

# SAN FELIPE DEL RIO CISD STATE MEDICAL PLAN

## SCHEDULE OF BENEFITS

This Schedule of Benefits is a summary of the benefits provided under your medical plan. Benefits are payable only if services are Eligible Expenses according to the provisions of your medical plan booklet.

To receive in-network benefits, care must be provided by a health care provider who is a member of the Preferred Provider Organization (PPO). Membership in the PPO changes constantly. **Please call the number on your ID card or PPO directory to verify PPO membership anytime you schedule health care services.**

### GENERAL PROVISIONS

#### *Calendar Year Deductible*

Individual Calendar Year Deductible	
In-Network:	\$0
Out-of-Network:	\$500
Family Calendar Year Deductible Maximum	
In-Network:	\$0
Out-of-Network:	\$1,500

The Family Calendar Year Deductible Maximum is accumulative.

#### *Coinsurance*

Individual Coinsurance Maximum	
In-Network:	\$1,500 per calendar year
Out-of-Network:	\$2,000 per calendar year
Family Coinsurance Maximum	
In-Network:	None
Out-of-Network:	None

Amounts applied toward the out-of-network coinsurance also will apply toward the in-network coinsurance. Amounts applied toward the in-network coinsurance will not apply toward the out-of-network coinsurance.

#### *Lifetime Maximum Benefit*

Per covered person	\$2,000,000
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The lifetime maximum benefit includes both in-network and out-of-network services.

### HEALTH CARE PRACTITIONER'S SERVICES

#### *Office Visits and Office Surgery*

In-Network:	Plan pays 100% after \$20 copay per visit \$35 copay per visit for specialist
Out-of-Network:	Plan pays 65% after calendar year deductible

Office visit copays will apply toward the in-network coinsurance maximums.

A specialist is any physician other than a family practitioner, internist, OB/GYN or pediatrician. Office visit copays do not apply toward the individual or family deductible or coinsurance maximum.

#### *Inpatient Visits*

In-Network:	Plan pays 85%
Out-of-Network:	Plan pays 65% after calendar year deductible

All inpatient hospital admissions (acute care, mental health care, chemical dependency, and physical rehabilitation) require precertification.

#### *Chiropractic Care*

In-Network:	Plan pays 100% after \$20 copay
Out-of-Network:	Plan pays 65% after calendar year deductible

Plan-paid benefits for Chiropractic Care are limited to 30 visits per person, per calendar year. This limit includes both in-network and out-of-network services. Office visit copays do not apply toward the individual or family deductible or coinsurance maximum.

***Surgical Procedures***

In-Network: Plan pays 85%  
Out-of-Network: Plan pays 65% after calendar year deductible

***Maternity Care***

In-Network: Plan pays 85%  
Out-of-Network: Plan pays 65% after calendar year deductible

**DIAGNOSTIC X-RAYS AND LABORATORY TESTS**

In-Network: Plan pays 85%  
Out-of-Network: Plan pays 65% after calendar year deductible

**LABONE LAB CARD**

When you use your Lab Card, you pay nothing—no deductible or coinsurance—for outpatient laboratory testing services covered by your healthcare plan. This does not include STAT (Same day testing or inpatient testing).

When your physician orders lab work, explain that you are part of the Lab Card Program and your specimens must be sent to LabOne for you to receive free testing. Instructions for your physician are printed on the back of your Lab Card. Access to LabOne testing services may be achieved through any physician practice that has the capability to collect specimens in their office. LabOne will pick up your specimens directly from their office.

If your physicians do not collect specimens in their office, you can call LabOne at 1-800-646-7788 or go to [www.labcard.com](http://www.labcard.com) to find an approved LabOne collection center in your area. If you choose not to have your specimens sent to LabOne, your regular benefits will apply.

***The Lab Card program does not replace the benefits included in your current medical plan, it simply gives you the additional option of obtaining quality outpatient lab testing at no cost.***

**PREVENTIVE CARE**

In-Network: Plan pays 100%  
Out-of-Network: Plan pays 65% after calendar year deductible (subject to R&C)

Eligible Expenses under the Preventive Benefit includes the following services:

- Mammogram – limited to one (1) per calendar year) for women who are fifty (50) and older.
- PSA (Prostate Specific Antigen test) – limited one (1) per calendar year.
- Colon-Rectal examination - Coverage for medically-recognized screening examination for the detection of colorectal cancer for covered individuals who are fifty (50) years of age or older and at normal risk for developing colon cancer. This benefit includes expenses incurred while conducting a medically-recognized screening examination for the detection of colorectal cancer. This includes annual fecal occult blood tests and a flexible sigmoidoscopy (examination of the large intestine) performed every five (5) years or a colonoscopy performed every five (5) years.

**ROUTINE CARE**

***Office Visits***

In-Network: Plan pays 100% after \$20 copay per visit  
Out-of-Network: Plan pays 65% after calendar year deductible

Office visit copays will apply toward the in-network coinsurance maximums.

***Other Routine Care Expenses***

In-Network: Plan pays 85%  
Out-of-Network: Plan pays 65% after calendar year deductible

Other Routine Care Expenses mean Eligible Expenses that are received, but that are not performed in your Health Care Practitioner’s office.

Eligible Expenses under the Routine Benefit includes the following services:

- Routine Hearing Exam – one per calendar year
- Routine Vision Exam – one per calendar year. Covers exam only, no refraction.
- Well Woman Exam – one per calendar year
- Adult Routine Physical Exam – one per calendar year, ages 6 (six) and older
- Well Baby Care – to age 6 (six)
- Routine Lab
- Routine X-rays
- Routine Immunizations (ages 6 and older) unless listed as not covered under the *Exclusions and Limitations*
- Routine Mammography – one per calendar years, ages 35 (thirty-five) to 50 (fifty)

## **PRESCRIPTION DRUG PROGRAM**

### ***Retail Card***

Generic Prescriptions:	Plan pays 100% after \$5 copay per prescription
Formulary Prescriptions:	Plan pays 100% after \$25 copay per prescription
Brand Name Prescriptions:	Plan pays 100% after \$40 copay per prescription

Each copay will purchase up to a 34-day supply of medication. Prescription drug copays do not apply toward any deductible or coinsurance maximums.

### ***Mail Order Service***

Generic Prescriptions:	Plan pays 100% after \$5 copay per prescription
Formulary Prescriptions:	Plan pays 100% after \$50 copay per prescription
Brand Name Prescriptions:	Plan pays 100% after \$80 copay per prescription

Each copay will purchase up to a 90-day supply of medication. Prescription drug copays do not apply toward any deductible or coinsurance maximums.

### **Specialty Drugs**

\$100 copay per prescription, \$1,200 maximum out of pocket

This Plan offers a specialty drug benefit called SpecialtyRx. Specialty drugs treat chronic disorders such as hemophilia, growth hormone deficiency, multiple sclerosis, immune disorders, hepatitis c, cystic fibrosis, respiratory syncytial virus, genetic emphysema, and others. This benefit is accessed through Caremark. This service provides the Plan and Covered Individual a convenient and cost-effective way to order select oral medications, injectable drugs and supplies through Caremark SpecialtyRx. To locate a listing of drugs covered under this benefit visit the TML Intergovernmental Employee Benefits Pool website located at [www.tmliebp.org](http://www.tmliebp.org) and select links.

Caremark's SpecialtyRx drug program is available through the mail order services at 866-295-2779. You will receive one month's supply per specialty drug copay. Once the SpecialtyRx maximum out of pocket for the calendar year has been satisfied, the copay will not apply. The out of pocket only applies to the SpecialtyRx drugs and does not include any other retail or mail order prescriptions

The Prescription Mail Order Service will be the only provider of these drugs for which a benefit will be eligible under This Plan. All other providers supplying products to treat these chronic disorders will not be considered an eligible expense under This Plan.

## **HOSPITAL SERVICES**

### ***Inpatient***

In-Network:	Plan pays 85%
Out-of-Network:	Plan pays 65% after calendar year deductible

All inpatient hospital admissions (acute care, mental health care, chemical dependency, and physical rehabilitation) require precertification. If an inpatient hospital admission is not precertified, benefits will be reduced by 50%. The reduction in benefits will not apply toward any deductible or coinsurance maximum.

**Outpatient**

In-Network: Plan pays 85%  
Out-of-Network: Plan pays 65% after calendar year deductible

**Emergency Room ~ Medical Emergency within 72 Hours of Onset**

Facility Charges Plan pays 90% after \$50 copay per visit  
Physician Charges Plan pays 90%, no deductible

**Non-emergency Situations**

Facility Charges  
In-Network: Plan pays 85% after \$50 copay per visit  
Out-of-Network: Plan pays 65% after \$50 copay per visit and calendar year deductible  
Physician Charges  
In-Network: Plan pays 85%  
Out-of-Network: Plan pays 65% after calendar year deductible

The emergency room copay will apply toward the appropriate coinsurance maximums. The \$50 copay is waived if you are admitted from the emergency room for an inpatient hospital confinement.

Medical Emergency means the sudden onset of an injury or illness manifesting itself by acute symptoms of sufficient severity, including pain, such that the absence of immediate medical attention could reasonably be expected to result in: 1) placing the covered person’s health in serious jeopardy; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ. A Medical Emergency includes, but is not limited to, unusual or excessive bleeding, broken bones, sprains, strains, acute abdominal or chest pain, unconsciousness, convulsions, difficult breathing, suspected heart attack, sudden persistent pain, severe or multiple injuries or burns, and poisonings.

**OUTPATIENT PHYSICAL MEDICINE SERVICES**

In-Network Plan pays 85%  
Out-of-Network: Plan pays 65% after calendar year deductible

The maximum allowable charge per session is \$50. Outpatient Physical Medicine Services are limited to 30 sessions per covered person, per calendar year. This limit includes both in-network and out-of-network services. Physical Medicine Services means those modalities, procedures, tests, and measurements listed in the *Physicians’ Current Procedural Terminology Manual* (Procedure Codes 97010-97799). They include, but are not limited to, physical therapy, occupational therapy, hot or cold packs, whirlpool, diathermy, electrical stimulation, massage, ultrasound, manipulation, muscle or strength testing, and orthotic or prosthetic training.

**MEDICAL EMERGENCY**

During the first 72 hours following the onset of a Medical Emergency, the plan will pay in-network benefits regardless of whether services are received from an in-network or an out-of-network provider. After the first 72 hours, benefits will depend upon your choice of an in-network or out-of-network provider. Medical Emergency means the sudden onset of an injury or illness manifesting itself by acute symptoms of sufficient severity, including pain, such that the absence of immediate medical attention could reasonably be expected to result in: 1) placing the covered person’s health in serious jeopardy; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ. A Medical Emergency includes, but is not limited to, unusual or excessive bleeding, broken bones, sprains, strains, acute abdominal or chest pain, unconsciousness, convulsions, difficult breathing, suspected heart attack, sudden persistent pain, severe or multiple injuries or burns, and poisonings.

**MENTAL HEALTH CARE**

**Outpatient Office Visits**

In-Network: Plan pays 85% after \$15 copay  
Out-of-Network: Plan pays 65% after calendar year deductible

Outpatient office visits for Mental Health Care are limited to 30 visits per covered person, per calendar year. This limit includes both in-network and out-of-network services.

***Psychological Testing***

In-Network: Plan pays 85%  
Out-of-Network: Plan pays 65% after calendar year deductible

***Inpatient Facility***

In-Network: Plan pays 85%  
Out-of-Network: Plan pays 65%, after calendar year deductible

***Inpatient Practitioner***

In-Network: Plan pays 85%  
Out-of-Network: Plan pays 65% after calendar year deductible

Inpatient services for Mental Health Care are limited to 30 days per covered person, per calendar year. This limit includes both in-network and out-of-network services.

Mental Health Care services received in a Psychiatric Day Treatment Facility, a Crisis Stabilization Unit or Facility, or a Residential Treatment Center for Children and Adolescents in lieu of hospitalization will be considered inpatient services. Each full day of treatment in such a facility will be considered equal to one-half of one day of inpatient treatment.

All inpatient services require precertification. If inpatient treatment is not precertified, benefits will be reduced by 50% for Eligible Expenses. The reduction in benefits will not apply toward any deductible or coinsurance maximum.

Mental Health Care does not include treatment of a "Serious Mental/Nervous Illness". Treatment for a Serious Mental/Nervous Illness is payable as any other illness, subject to the Plan's \$1,000,000 lifetime maximum, as stated in the Schedule of Medical Benefits. Benefits for the treatment of a Serious/Mental Nervous condition will not apply to and will not be limited by this Plan's Mental/Nervous Lifetime Maximum. The term "Serious Mental/Nervous Illness" means the following psychiatric illnesses as defined by the American Psychiatric Association in the latest version of the Diagnostic and Statistical Manual (DSM):

1. Schizophrenia;
2. Paranoia and other psychotic disorders;
3. Bipolar disorders (mixed, manic, depressive and hypomanic);
4. Major Depressive disorders (single episode or recurrent);
5. Schizo-affective disorders (bipolar or depressive);
6. Pervasive Developmental disorders;
7. Obsessive Compulsive disorders (OCD); and
8. Depression in childhood and adolescence.

**Treatment of chemical dependency is limited to a lifetime maximum benefit of three series of treatment.**

**EXTENDED CARE SERVICES**

***Home Health Care***

In-Network: Plan pays 85% up to \$10,000 per calendar year  
Out-of-Network: Plan pays 65% after calendar year deductible, up to \$7,000 per calendar year

In-network benefits will apply toward the out-of-network limit and vice versa.

***Hospice Care***

In-Network: Plan pays 85% up to a lifetime maximum benefit of \$20,000  
Out-of-Network: Plan pays 65% after calendar year deductible, up to a lifetime maximum benefit of \$14,000

In-network benefits will apply toward the out-of-network limit and vice versa.

***Skilled Nursing or Extended Care Facility***

In-Network: Plan pays 85% up to \$10,000 per calendar year  
Out-of-Network: Plan pays 65% after calendar year deductible, up to \$7,000 per calendar year

In-network benefits will apply toward the out-of-network limit and vice versa.

Home Health Care, Hospice Care, and confinement in a Skilled Nursing or Extended Care Facility all require precertification. If Extended Care Services are not precertified, benefits will be reduced by 50% for each period of service that was not precertified. The reduction in benefits will not apply toward any deductible or coinsurance maximum.

**ALL OTHER ELIGIBLE EXPENSES**

In-Network:

Plan pays 85%

Out-of-Network:

Plan pays 65% after calendar year deductible

**ANCILLARY PROVIDER CHARGES**

Ancillary charges from a Non Network emergency room physician, radiologist, pathologist, anesthesiologist or ambulance will be paid at the Network level if the facility is a Network facility. The charges will still be subject to the usual and customary allowable amount.

**END STAGE RENAL DISEASE (ESRD) AND DIALYSIS**

When a Covered Person (employee or dependent) is diagnosed with ESRD stage V, which is going to require dialysis treatment, all dialysis services must be precertified with the Plan Administrator's Medical Management department before benefits will be considered. If Precertification does not take place, the Covered Person may be responsible for payment of all dialysis services that occur before any Precertification. Please refer to the Precertification section in the Plan Document for the process to use in pre-certifying the dialysis treatments.