTF	100% of Allowable Amount	70% of Allowable Amount after Calendar Year Deductible
Speech and Hearing Services Immunizations (birth through the day of the 6th birthday)	100% of Allowable Amount	100% of Allowable Amount
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	75% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Hearing Aids Maximum Benefit	Hearing aids are subject to a \$1,000 maximum amount each 36-month period*	

Physical Medicine Services

Physical Medicine Services (includes but is not limited to physical, occupational, and manipulative therapy)	75% of Allowable Amount after Calendar Year Deductible	50% of Allowable Amount after Calendar Year Deductible
Calendar Year Maximum	Limited to 35 visits each Calendar Year*	

*All benefit payments made for both In-Network and Out-of-Network services will apply toward the Maximum Lifetime Benefits amount.

Prescription Drug Program

Prescription Drugs

	Participating Pharmacy	Non-Participating Pharmacy (member files claim)
Retail Prescription** (All Copayment Amounts are per 30-day supply and will not apply to Coinsurance Stop-Loss Amount)		
Generic	\$20 Copayment Amount	80% of Allowable Amount minus Copayment Amount
Preferred Brand Name	\$40 Copayment Amount	80% of Allowable Amount minus Copayment Amount
Non-Preferred Brand Name	\$60 Copayment Amount	80% of Allowable Amount minus Copayment Amount
Mail Service Prescription** (All Copayment Amounts are per 30-day supply and will not apply to Coinsurance Stop-Loss Amount)		
Generic	\$20 Copayment Amount	\$20 Copayment Amount
Preferred Brand Name	\$40 Copayment Amount	\$40 Copayment Amount
Non-Preferred Brand Name	\$60 Copayment Amount	\$60 Copayment Amount

**Generic-Incentive Members electing to purchase Preferred/Non-Preferred Brand Name Drugs when 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.

Diabetes Supplies are available under the Prescription Drug Program portion of your plan. Diabetes Supplies include insulin and insulin analog preparations, insulin syringes necessary for self-administration, prescriptive oral agents, all required test strips and tablets which test for glucose, ketones, and protein, lancets and lancet devices, biohazard disposable containers, glucoagon 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.



BENEFIT HIGHLIGHTS		BlueChoice Network	
<i>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.</i>			
Overall Payment Provisions	PPO (In-Network)	Non-PPO (Out-of-Network)	
Calendar Year Deductible Applies to all Eligible Expenses (unless otherwise indicated).			
Family coverage: When one family member meets the individual Deductible, benefits become available under the plan for that individual.	\$5,000 Individual / \$10,000 Family	\$10,000 Individual / \$20,000 Family	
4 th quarter Deductible carryover provision does not apply	Yes	Yes	
Deductible credit from prior carrier (applied on initial group enrollment only)	Yes	Yes	
Out-of-Pocket Maximum Deductible, Copayment Amounts, and Copayments (if any) apply to Out-of-Pocket Maximum.	\$5,000 Individual / \$10,000 Family	\$20,000 Individual / \$40,000 Family	
Credit for Out-of-Pocket Maximum from prior carrier (applied on initial group enrollment only)	Network Deductible & Out-of-Pocket Maximum will only apply toward Network Deductible & Out-of-Pocket Maximum	Out-of-Network Deductible & Out-of-Pocket Maximum will also apply toward Network Deductible & Out-of-Pocket Maximum	
Maximum Lifetime Benefits Per individual	Unlimited	Unlimited	
Inpatient Hospital Expenses (must be preauthorized)	100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible	
Penalty for failure to preauthorize	None	\$250	
Medical / Surgical Expenses			
Medical / Surgical Expenses Physician office visit/consultation, including lab & x-ray Physician surgical services in any setting Lab & x-ray in other outpatient facilities & Certain Diagnostic Procedures: Bone Scan, Cardiac Stress Test, CT Scan (with or without contrast), Ultrasound, MRI, Myelogram, PET Scan Home Infusion Therapy (must be preauthorized)	100% of Allowable Amount after Calendar Year Deductible 100% of Allowable Amount after Calendar Year Deductible 100% of Allowable Amount after Calendar Year Deductible 100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible 70% of Allowable Amount after Calendar Year Deductible 70% of Allowable Amount after Calendar Year Deductible 70% of Allowable Amount after Calendar Year Deductible	
In Vitro Fertilization Services	Declined	Declined	
All other outpatient services and supplies	100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible	

Extended Care Expenses	PPO (In-Network)	Non-PPO (Out-of-Network)
Extended Care Expenses (must be preauthorized) Skilled Nursing Facility Home Health Care Hospice Care	100% of Allowable Amount after Calendar Year Deductible Limited to 25 days maximum each Calendar Year* Unlimited	70% of Allowable Amount after Calendar Year Deductible
Special Provisions Expenses		
Treatment of Chemical Dependency (must be preauthorized)	Covered as any other physical illness	Covered as any other physical illness
Inpatient treatment must be provided in a Chemical Dependency Treatment Center	Covered as any other physical illness	Covered as any other physical illness
All other outpatient treatment	Covered as any other physical illness	Covered as any other physical illness
Serious Mental Illness (must be preauthorized)		
Inpatient Services Hospital services (facility)	100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
Physician services	100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
Outpatient Services Services performed in a Physician's office, including lab & x-ray	100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
Other outpatient services and psychological testing	100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
Mental Health Care (must be preauthorized)		
Inpatient Services Hospital services (facility)	100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
Physician services	100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
Outpatient Services Services performed in a Physician's office, including lab & x-ray	100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
Other outpatient services and psychological testing	100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible

* Benefits used In-Network and Out-of-Network will apply toward satisfying any day, wait, Calendar Year, or Lifetime Maximum amounts indicated.

	PPO (In-Network)	N.O.P.P.O. (Out-of-Network)
Special Provisions Expenses, cont.		
Emergency Care/Outpatient Hospital Emergency Room Accidental Injury & Medical Emergency Care		
Facility charges:	100% of Allowable Amount after Calendar Year Deductible	100% of Allowable Amount after Calendar Year Deductible
Physician charges:	100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
Non-Emergency Situations		
Facility charges:	100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
Physician charges:	100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
Urgent Care		
Each Urgent Care center visit, including all lab & x-ray services, certain Diagnostic Procedures, and all other services and supplies:	100% of Allowable Amount	70% of Allowable Amount
Preventive Care		
Routine annual physicals, well-baby care, immunizations (after 6 th birthday), and other preventive health services as determined by the USPSTF:	100% of Allowable Amount	100% of Allowable Amount
Speech and Hearing Services		
Immunizations (both through the day of the 6 th birthday):	Covered same as any other sickness	Covered same as any other sickness
Services to restore loss of or correct an impaired speech or hearing function with hearing aids:	100% of Allowable Amount after Calendar Year Deductible	100% of Allowable Amount after Calendar Year Deductible
Hearing Aids:	Hearing aids are subject to a \$1,000 maximum amount each 36-month period*	100% of Allowable Amount after Calendar Year Deductible
Hearing Aids Maximum Benefit:	Limited to 35 visits each Calendar Year*	70% of Allowable Amount after Calendar Year Deductible
Physical Medicine Services		
Physical Medicine Services (includes but is not limited to physical, occupational, and manipulative therapy):	100% of Allowable Amount after Calendar Year Deductible	70% of Allowable Amount after Calendar Year Deductible
Calendar Year Maximum:	Limited to 35 visits each Calendar Year*	Limited to 35 visits each Calendar Year*
* Benefits used In-Network and Out-of-Network will apply toward satisfying any day, visit, Calendar Year, or Lifetime Maximum amounts indicated.		
Prescription Drug Program	Participating Pharmacy	Non-Participating Pharmacy (member files claim)
Prescription Drugs		
Retail Pharmacy (Dispensing is limited to a 30-day supply, no more than a 90-day supply)	100% of Allowable Amount after the Calendar Year Deductible	70% of Allowable Amount after the Calendar Year Deductible
Mail Service Pharmacy (Dispensing is limited to a 30-day supply, no more than a 90-day supply)	100% of Allowable Amount after the Calendar Year Deductible	70% of Allowable Amount after the Calendar Year Deductible

EMPLOYEE INFORMATION

- **The following applies to dependent coverage:**
 - Dependent children covered for maternity benefits.
 - 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.
- **Payment of work required to accept amounts negotiated with BCBSX and are paid according to this BCBSX-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 BCBSX-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 Plan Providers and the definition of Allowable Amount in the benefit booklet.
- **Preexisting condition 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.
- **Reimbursement of Medical Expenses:** 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:
 - 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.
- **Deductible (Embedded):** The benefits of the Plan will be available after satisfaction of the applicable Deductible. The Deductible will be increased in the future in direct proportion to the increase as determined from the cost-of-living adjustments based on the Consumer Price Index (CPI-U). The Deductibles are explained as follows:
 1. The individual Deductible amount as shown on this Benefits Highlights under "Calendar Year Deductible," must be satisfied by each Participant under your coverage each Calendar Year. This Deductible, unless otherwise indicated, will apply to all combined Inpatient, Hospital Expenses, Medical-Surgical Expenses, Extended Care Expenses, and Special Provisions Expenses you incur during a Calendar Year.
 2. If you have several covered Dependents, all charges used to apply toward a "per individual" Deductible amount will be applied toward the "per family" Deductible amount shown on this Benefits Highlights. When that family Deductible amount is reached, no further individual Deductibles will have to be satisfied for the remainder of that Calendar Year. No Participant will contribute more than the individual Deductible amount to the "per family" Deductible amount.
- **Out-of-Pocket Maximum:** Most of your Eligible Expense payment obligations are applied to the Out-of-Pocket Maximum. The Out-of-Pocket Maximum will be increased in the future in direct proportion to the increase as determined from the cost-of-living adjustments based on the Consumer Price Index (CPI-U).
 1. The Out-of-Pocket Maximum will not include:
 - Services, supplies, or charges limited or excluded by the Plan;
 - Expenses not covered because of a benefit maximum has been reached;
 - Any Eligible Expense paid by the Primary Plan when BCBSX is the Secondary Plan for purposes of coordination of benefits;
 - Penalties for failing to obtain preauthorization.
 2. When the Out-of-Pocket Maximum amount for the In-Network or Out-of-Network Benefits level for a Participant in a Calendar Year equals the "per individual" "Out-of-Pocket Maximum" shown on this Benefits Highlights for that level, the benefit percentages automatically increase to 100% for purposes of determining the benefits available for additional Eligible Expenses incurred by that Participant for the remainder of that Calendar Year for that level.
 3. When the Out-of-Pocket Maximum amount for the In-Network or Out-of-Network Benefits level for all Participants under your coverage in a Calendar Year equals the "per family" "Out-of-Pocket Maximum" shown on this Benefits Highlights for that level, the benefit percentages automatically increase to 100% for purposes of determining the benefits available for additional Eligible Expenses incurred by all family Participants for the remainder of the Calendar Year for that level. No Participant will be required to contribute more than the individual Out-of-Pocket Maximum to the family Out-of-Pocket Maximum.

† Please be reminded that Health Savings Accounts (HSAs) have tax and legal ramifications. Blue Cross and Blue Shield of Texas does not provide legal or tax advice, and nothing herein should be construed as legal or tax advice. These materials, and any tax-related statements in them, are not intended or written to be used, and cannot be used or relied on, for the purpose of avoiding tax penalties. Tax-related statements, if any, may have been written in connection with the promotion or marketing of the transaction(s) or matter(s) addressed by these materials. You should seek advice based on your particular circumstances from an independent tax advisor regarding the tax consequences of specific health insurance plans or products.

Blue Cross® and Blue Shield® of Texas*
BlueCare® Freedom Dental
D201 Summary of Benefits

TYPE OF SERVICE	BENEFIT**
GENERAL PROVISIONS Calendar Year Deductible (4th quarter carryover applies) Deductible Credit from Prior Carrier Calendar Year Maximum per Participant	\$50 Indiv/\$150 Family No \$1000
DIAGNOSTIC AND PREVENTIVE CARE BENEFITS (deductible waived) Oral Examinations (2 exams per Calendar Year) Prophylaxis (2 cleanings per Calendar Year) Fluoride Treatment Dental X-rays (Subject to booklet provisions)	100%
MISCELLANEOUS SERVICES Sealants/ Space Maintainers / Lab Tests / Palliative Care	80%
RESTORATIVE SERVICES Amalgams & Composites / Simple Extractions / Pin Retention	80%
GENERAL SERVICES Anesthesia / Stainless Steel Crowns	50%
ENDODONTIC SERVICES Root canal therapy/ Direct pulp cap / Apicoectomy/apexification / Retrograde filling Root amputation/hemisection / Therapeutic pulpotomy / Gross pulpal debridement	50%
PERIODONTAL SERVICES Periodontal scaling and root planning / Full mouth debridement / Gingivectomy/gingivoplasty Gingival flap procedure/ Osseous surgery/ Osseous grafts / Soft tissue grafts	50%
ORAL SURGERY SERVICES Surgical tooth extractions/ Alveoloplasty / Vestibuloplasty	50%
CROWNS, INLAYS/ONLAYS SERVICES Prefabricated post and cores / Recementation of crowns, inlays/onlays / Crown repair	50%
PROSTHODONTIC SERVICES Reline/Rebase / Bridges and dentures / Recementation and repair of bridges	50%
ORTHODONTIC BENEFITS Orthodontic Diagnostic Procedures and Treatment / Available to Adults and Children Lifetime Maximum per Participant	N/A N/A

** If services are provided by a BlueCare Dentist, the benefits described above will be paid based on the Allowable Amount for BlueCare Dentists which is a reduced fee schedule (this means less out-of-pocket). The BlueCare Dentist cannot balance bill for charges in excess of the Allowable Amount. If services are provided by a non-BlueCare dentist, the benefits will be based on the lesser of the billed charges or the amount BCBSTX would have considered for payment for the same covered procedure, service or supply provided by a Dentist with similar experience and/or skill in the same locale. It is possible for the non-BlueCare Dentist to balance-bill for amounts above that which BCBSTX allows, resulting in higher out-of-pocket expenses.

- This is a general summary of your benefit design. Please refer to your benefit booklet for other details and for limitations and exclusions.
- The following eligibility provisions apply:
 - Dependent children are covered to age 25. Disabled dependent children can be covered beyond age 25.
 - Retirees are not eligible for coverage.
 - Employees may enroll dependent children up to age 5 on the first of the month following application with no late enrollment penalty.
 - Open enrollment – employees and/or dependents not presently covered may enroll for dental 31 days prior to the anniversary date.
- A preexisting condition exclusion will apply to expenses involving the replacement of teeth that were missing prior to the effective date of the dental contract. This exclusion will not apply to:
 - Any participant who becomes effective on the dental contract date who was covered under a previous group dental care contract by the Employer.
 - Any participant who has been continuously covered for 24 months under a group dental care contract with BCBSTX which included prosthetic benefits.
- When the course of treatment will be in excess of \$300, a predetermination request should be submitted to BCBSTX in advance of treatment.
- Plan D201 is available to group sizes of 2 or more employees.

Value-Added Vision Program offered by Davis Vision for Blue Cross and Blue Shield of Texas members



Please call Davis Vision at **1-800-501-1459** with questions
or visit our open enrollment Web site:

www.davisvision.com and enter control code **2295**

Blue Cross and Blue Shield of Texas (BCBSTX) is very pleased to provide you with this information about your value-added vision program through Davis Vision, Inc., a leading national provider of routine vision care programs.

Who are the network providers?

Please call Davis Vision at **1-800-501-1459** to obtain a list of the network providers nearest you, or you may access our Web site at **www.davisvision.com** and utilize our "Open Enrollment" feature. You will be prompted to enter your Client Control Number, which is **2295**.

How do I receive services from a Davis Vision network provider?

- Call the network provider of your choice and schedule an appointment.
- Identify yourself as a Davis Vision plan participant and a BCBSTX member.
- Present your BCBSTX ID card at the time of your visit. Your Davis Vision ID number will be the same as your member number on your BCBSTX ID card.

It's that easy to receive services!

Information about Laser Vision Correction:

Davis Vision is pleased to provide you and your eligible dependents with the opportunity to receive Laser Vision Correction Services at significant discounts through the Davis Vision network.

Mail order contact lenses:

Lens 123 is a fast and convenient way to purchase replacement contact lenses at significant savings. For more information, please call 1-800-LENS-123 (1-800-536-7123) or visit the Lens 123 Web site at **www.Lens123.com**.

Are there any exclusions?

The following items are not covered by this vision program:

- Medical treatment of eye disease or injury.
- Vision therapy.
- Special lens designs or coatings, other than those previously described.
- Services preformed by an out-of-network location.
- Replacement of lost eyewear.
- Services not performed by licensed personnel.

Member Discount Fee Schedule:¹

Eye Examinations²	You Pay:
Complete Examination	15% off or \$5 off retail cost
Contact Lens Examination	15% off or \$10 off retail cost
Frames³	
Priced up to \$70 retail	\$40
Priced over \$70 retail	\$40 plus 10% off the amount over \$70
Spectacle Lenses (Uncoated plastic)³	
Single Vision	\$35
Bifocal	\$55
Trifocal	\$65
Lenticular	\$110
Contact Lenses	
Conventional ²	20% off
Disposable/Planned Replacement ²	10% off
Spectacle Lens Options (Add to lens prices)³	
Standard Progressive ⁴	\$60 or \$75
Premium Progressive ⁴	\$110 or \$125
Glass Lenses	\$18
Polycarbonate Lenses	\$30
Blended Invisible Bifocals	\$20
Intermediate Vision Lenses	\$30
Photogrey Extra® Lenses	\$35
Scratch-resistant Coating	\$15
ARC (anti-reflective coating)	\$45
Ultraviolet (UV) Coating	\$15
Solid Tint	\$10
Gradient Tint	\$12
Hi-Index Lenses	\$55
Plastic Photosensitive Lenses	\$65
Polarized Lenses	\$75

¹ Due to **Wal-Mart's** everyday low prices members will receive services at or below the Davis Vision discount fee schedule.

² Discount will be applied to the Usual and Customary price for services.

³ Special lens designs, materials, powers and frames may require additional cost.

⁴ Pricing at some retail locations may vary.

The relationship between Blue Cross and Blue Shield of Texas and Davis Vision, Inc is that of independent contractors. This is a value-added vision program only. However, some of the services offered may be covered under your health plan. To find out if you have vision benefits through your plan, refer to your coverage documents. Use of this program does not affect your premium, nor do costs of the program services and products count toward calendar year or lifetime maximums and/or plan deductibles.

LIFE INSURANCE HIGHLIGHTS

For the employee

*Flexible Premium Life Insurance to Age 121
Policy Form PRFNG-NI-07 or ICC-07-PRFNG-NI-07*



Voluntary permanent life insurance can be an ideal complement to the group term and optional term your employer might provide. Designed to be in force when you die, this voluntary universal life product is yours to keep, even when you change jobs or retire, as long as you pay the necessary premium. Group and voluntary term, on the other hand, typically is not portable if you change jobs and, even if you can keep it after you retire, usually costs more and declines in death benefit.

The policy, PURELIFE, is underwritten by Texas Life Insurance Company, and it has these outstanding features:

- **High Death Benefit.** With one of the highest death benefits available at the worksite,¹ PURELIFE gives your loved ones peace of mind, knowing there will be significant life insurance in force should you die prematurely.
- **Minimal Cash Value.** Designed to provide high death benefit, PURELIFE does not compete with the cash accumulation in your employer-sponsored retirement plans.
- **Long Guarantees.** Enjoy the assurance of a policy that has a guaranteed death benefit to age 121 and level premium that guarantees coverage for a significant period of time (after the guaranteed period, premiums may go down, stay the same, or go up).
- **Refund of Premium.** Unique in the marketplace, PURELIFE offers you a refund of five years' premium, should you surrender the policy if the premium you pay when you buy the policy ever increases. *(Conditions apply.)*
- **Accelerated Death Benefit Rider.** Should you be diagnosed as terminally ill with the expectation of death within 12 months, you will have the option to receive 92% of the death benefit (percentages lower in Massachusetts), minus a \$150 administrative fee. This valuable living benefit gives you peace of mind knowing that, should you need it, you can take the large majority of your death benefit while still alive. *(Conditions apply.)*

You may apply for this permanent, portable coverage, not only for yourself, but also for your spouse, minor children and grandchildren.

¹ Voluntary and Universal Whole Life Products, Eastbridge Consulting Group, October 2008

See the PURELIFE brochure for details.

TEXASLIFE INSURANCE COMPANY

Since 1901 | 900 WASHINGTON | POST OFFICE BOX 830 | WACO, TEXAS 76703-0830

PureLife Standard Risk Table Premiums — Express Issue

Issue Age (ALB)	Bi-Weekly Premiums for Life Insurance Face Amounts Shown									GUARANTEED PERIOD Age to Which Coverage is Guaranteed at Table Premium	
	\$10,000	\$15,000	\$20,000	\$25,000	\$30,000	\$40,000	\$50,000	\$75,000	\$100,000		
15D-10				3.00							63
11-15				3.24							61
16				3.58							64
17-20				3.58	4.16	5.31	6.47	9.35	12.24		60
21				3.81	4.44	5.68	6.93	10.04	13.16		62
22				3.81	4.44	5.68	6.93	10.04	13.16		61
23-25				3.93	4.57	5.87	7.16	10.39	13.62		59
26				4.04	4.71	6.05	7.39	10.74	14.08		59
27-28				4.16	4.85	6.24	7.62	11.08	14.54		58
29				4.27	4.99	6.42	7.85	11.43	15.00		58
30-31				4.39	5.13	6.60	8.08	11.77	15.47		56
32				4.62	5.40	6.97	8.54	12.47	16.39		57
33				4.85	5.68	7.34	9.00	13.16	17.31		58
34				5.08	5.96	7.71	9.47	13.85	18.24		58
35				5.43	6.37	8.27	10.16	14.89	19.62		60
36				5.66	6.65	8.64	10.62	15.58	20.54		60
37				5.89	6.93	9.00	11.08	16.27	21.47		60
38				6.24	7.34	9.56	11.77	17.31	22.85		61
39				6.70	7.90	10.30	12.70	18.70	24.70		63
40				7.16	8.45	11.04	13.62	20.08	26.54		64
41				7.74	9.14	11.96	14.77	21.81	28.85		65
42				8.54	10.11	13.25	16.39	24.24	32.08		67
43				9.35	11.08	14.54	18.00	26.66	35.31		69
44				10.16	12.05	15.84	19.62	29.08	38.54		71
45				11.08	13.16	17.31	21.47	31.85	42.24		72
46				12.00	14.27	18.79	23.31	34.62	45.93		73
47				12.81	15.24	20.08	24.93	37.04	49.16		74
48				13.74	16.34	21.56	26.77	39.81	52.85		75
49				14.77	17.59	23.22	28.85	42.93	57.00		76
50	6.84	9.90	12.97	16.04	19.11	25.25	31.39				77
51	7.44	10.80	14.17	17.54	20.91	27.65	34.39				78
52	8.17	11.91	15.65	19.39	23.13	30.60	38.08				80
53	8.91	13.02	17.13	21.24	25.34	33.56	41.77				82
54	9.65	14.13	18.60	23.08	27.56	36.51	45.47				83
55	10.30	15.10	19.90	24.70	29.50	39.10	48.70				84
56	10.76	15.79	20.82	25.85	30.88	40.94	51.00				84
57	11.08	16.27	21.47	26.66	31.85	42.24	52.62				83
58	11.45	16.83	22.20	27.58	32.96	43.71	54.47				83
59	11.91	17.52	23.13	28.74	34.34	45.56	56.77				83
60	12.60	18.56	24.51	30.47	36.42	48.33	60.24				83
61	13.67	20.15	26.64	33.12	39.60	52.57	65.54				84
62	14.96	22.09	29.22	36.35	43.48	57.74	72.00				86
63	16.39	24.24	32.08	39.93	47.77	63.47	79.16				88
64	17.82	26.38	34.94	43.50	52.07	69.19	86.31				90
65	19.16	28.39	37.62	46.85	56.08	74.54	93.00				91
66	20.73										94
67	21.93										95
68	23.17										95
69	24.24										95
70	25.16										93

PureLife is permanent life insurance to Attained Age 121 that can never be cancelled as long as you pay the necessary premiums. After the Guaranteed Period, the premiums can be lower, the same, or higher than the Table Premium. See the brochure under "Permanent Coverage".

ANGELS OF CARE 401(K) PLAN ENROLLMENT INFORMATION

TYPE OF PLAN: Non-Standard 401(k) Profit Sharing Plan Plan Number: #001

PLAN YEAR: January 1st through December 31st

PLAN ADMINISTRATOR: Angels of Care Pediatric Home Health Corp
8001 S. Highway 75, Sherman, TX 75090

ADDITIONAL PARTICIPATING EMPLOYERS: AOC Senior Home Health Corp
AOC-DME Corp
AOC Services, Inc.

ELIGIBILITY: You will be eligible to begin making 401(k) contributions to the Plan if you are 18 years old and complete 30-days as a full time employee. You may enter the Plan on the first day of any month following meeting these requirements. You must complete 500 hours of service within the 6 month time period following your Date of Hire to become eligible to receive a portion of any contributions your Employer makes to the Plan.

PARTICIPATION:

As a participant in the 401(k) arrangement, you may enter into a salary reduction agreement with the Employer. You may elect to defer up to \$16,500 for 2011. "Catch-Up" Contributions of an additional \$5,500 may be contributed by participants at least 50 years of age during 2011.

The amount you elect to defer and any earnings thereon will not be subject to income tax until it is distributed to you from the Plan. However, it will be subject to Social Security taxes.

You are not required to contribute any money in order to participate in our Plan. However, you may receive additional amounts, called "matching contributions" if you contribute a portion of your wages.

At your Employer's sole discretion, your Employer may also contribute "profit sharing" funds to the accounts of all eligible participants. In order to receive a profit sharing plan contribution, you must be employed by the Employer on the last day of the Plan Year and must complete at least 1,000 Hours of Service during the Plan Year.

VESTING:

Employee 401(K) Plan Contributions are **immediately 100% vested**. Contributions made by your Employer (matching and discretionary contributions) are subject to the Plan's vesting requirements. You will receive credit for a year of service each time you complete a minimum of 1,000 hours of service during the Plan Year. The Plan excludes any year of service prior to 2006 or before you reach age 18.

Vesting Schedule

2 years	20%
3 years	40%
4 years	60%
5 years	80%
6 years	100%

WITHDRAWALS:

Withdrawals from your retirement account are not permitted prior to age 65, except in the event of death, total disability, proven financial hardship (*IRS Safe Harbor Rules apply*), or upon termination of employment. Distributions are made as soon as administratively feasible following a Participant's Separation from Service.

ENROLLMENT:

Please call your Employer's Human Resources department for enrollment and beneficiary forms. Contact our Investment Advisor, Bryan Keathley at Safe Harbor Benefits, Inc. 817-226-3372 for information on portfolio choices.

BLUE CROSS BLUE SHIELD ENROLLMENT FORM

ANGELS OF CARE

Name:	Date of Birth:
Address:	Date of Hire:
	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Social Security #:	Email:
Home Phone #:	Business Phone #:

SELECT COVERAGE:

MEDICAL OPTION #1: <input type="checkbox"/> PPO RM-26		<input type="checkbox"/> Decline Medical	
Select Enrollees: (per paycheck cost)			
<input type="checkbox"/> Employee Only (\$112.03)	<input type="checkbox"/> Employee/Children (\$321.65)		
<input type="checkbox"/> Employee/ Spouse (\$452.65)	<input type="checkbox"/> Employee/Family (\$662.28)		

MEDICAL OPTION #2: <input type="checkbox"/> PPO RM-34		<input type="checkbox"/> Decline Medical	
Select Enrollees: (per paycheck cost)			
<input type="checkbox"/> Employee Only (\$53.81)	<input type="checkbox"/> Employee/Children (\$216.84)		
<input type="checkbox"/> Employee/ Spouse (\$318.75)	<input type="checkbox"/> Employee/Family (\$481.80)		

MEDICAL OPTION #3: <input type="checkbox"/> HSA RMH-3		<input type="checkbox"/> Decline Medical	
Select Enrollees: (per paycheck cost)			
<input type="checkbox"/> Employee Only (\$61.83)	<input type="checkbox"/> Employee/Children (\$231.29)		
<input type="checkbox"/> Employee/ Spouse (\$337.19)	<input type="checkbox"/> Employee/Family (\$506.66)		

DENTAL: <input type="checkbox"/> D201		<input type="checkbox"/> Decline Dental	
Select Enrollees: (per paycheck cost)			
<input type="checkbox"/> Employee Only (\$10.34)	<input type="checkbox"/> Employee/Children (\$21.30)		
<input type="checkbox"/> Employee/ Spouse (\$21.86)	<input type="checkbox"/> Employee/Family (\$33.66)		

List Dependents to be enrolled:

Name	Gender	Relationship	Date of Birth	Social Security Number	Home Address if different from employee's
		Spouse			
		Child			
		Child			
		Child			
		Child			
		Child			

Term Life and AD&D Insurance – Free \$15,000 for Full Time Employee taking Health Insurance.

Please list your beneficiaries. (Name, address, Relationship)

Primary Beneficiary:

Contingent Beneficiary:

(Life and AD&D benefits reduce by 35% of the original amount at age 65, and further reduce to 50% at age 70)

BLUE CROSS BLUE SHIELD ENROLLMENT FORM

ANGELS OF CARE

Reason for Application: Open Enrollment Divorce Marriage Birth Adoption

Date of Event: _____

PREVIOUS COVERAGE INFORMATION:

In order to receive credit for pre-existing condition waiting periods, you must provide information about the last 12 months of coverage for you and any dependents listed. If you have a certificate of prior coverage, please attach a copy of this to the enrollment application.

Name of Primary Enrollee: _____

Employer's Name: _____ Group Policy # _____

Name and address of other insurance company:

Effective Date of Coverage _____ Cancellation Date _____

Declination of Health Coverage:

This is to certify the available coverage has been explained to me. I have been given the opportunity to apply for the coverage offered to me and my eligible dependents and have voluntarily elected to decline the coverage as indicated below. If I desire to apply for coverage at a later date, I understand there may be a delay in the effective date of the coverage as well as a pre-existing condition waiting period.

Reason for Declining:

Employee: Other Group Coverage Medicare Medicaid Other, Explain _____

Spouse: Other Group Coverage Medicare Medicaid Other, Explain _____

Children: Other Group Coverage Medicare Medicaid Other, Explain _____

COVERAGE CONDITIONS:

I am a Full Time employee of Angels of Care. I am eligible to participate in the coverage(s) afforded by my Employer's plan, which is either underwritten or administered by Blue Cross and Blue Shield of Texas or Dearborn National Life Insurance Company. On behalf of myself and any dependent(s) listed on this Enrollment Application, I apply for those coverage(s) for which I am eligible. I state that the information given on this Enrollment Application is true and correct.

- Only those coverage(s) and amounts for which I am eligible will be available to me. I understand that if this Enrollment Application is accepted, the coverage will become effective in accordance with the provisions of the Contract Plans.
- I understand that the Health coverage for which I am applying may have a pre-existing condition exclusion waiting period.
- I agree that my Employer acts as my agent. I authorize necessary payroll deductions by my Employer, if any to cover the cost of my coverage.
- I understand that payroll deductions by my Employer will be pre-tax deductions, per Section 125 of the Plan Document.
- I understand that my participating in the coverage is subject to any future amendments. I also understand that all notices given to my Employer are binding upon me.

Applicant's Signature _____ Date _____

HSA Application

Complete electronically (Optional)



Send applications here ➔

1 Personal Information.

Name _____ Soc. Sec. # _____ Date of Birth _____
Street Address _____ City _____ State _____ Zip _____
Mailing Address if different from above _____ City _____ State _____ Zip _____
Home Phone _____ Work Phone _____ Employer Angels of Care Occupation _____
E-mail _____ Driver's License _____ (Please attach copy) State Issued _____
Mother's Maiden Name _____ Birth Place _____ Agent/Broker Safe Harbor Benefits, Inc.
Online Banking (Optional) Yes, please sign me up No Debit Card (optional) Yes, send me a free debit card No

2 Contribution Information.

Please Read (no completion necessary)

Employer Contributions and Payroll Deferral. If applicable, your employer will provide you with a form to elect to defer a portion of your salary into your HSA.

Contributions Not Made Through Employer. If you are making contributions on your own, not through your employer or through payroll deferral, please use our Application for Individuals or use this Application and complete a separate HSA Contribution Form, both are available at www.HSAResources.com.

Please Note. HSA Resources charges a \$25 annual fee. If not paid for by the employer or separately by you, these fees are deducted from your HSA.

3 Signatures.

I have received either in print or electronically (available anytime at www.HSAResources.com, or by calling 320-223-6300), read and agree to the terms in the HSA Custodial Agreement and Disclosure Statement, the Truth-in-Savings Disclosure, the Fee Schedule, and Terms and Conditions of my Account. I acknowledge that I am bound by the terms and conditions in these documents and any amendments thereof. If applicable, I hereby designate the beneficiaries for this HSA as those named on the second page of this Application in the HSA Designation of Beneficiary section. If applicable, I hereby authorize the person named on the second page of this Application in the HSA Authorized Signer section as an authorized signer for this HSA. You understand that we have a current need to verify your identity and creditworthiness, therefore, by signing below, you authorize us to verify your credit record and employment history by any means necessary, including preparation of a credit report by a credit agency. I acknowledge that the information provided is subject to Falcon National Bank's Privacy Policy but will be shared with HSA Resources, LLC, and limited information may be shared with your insurance agent and your employer. I understand that I am solely responsible to determine my eligibility to make this HSA contribution and to determine the tax deductibility of the contribution; including an understanding that I must be covered under a "High Deductible Health Plan" for annual contribution eligibility. I agree that I will consult with my tax or legal advisor if I need advice. I acknowledge that HSA Resources, LLC and Falcon National Bank, cannot and do not provide me with tax or legal advice. I am solely responsible for determining the tax consequences of all distributions. If applicable, I hereby apply for an Instant Cash and Check Card (ICC) to be used in conjunction with this account. I agree that use of the ICC Card will be subject to the terms and conditions contained in the Terms and Conditions of my Account. I release and agree to hold the HSA custodian and HSA Resources, LLC harmless against any and all claims or losses arising from my actions. I certify that the information provided by me on this Application is accurate.

T.I.N./Backup Withholding. (Cross out item (3) if you are subject to backup withholding) Under penalties of perjury, I certify (1) that the number shown is my correct taxpayer ID number or social security number, (2) that I am a U.S. person (including U.S. resident alien), (3) and that I am not subject to backup withholding because (a) I am exempt from backup withholding or (b) because I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends or (c) because the IRS has notified me that I am no longer subject to backup withholding. The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Minnesota Legal Requirement. (Cross out item (1) or (2) if untrue) (1) I have not had a transaction account closed at this or another financial intermediary within 12 months before mailing this Application: (2) I have not been convicted of a criminal offense because of the use of a check or other similar items within 24 months of making this Application.

Sign ➔

HSA Owner Signature Date

Check here if you completed the second page of this application.
Page 1 (this page) - Required information to open an HSA
Page 2 (next page) - Optional - can be completed at any time.

Internal Use: Broker/Agent user ID _____

HSA Payroll Deferral Form

1 General Information

Your Name: _____
 Company Name _____ ("Employer")

2 Payroll Deferral Request

Payroll Deferral. I request that my Employer defer the following amount from my pay and direct the money into an HSA with the custodian named above. Please make sure you know how much you are eligible to contribute. Check only one box.

- Per Pay Period.** \$ _____ Multiply by number of pay periods to get annual contribution amount.
- Annual Amount.** \$ _____ This amount will be divided by the # of pay periods per year (or the remaining # of pay periods).
- Other** \$ _____ Use for unique situations - please explain.
 Please Explain "Other" _____

3 Signature and Submission Information

I agree to the above deferral request and will submit this form to my Employer for processing. I also authorize my Employer to make withdrawals from my HSA in the event that a credit entry is made in error. I understand that the custodian may provide my HSA account number to my Employer to facilitate the money transfer. I further understand that the date of my payroll may differ from the date the funds are actually deposited and are available for use.

 Please sign here

 Date

Employer Instructions: Use this form when you allow payroll deferral into an HSA. Please collect this data from each employee (print or copy this form for more copies of it) and consolidate employee deferrals onto one spreadsheet, "The employee Contribution Worksheet (previous sheet)," or one of your own. Then forward that spreadsheet to the HSA Custodian along with a check or ACH instructions for payment. Keep this Employee Payroll Deferral Form for your records, the HSA Custodian does not need a copy.



Branch Locations

Abilene
325-690-0583

Amarillo
806-353-2700

Austin
512-996-9559

Corpus Christi

Dallas
972-702-0300

El Paso

Fort Worth
817-810-0660
817-810-0636

Lubbock

McAllen
956-676-4522

Nacogdoches

North Houston
281-893-5560
281-893-5555

San Angelo

San Antonio
210-841-5759

South Houston
281-333-8650
281-333-8584

Texarkana
903-832-0517

Tyler
903-534-5684

Waco

Wichita Falls
940-761-9986