TEXAS Educators: DRAFT SCHEDULE OF BENEFITS (v4)

SCHEDULE OF BENEFITS

The following is a summary of the benefit options available to each participant during a qualified enrollment period. Descriptions below summarize participant cost sharing, prior authorization requirements, limitations and exclusions. The Plan utilizes a preferred provider network for professional and ancillary services (i.e. physician, specialist, outpatient diagnostic, etc.) only. All facility services for inpatient and outpatient are offered on an "OPEN ACCESS" basis that does not limit the facility where services are performed. Most OPEN ACCESS services must be PRE-CERTIFIED for coverage to be in place. The Plan has contracted with strategic Texas hospital and provider systems and you may learn how this will benefit you when contacting the concierge prior to engaging services.

PLAN FEATURES		HD		Low		Basic		Choice	
GENERAL FEATURES									
Type of Coverage		Point of Service		Point of Service		Point of Service		Point of Service	
Professional & Anciliary - Preferred Network		PHCS/Multiplan		PHCS/Multiplan		PHCS/Multiplan		PHCS/Multiplan	
Inpatient & Outpatient - Facility		Open Access Multiple Texas Hospital & Provider Systems		Open Access Multiple Texas Hospital & Provider Systems		Open Access Multiple Texas Hospital & Provider Systems		Open Access Multiple Texas Hospital & Provider Systems	
PCP Requirement		None		None		None		None	
DEDUCTIBLE & COINSURANCE		In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
Deductible - Individual		$3,000		$6,000		$3,000		$1,500	
Deductible - Family		$6,000		$12,000		$6,000		$3,000	
Coinsurance		80% after Deductible	70% after Deductible	80% after Deductible	70% after Deductible	80% after Deductible	70% after Deductible	80% after Deductible	70% after Deductible
Out of Pocket Maximum *(includes deductible, coinsurance and copays)*		In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
Individual		$7,500		$7,500		$7,500		$7,500	
Family		$15,000		$15,000		$15,000		$15,000	
Maximum Plan Year Benefits		Unlimited		Unlimited		Unlimited		Unlimited	
MEDICAL BENEFITS	**Prior Auth Required**[3]	**Member Pays**		**Member Pays**		**Member Pays**		**Member Pays**	
PHYSICIAN SERVICES		In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
Primary Care Office Visit *(applies to visit only)*	No	20% after deductible	30% after deductible	$30 Copay	30% after deductible	$30 Copay	30% after deductible	$30 Copay	30% after deductible
Specialist Office Visit	No	20% after deductible	30% after deductible	$70 Copay	30% after deductible	$70 Copay	30% after deductible	$70 Copay	30% after deductible
Services provided in a Physicians Office (other than the office visit copay)	No	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible
Urgent Care	No	20% after deductible	30% after deductible	$50 Copay	30% after deductible	$50 Copay	30% after deductible	$50 Copay	30% after deductible
Telemedicine Services (1 800 MD)	No	$0	no coverage	$0	no coverage	$0	no coverage	$0	no coverage
PREVENTIVE & WELLNESS SERVICES *(ACA required preventive services only)*		In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
Services at **Physician Office**	No	$0 Copay	30% after deductible	$0 Copay	30% after deductible	$0 Copay	30% after deductible	$0 Copay	30% after deductible
Outpatient Hospital Free Standing Facility Services	Yes	$0 Copay		$0 Copay		$0 Copay		$0 Copay	
HOSPITAL/FACILITY SERVICES		Open Access		Open Access		Open Access		Open Access	
Inpatient Hospitalization	Yes	30% after deductible		30% after deductible		30% after deductible		30% after deductible	
Inpatient Visits - Physician	Incl in Hospital	30% after deductible		30% after deductible		30% after deductible		30% after deductible	
Inpatient Surgery (Second surgical opinion may be required)	Yes	30% after deductible		30% after deductible		30% after deductible		30% after deductible	
Inpatient Diagnostic Services *(Lab, x-ray, CT, MRI, MRA, PET scan)*	Incl in Hospital	30% after deductible		30% after deductible		30% after deductible		30% after deductible	
Outpatient Hospital Free Standing Facility Services and Surgery	Yes	30% after deductible		30% after deductible		30% after deductible		30% after deductible	
Anesthesia	No	30% after deductible		30% after deductible		30% after deductible		30% after deductible	
Emergency Room Services (Life threatening Services)	No	30% after deductible		30% after deductible		30% after deductible		30% after deductible	
Emergency Room Services (Non-Emergent Care)	No	Not Covered / 100% paid by Member		Not Covered / 100% paid by Member		Not Covered / 100% paid by Member		Not Covered / 100% paid by Member	
DIAGNOSTIC SERVICES **(Outpatient)**		In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
Laboratory Services	No	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible
Radiology (x-ray, ultrasound)	No	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible
CT / MRI / MRA / PET Scan	Yes	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible
PREGNANCY BENEFITS		In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
Physician Visits	No	20% after deductible	30% after deductible	$30 Copay	30% after deductible	$30 Copay	30% after deductible	$30 Copay	30% after deductible
Testing/Childbirth/Delivery	No	30% after deductible		30% after deductible		30% after deductible		30% after deductible	
MENTAL & NERVOUS; CHEMICAL DEPENDENCY		In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
Office Visits *(outpatient)*	No	20% after deductible	30% after deductible	$30 Copay	30% after deductible	$30 Copay	30% after deductible	$30 Copay	30% after deductible
Inpatient *(Facility)*	Yes	30% after deductible		30% after deductible		30% after deductible		30% after deductible	
Outpatient *(Facility)*	Yes	30% after deductible		$30 Copay		$30 Copay		$30 Copay	
OTHER SERVICES; Network requirements		In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
Allergy Office visits (The copay applies for the office visit only)	No	20% after deductible	30% after deductible	$100 Copay	30% after deductible	$100 Copay	30% after deductible	$100 Copay	30% after deductible
Allergy Services Testing / injections	Yes	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible
Air Ambulance Transportation - NON Emergency	Yes	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible
Home Health Care (Limited to 30 visits per plan year)	Yes	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible
Hospice Care *(Outpatient/Home)*	Yes	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible
Rehabilitation/Habilitation Services *(limited to 30 visits per plan year)*	No	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible
Second Surgical Opinion (may be required)	No	$0 Copay	30% after deductible	$0 Copay	30% after deductible	$0 Copay	30% after deductible	$0 Copay	30% after deductible
OTHER SERVICES: Open Access		Open Access		Open Access		Open Access		Open Access	
Hospice Care *(Inpatient)*	Yes	30% after deductible		30% after deductible		30% after deductible		30% after deductible	
Emergency Medical Transportation	No	30% after deductible		30% after deductible		30% after deductible		30% after deductible	
Air Ambulance Transportation - Emergency *(Pre-cert as soon as reasonably possible)*	Yes	30% after deductible		30% after deductible		30% after deductible		30% after deductible	
PHARMACY BENEFITS		**Participating Pharmacies**		**Participating Pharmacies**		**Participating Pharmacies**		**Participating Pharmacies**	
PREVENTIVE Prescriptions ONLY *(Subject to Formulary & ACA requirements)*		Member Pays		Member Pays		Member Pays		Member Pays	
Pharmacy Retail – up to a 30 day supply		Generic Only $0 Copay Brand Drugs - Not Covered		Generic Only $0 Copay Brand Drugs - Not Covered		Generic Only $0 Copay Brand Drugs - Not Covered		Generic Only $0 Copay Brand Drugs - Not Covered	
Pharmacy Mail Order – up to a 90 day supply		Generic Only $0 Copay Brand Drugs - Not Covered		Generic Only $0 Copay Brand Drugs - Not Covered		Generic Only $0 Copay Brand Drugs - Not Covered		Generic Only $0 Copay Brand Drugs - Not Covered	
NON-PREVENTIVE Prescriptions - (Subject to Formulary)		Member Pays		Member Pays		Member Pays		Member Pays	
Retail Pharmacy– (up to a 30 day supply)		Generic – 30% after deductble Preferred Brand - 30% after deductible Non Preferred Brand - 30% after deductible		Generic – $10 Copay Preferred Brand - $35 Copay Non Preferred Brand - Not Covered		Generic – $10 Copay Preferred Brand - $35 Copay Non Preferred Brand - 30% to $125 Max		Generic – $10 Copay Preferred Brand - $35 Copay Non Preferred Brand - 30% to $125 Max	
Mail Order Pharmacy (90 day supply)		Generic – 30% after deductble Preferred Brand - 30% after deductible Non Preferred Brand - 30% after deductible		Generic – $25 Copay Preferred Brand - $87.50 Copay Non Preferred Brand - Not Covered		Generic – $25 Copay Preferred Brand - $87.50 Copay Non Preferred Brand - 30% to $125 Max		Generic – $25 Copay Preferred Brand - $87.50 Copay Non Preferred Brand - 30% to $125 Max	
SPECIALTY MEDICATIONS		Member Pays		Member Pays		Member Pays		Member Pays	
Rx Contain Program		50% after deductible; $500 Maximum		$0 Copay[1]		$0 Copay[1]		$0 Copay[1]	
Retail Pharmacy– (up to a 30 day supply)		50% after deductible; $500 Maximum		50% after deductible; $500 Maximum		50% after deductible; $500 Maximum		50% after deductible; $500 Maximum	
Mail Order Pharmacy (90 day supply)		50% after deductible; $500 Maximum		50% Copay; $500 Maximum		50% Copay; $500 Maximum		50% Copay; $500 Maximum	
Cost Analysis		**HD**		**Low**		**Basic**		**Choice**	
Employee Only		$431.30		$401.30		$446.20		$566.19	
Employee and Spouse		$1,151.00		$1,096.40		$1,167.72		$1,329.98	
Employee and Children		$728.44		$688.83		$753.30		$905.57	
Employee and Family		$1,414.40		$1,351.52		$1,445.36		$1,709.40	

[1] RXContain Program provides certain specialty medications at a $0 copay if the participants family income is below $100,000 annually.