

2027 Summary of Plan Benefits		
The City of Fort Worth Health Center and Consumer Choice plans provide services in the office of a Primary Care Physician (PCP) and Specialist. For purposes of the City's Health Plan, a PCP will be a physician who has contracted with Blue Cross Blue Shield as a Primary Care Provider. This will include providers who have contracted as a Family Practitioner, General Practitioner, Internal medicine, Pediatric or OB/GYN provider and are listed in the insurance provider directory as a PCP or an OB/GYN provider. All other providers will be considered Specialists. A member is not required to elect a specific PCP and a referral from the PCP is not required to see a Specialist. Below are some general services and your payment amount or percentage.		
Plan Features	Health Center Plan	Consumer Choice Plan
Network	Blue Choice PPO	Blue Choice PPO
Medical Lifetime Maximum	Unlimited	Unlimited
Annual Deductible		
• Individual	\$1,500	\$3,500
• Family	\$3,000	\$5,400
Plan Coinsurance		
Percent the member pays after deductible is met	20%	20%
Facility Coinsurance	20%	20%
Total Out of Pocket Max—includes deductibles, copays, coinsurance, prescription deductible, prescription copays		
• Individual	\$6,000	\$6,550
• Family	\$12,000	\$13,000
Physician Office Visit		
-Health Center PCP	\$0 copay	\$60 contracted rate****
-PCP / OBGYN / Peds	\$30 copay	20% after deductible
-Specialist	\$50 copay	20% after deductible
Allergy Testing & Treatment Office Visit (OV) (Serum/Injections)	\$50 Copay OV & testing only. Injections without OV \$0 copay	20% after deductible
Routine Physicals/Immunization		
• Children *	\$0	\$0 deductible waived
• Adult 18 and older * 1 exam per calendar year	\$0	\$0 deductible waived
Routine GYN Exam *		
1 routine GYN exam per year with 1 Pap smear & related lab fees	\$0	\$0 deductible waived
Routine Mammogram		
Annual mammogram for females ages 40 & over if at a free-standing lab	\$0	\$0 deductible waived
Colonoscopy		
• Initial screening		
• 1 screening every 10 calendar years for individual age 50 & over or with family history	\$0 deductible waived	\$0 deductible waived
• Subsequent Colonoscopy(ies) (Physician charge)	20% after deductible	20% after deductible
Refractive Eye Exam (1 exam every 24 months)	\$0	\$0 deductible waived
Short-Term Rehabilitation		
Physical, speech or occupational therapy for acute conditions. 60 visits per calendar year.	\$50	20% after deductible
Musculoskeletal Rehabilitation		
Airrosti Clinic	\$15 copay	15% after deductible
Spinal Manipulation—24 visits per calendar year limited to one visit and treatment per day. Limited to actual spinal manipulation only.	\$50	20% after deductible
Diagnostic X-ray & Lab		
• Free-standing facility & services rendered in a physician's office when office visit is not billed	\$0	20% after deductible
• Outpatient hospital	20% after deductible	20% after deductible
Complex Imaging (MRI, PET & CAT scans) (Facility)	20% after deductible	20% after deductible
Emergency Room	\$300 copay, waived if admitted	20% after deductible
Non-emergency use of emergency room	\$300 + 50% after deductible	50% after deductible
Ambulance Services-Emergency Only	20% after deductible	20% after deductible
Urgent Care Center	\$75 copay	20% after deductible
Plan Features		
Convenient Care Clinic (e.g. Minute Clinic at CVS)	\$30 copay	20% after deductible
Virtual Visits through Teladoc	\$0	20% after deductible
Hospital Services		
• Inpatient	20% after deductible	20% after deductible
• Outpatient	20% after deductible	20% after deductible
SurgeryPlus	\$0 deductible waived	0% after deductible
Physician Non-Office Visit (Hospital)	20% after deductible	20% after deductible
Maternity		
• Office Visit	\$30	20% after deductible
	(copay for initial visit only)	
• Delivery Expenses	20% after deductible	20% after deductible
Durable Medical Equipment	20% after deductible	20% after deductible

Skilled Nursing/Convalescent Facility 60 days per calendar year	20% after deductible	20% after deductible
Home Health Care 60 visits per calendar year	20% after deductible	20% after deductible
Hospice Care 360 days lifetime maximum • Inpatient • Outpatient-includes bereavement counseling & respite care	20% after deductible 20% after deductible	20% after deductible 20% after deductible
Mental Health & Chemical Dependency Services • Inpatient • Outpatient Visit (Physician)	20% after deductible \$0	20% after deductible 15% after deductible
PRESCRIPTION DRUGS - Rightway		
Annual Rx deductible	\$100	combined with medical
• Retail—up to 30 day supply		
- Generic	20% after deductible \$10 min/\$30 max	20% after deductible**
- Preferred (formulary)	20% after deductible \$30 min/\$50 max	20% after deductible***
- Non-Preferred (non-formulary)	20% after deductible \$50 min/\$75 max	20% after deductible
- Specialty	20% after deductible to a max of \$200	20% after deductible
• 90 day Maintenance Medications- no mandatory pharmacy		
- Generic	20% after deductible \$25 min/\$50 max	20% after deductible
- Preferred (formulary)	20% after deductible \$75 min/\$125 max	20% after deductible
- Non-Preferred (non-formulary)	20% after deductible \$125 min/\$175 max	20% after deductible
Note: *Assumes service is provided by a primary care physician (PCP) per National guidelines **Certain generic preventive maintenance medications are covered at 100%, deductible waived ***Certain preferred preventive maintenance medications are covered at 50%, deductible waived ****The contracted rate for services at the Health Center is \$60 A PCP can be a general practitioner, family practitioner, internal medicine, pediatrician, an OB/GYN. THE SUMMARY PLAN DESCRIPTION (SPD) PROVIDES A MORE DETAILED DESCRIPTION OF EACH PLAN AND IN THE EVENT THIS SUMMARY DIFFERS FROM THE SPD, THE SPD PREVAILS		