2018 Edinburg C.I.S.D. Health Insurance Benefit Highlights and Rates

2018 Benefits	ECISD Health Plan	
	In-Network Benefit	Out-Of-Network Benefit
Basic Medical Care		
Primary/Specialist Doctor Office Visit	$30 Co-pay	%50 Co-Insurance
Chiropractic Care **(limit 35 visits per calendar yr.)**	$30 Co-pay	%50 Co-Insurance
Diagnostic Testing (Blood Work) **At DHR Labs**	100%	%50 Co-Insurance
Routine Vision Exam **(One per calendar year)**	100%	100%
Diabetic Supplies ** **(Requires physician prescription)**	100%	100%
Colonoscopy -Physician charges ***Preventive**	100%	%50 after Deductible
Mammogram Screening ***Preventive**	100%	%50 after Deductible
Osteoporosis Screening ***Preventive**	100%	%50 after Deductible
Prostate Cancer Screening ***Preventive**	100%	%50 after Deductible
Well Baby Care	$30 Co-pay	%50 after Deductible
Hearing Exams	$30 Co-pay	%50 after Deductible
Cardiovascular Disease Screening ***Preventive**	100%	%50 after Deductible
Papillomavirus(HPV) & Cervical Cancer Screening	100%	%50 after Deductible
Prescription Drugs, Immunizations & Vaccines		
Preferred and Non Preferred Drug Annual Deductible	$50 per Calendar Year	
Generic Drug Annual Deductible	Waived	
Retail Prescriptions After Deductible		
Generic Drugs	$10 Co-pay	50% Co-Insurance
Preferred Brand Drugs	$45 Co-pay	50% Co-Insurance
Non-Preferred Brand Drugs	$65 Co-pay	50% Co-Insurance
Compound Drugs **(Maximum paid $300 Per Prescription)**	$45 Co-pay	50% Co-Insurance
Specialty Drugs	$10/$45/$65	50% Co-Insurance
Immunizations for Children & Adults **(Deductible Waived; subject to Co-pay at Doctor's Office)**	100%	
Immunizations for Children/Adolescents	Diphtheria, Tetanus, Pertussis, Haemophilus Influenza Type B, Hepatitis A, Hepatitis B, Human Papillomavirus (HPV), Influenza (Flu), Measles, Mumps, Rubella, Meningococcal, Inactivated Poliovirus, Rotavirus, Varicella (Chickenpox)	
Immunizations List for Adults	Hepatitis A, Hepatitis B, Human Papillomavirus (HPV), Influenza (flu), Measles, Mumps, Rubella, Meningococcal, Diphtheria, Tetanus, Pertussis, Varicella (Chickenpox), Pneumococcal, Zoster, Rabies, Pneumococcal, Meningitis, Tetanus Combo, Flu, HPV, Toxoid Combo	
Immunizations at Participating Pharmacies **(100% paid, Deductible Waived)**	Hepatitis A, Hepatitis B, Influenza (flu), Measles, Meningococcal, Diphtheria, Tetanus, Pertussis, Varicella (Chickenpox), Pneumococcal, Zoster	
Plan Provisions		
Calendar Year Deductible	$1,000/$3,000	$3,000/$9,000
Coverage once Deductible is Met	70%	50%
Hospital Emergency Room Services	$150 Co-Pay, then 70% after deductible	$150 Co-Pay, then 50% after deductible
Urgent Care	$75.00	50% Co- Insurance
Penalty for Failure to Pre-Certify Services	None	$250
Inpatient Hospital Daily Fee	$300	$900
Outpatient Facility/Physician Services	70%	50%
Out of Pocket Limit- Individual/ Family	$5,000/$14,700	Unlimited

Blue Cross Blue Shield 2018 Plan Year Rates

Coverage Tier	ECISD Monthly Contribution	Employee Monthly Premium
Employee Only	**$464.00**	**$90.00**
Employee/Spouse	**$464.00**	**$468.00**
Employee/Children	**$464.00**	**$352.00**
Family	**$464.00**	**$604.00**

**Once per calendar year allowed*

***Preferred diabetic supplies covered 100%. Non-preferred supplies will be subject to additional cost*

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BENEFIT HIGHLIGHTS *Prepared For* Edinburg CISD

Effective Date: 1/1/2018

Benefit Agreement #:

BlueChoice Network

This is a general summary of your benefits. *Please refer to your Summary of Benefits and Coverage (SBC), or you may request a copy of the policy or plan document for additional details and a description of the plan requirements and benefit design. This plan does not cover all health care expenses. Please carefully review the plan's limitations and exclusions.*

Overall Payment Provisions	In-Network Benefits	Out-of-Network Benefits
Deductibles		
Per-admission Deductible	*$300*	*$900*
☐ Plan ☒ Calendar Year Deductible	*$1,000 Individual / $3,000 Family*	*$3,000 Individual / $9,000 Family*
Applies to all Eligible Expenses except Inpatient Hospital Expenses (unless otherwise indicated)		
Three-month Deductible carryover applies	☒ *Yes*/☐ *No*	☒ *Yes*/☐ *No*
Deductible credit from prior carrier (Applied on initial group enrollment only)	☒ *Yes*/☐ *No*	☒ *Yes*/☐ *No*
Out-of-Pocket Maximum		
	$5,000 Individual / $14,700 Family	*Unlimited Individual / Unlimited Family*
Deductible applies to Out-of-Pocket	*Yes – no option*	*Yes***
Copayment applies to Out-of-Pocket	*Yes – no option*	*Yes***
** Copayment amounts and per admission deductibles are applied but will continue to be required after the benefit percentage increases to 100%.	*Network Deductible & Out-of-Pocket **will only** apply toward Network Deductible & Out-of-Pocket Maximum*	*Out-of-Network Deductible & Out-of Network Out-of-Pocket **will only** apply toward Out-of-Network Deductible & Out-of-Network Out-of-Pocket Maximum*
Credit for Out-of-Pocket Maximum from prior carrier (applied on initial group enrollment only)	☐ *Yes*/☒ *No*	☐ *Yes*/☒ *No*
Copayment Amounts Required		
Physician office visit/consultation	*$30 Copayment Amount*	
Refer to Medical/Surgical Expenses section for more information		
Urgent Care center visit	*$75 Copayment Amount*	
Refer to Urgent Care Services section for more information		
Outpatient Hospital Emergency Room/Treatment Room visit	*$150 Copayment Amount*	*$150 Copayment Amount*
Refer to Emergency Room/Treatment Room section for more information		
Maximum Lifetime Benefits		
Per Participant	*Unlimited*	

Inpatient Hospital Expenses		
Inpatient Hospital Expenses		
All services must be preauthorized		
All usual Hospital services and supplies, including semiprivate room, intensive care, and coronary care units	*70% of Allowable Amount after Deductible after $300 per-admission Deductible*	*50% of Allowable Amount after Deductible after $900 per-admission Deductible*
Penalty for failure to preauthorize services	*None*	*$250*

* Benefits used In-Network and Out-of-Network will apply toward satisfying any Annual Maximum benefits indicated

Medical/Surgical Expenses	In-Network Benefits	Out-of-Network Benefits
Medical / Surgical Expenses		
Services performed during the Physician's office visit/consultation, including lab & x-ray *(does not include Certain Diagnostic Procedures and surgical services)*	*100% of Allowable Amount after $30 Copayment Amount*	*50% of Allowable Amount after Deductible*
Lab & x-ray in other outpatient facilities (excluding Certain Diagnostic Procedures)	*100% of Allowable Amount*	*50% of Allowable Amount after Deductible*
-Physician surgical services performed in any setting	*70% of Allowable Amount after Deductible*	*50% of Allowable Amount after Deductible*
-Physician inpatient hospital visits	*70% of Allowable Amount after Deductible*	*50% of Allowable Amount after Deductible*
-Certain Diagnostic Procedures; such as Bone Scan, Cardiac Stress Test, CT -Scan (with or without contrast), MRI, Myelogram, PET Scan.	*70% of Allowable Amount after Deductible*	*50% of Allowable Amount after Deductible*
-Home Infusion Therapy *(Services must be preauthorized)*	*70% of Allowable Amount after Deductible*	*50% of Allowable Amount after Deductible*
-All other outpatient services and supplies	*70% of Allowable Amount after Deductible*	*50% of Allowable Amount after Deductible*
Virtual Visit MDLIVE (Standard) -Virtual Visit Medical ☐ *Yes/* ☒ *No*	*% of Allowable Amount after Copayment* ***Or*** *of Allowable Amount after Deductible*	*Same as OON OV*
-Virtual Visit Behavioral Health ☐ *Yes/* ☒ *No* **Note: Behavioral Health Virtual Visit Applies to MHP**	*% of Allowable Amount after Copayment* ***Or*** *% of Allowable Amount after Deductible*	*Same as OON MH*
-Telemedicine Vendor (Specific procedures and providers) ☒ Does not apply ☐ TeleDoc ☐ Doctor on Demand	*100% of Amount after $ Deductible* **Note: Claims will be paid at billed charge**	
In Vitro Fertilization Services	☒ *Decline*	

Extended Care Expenses		
Extended Care Expenses *All services must be preauthorized*		
	100% of Allowable Amount	*50% of Allowable Amount after Deductible*
Skilled Nursing Facility	*Limited to 25 day maximum each Year**	
Home Health Care	*Limited to 60 visit maximum each Year**	
Hospice Care	*Unlimited*	

* Benefits used In-Network and Out-of-Network will apply toward satisfying any Annual Maximum benefits indicated

Special Provisions Expenses	In-Network Benefits	Out-of-network Benefits
Mental Health (Serious Mental Illness (SMI) included) and Chemical Dependency (Substance Use Disorder)		
Inpatient Services *Inpatient Chemical Dependency treatment must be provided in a Chemical Dependency/Residential Treatment Center (RTC)*		
-Hospital services (facility)	*70% of Allowable Amount after Deductible after $300 per-admission Deductible*	*50% of Allowable Amount after Deductible after $900 per-admission Deductible*
-Physician services	*70% of Allowable Amount after Deductible*	*50% of Allowable Amount after Deductible*
Penalty for failure to preauthorize services *Preauthorization required for inpatient, residential treatment centers (RTC), partial hospital program admissions, and certain outpatient professional services*	*None*	*$250*
Outpatient Services		
-Services performed during Physician office visit/consultation (does not include psychological testing)	*100% of Allowable Amount after $30 Copayment Amount*	*50% of Allowable Amount after Deductible*
-All outpatient services and psychological testing	*70% of Allowable Amount after Deductible*	*50% of Allowable Amount after Deductible*
Emergency Room/Treatment Room		
Accidental Injury & Emergency Care		
-Facility charges	*70% of Allowable Amount after $150 Copayment Amount & Deductible (Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply)*	
-Physician charges	*70% of Allowable Amount after Deductible*	
Non-Emergency Care		
-Facility charges	*70% of Allowable Amount after $150 Copayment Amount & Deductible (Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply)*	*50% of Allowable Amount after $150 Copayment Amount & Deductible (Copayment Amount waived if admitted, Inpatient Hospital Expenses will apply)*
-Physician charges	*70% of Allowable Amount after Deductible*	*50% of Allowable Amount after Deductible*
Urgent Care Services		
Urgent Care center visit, including lab & x-ray services *(does not include Certain Diagnostic Procedures and surgical services)*	*100% of Allowable Amount after $75 Copayment Amount*	*50% of Allowable Amount after Deductible*
Certain Diagnostic Procedures; such as Bone Scan, Cardiac Stress Test, CT -Scan (with or without contrast), MRI, Myelogram, PET Scan, surgical procedures and all other services and supplies.	*70% of Allowable Amount after Deductible*	*50% of Allowable Amount after Deductible*
Ground and Air Ambulance Services Preauthorization required if transferring to another facility.	*70% of Allowable Amount after Deductible*	
Preventive Care		
Routine annual physical examinations, well-baby care exams, immunizations 6 years of age & over, and any other preventive health services as determined by USPSTF	*100% of Allowable Amount*	*50% of Allowable Amount after Deductible*
Immunizations for Dependent children through the date of the child's 6th birthday	*100% of Allowable Amount*	☒*100% of Allowable Amount*

Special Provisions Expenses, cont.	In-Network Benefits	Out-of-network Benefits
Speech and Hearing Services		
Services to restore loss of or correct an impaired speech or hearing		

function	*100% of Allowable Amount after $30 Copay*	*50% of Allowable Amount after Deductible*
Hearing Aid Maximum	*Hearing aids are subject to 1 per ear per 36 month period*	

Physical Medicine Services

Chiropractic Care-Office Services	*100% of Allowable Amount after $30 Copay*	*50% of Allowable Amount after Deductible*
Maximum	*Limited to 35 visits each Year** *All other Physical Medicine Services rendered by any other eligible Provider will be allowed on the same basis as any other sickness.*	
Physical Medicine Services (includes, but is not limited to physical, occupational, speech and manipulative therapy)		
-Physician charges	*100% of Allowable Amount after $30 Copay*	*50% of Allowable Amount after Deductible*
-Outpatient charges	*70% of Allowable Amount after Deductible*	
Maximum	*Limited to 35 visits each Year**	

* Benefits used In-Network and Out-of-Network will apply toward satisfying any Annual Maximum benefits indicated

Other Common Services	*In-Network Benefits*	*Out-of-network Benefits*

Allergy

Allergy Injection with an office visit	*100% of Allowable Amount after $30 Copay*	*50% of Allowable Amount after Deductible*
Allergy Injections without an office visit	*70% of Allowable Amount after Deductible*	

Anesthesia

	70% of Allowable Amount after Deductible	*50% of Allowable Amount after Deductible*

Autism Applied Behavior

Texas State Mandate		
-Physician charges	*100% of Allowable Amount after $30 Copay*	*50% of Allowable Amount after Deductible*
-Facility charges	*70% of Allowable Amount after Deductible*	
	No maximums apply.	

Cardiac Rehabilitation

-Physician charges	*100% of Allowable Amount after $30 Copay*	*50% of Allowable Amount after Deductible*
-Facility charges	*70% of Allowable Amount after Deductible*	
	*Limited to 35 visits each Year**	

Chemotherapy

	70% of Allowable Amount after Deductible	*50% of Allowable Amount after Deductible*

Diabetic Treatment

-Physician charges	*100% of Allowable Amount after $30 Copay*	*50% of Allowable Amount after Deductible*
	Diabetic supplies are covered under the pharmacy benefit.	

Diagnostic Imaging

	70% of Allowable Amount after	*50% of Allowable Amount after*

	Deductible	*Deductible*
Dialysis		
	70% of Allowable Amount after Deductible	*50% of Allowable Amount after Deductible*
Durable Medical Equipment		
	70% of Allowable Amount after Deductible	*50% of Allowable Amount after Deductible*
Family Planning Services		
Elective Sterilization	*Not covered*	*Not covered*
Procedures	*70% of Allowable Amount after Deductible*	*50% of Allowable Amount after Deductible*
Infertility Treatment	*Not Covered*	*Not Covered*
Maternity Care - Mother		
	70% of Allowable Amount after Deductible after $300 per - admission Deductible	*50% of Allowable Amount after Deductible after $900 per - admission Deductible*
Newborn Care		
	70% of Allowable Amount after Deductible after $300 per - admission Deductible	*50% of Allowable Amount after Deductible after $900 per - admission Deductible*