# Whiteface ISD Employee Benefits plan

## SCHEDULE OF MEDICAL BENEFITS

Our Plan has changed effective September 1, 2013. The Plan is a member of the Healthsmart PPO network; however, the PPO network no longer includes any facilities. Facilities are considered Section I providers which includes hospitals, clinics, ambulatory surgery centers and other covered facilities. For these services, there will be no benefit difference among them, and you may choose any provider. The only exception to this is two hospitals with whom the Plan has direct discounts which are favorable to the Plan, and because of these discounts the Plan can offer greater benefits. Please refer to the Section I providers Schedule for the names of these hospitals.

Physicians and all other providers are considered Section II providers and the Healthsmart PPO is in place. You will generally enjoy greater benefits by selecting a PPO network provider vs. a non-PPO network provider.

Each covered person has a free choice of any provider, and the covered person, together with his provider, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care.

This Schedule is provided as a convenience only and is not all-inclusive. The benefits described in this Schedule are subject to change, and are subject to all Plan terms, conditions, maximums, limitations and exclusions applicable to a claim at the time the claim is incurred. **This description should not be considered a guarantee of eligibility, coverage or benefits.** All benefit determinations will be based upon the provisions of this Plan and the decision of the Plan Administrator in its sole discretion.

***Lifetime Maximum Benefits***
***The following lifetime maximums apply to each covered person:***

| *Lifetime Maximum Benefits for:* | |
|---|---|
| ***Lifetime Maximum for All Essential Health Benefits*** | ***Unlimited*** |
| ***Hospice Care*** | ***$10,000*** |

**The plan year for this Plan is the calendar year from September 1 through August 31 each year.**

***Plan Year Maximum Benefits***
***Plan year maximums for a benefit which is payable under both Section I and Section II providers will be combined and applied to the maximums listed below. The following plan year maximums apply to each covered person:***

| *Plan Year Maximum Benefits per Covered Person for:* | |
|---|---|
| ***Home Health Care*** | ***60 visits*** |

***Deductible, Percentage Payable and Out-of-Pocket Expense Limits***

| | **Section I Providers and PPO Network Providers** | **Non-PPO Network Providers** |
|---|---|---|
| Plan Year Deductible | | |
| • Individual | $1,500 | $4,500 |
| • Family Unit | $3,000 | $9,000 |

| | | |
|---|---|---|
| Percentage Payable (unless otherwise stated) | 80% | 60% |
| Out-of Pocket Expense Limit<br>• Individual<br>• Family Unit | <br>$2,000<br>$4,000 | <br>$6,000<br>$12,000 |
| *The out-of-pocket expense limit does not include the deductible amount and does not apply to benefits for chiropractic care. | | |

**Section I**

**Applicable to facilities including, but not limited to:**

- **Hospitals**
- **Ambulatory Health Care Centers**
- **Dialysis Facilities**

***Payment Levels and Limits – Hospitals, Ambulatory Health Care Centers and Other Facilities***

This section of the Schedule of Medical Benefits applies only to covered expenses which are rendered by hospital facilities, ambulatory health care centers, ambulatory surgery centers, dialysis clinics and other covered facilities. The benefits shown apply to all such covered, licensed providers of service without regard to participation in a PPO.

| Percentage Payable For: | Inpatient Services | Limits: |
|---|---|---|
| Hospital Medical/Surgical Inpatient Room & Board & Ancillary | 80% of allowable claim limits for semi-private room and ancillary charges<br>• **subject to a $1,000 copayment per hospital treatment*** | |
| Mental or Nervous Disorder and Substance Abuse Treatment Inpatient Room & Board & Ancillary | 80% of allowable claim limits for semi-private room and ancillary charges<br>• **subject to a $1,000 copayment per hospital treatment*** | |
| *The Plan has arranged for a special negotiated discount arrangement at the following facilities. **The $1,000 copayment requirement is waived for all of these hospital providers:**<br>• Covenant Hospital, Lubbock Texas<br>• Covenant Hospital, Levelland Texas | | |
| Skilled Nursing Facility, Convalescent Care and Extended Care Facility | 80% of allowable claim limits for semi-private room and ancillary charges<br>• deductible applies | |
| **Hospital Emergency Room Services** | | |
| Hospital Emergency Room - Accident or Illness | 80% of allowable claim limits<br>• deductible applies subject to a **$1,000 copayment per hospital treatment*** | |
| **Facility Outpatient Diagnostic Services** | | |
| Diagnostic X-ray and Laboratory | 80% of allowable claim limits<br>• deductible applies **$1,000 copayment per treatment*** | |
| Facility Charges for Routine Preventive Care | 100% of allowable claim limits<br>• deductible waived | First $750 covered at 100% charges above subject to deductible per plan year* |

| All Other Covered Facility Services and Supplies | | |
|---|---|---|
| Home Health Care Facility Charges | 80% of allowable claim limits<br>• deductible applies | 100 visits per plan year maximum |
| Hospice Facility Charges | 100% of allowable claim limits<br>• deductible waived | Limited to $10,000 per lifetime maximum benefit |
| Other Covered Expenses | 80% of allowable claim limits<br>• deductible applies | |

## ***Section II***

**Applicable to all other providers of service:**

***Payment Levels and Limits – Physician and Other Provider Expenses***

The following tables apply to all providers of service other than hospital facilities, ambulatory health care centers, and other covered facilities. Benefits are available, as shown, for reimbursement of covered expenses based upon the provider's participation in the PPO network.

| Physician's Office Services | | | |
|---|---|---|---|
| **Percentage Payable For:** | **PPO Network Providers** | **Non-PPO Network Providers** | **Limits** |
| Office Visit – Medical | 100 % of PPO rate after a copayment of $35 per visit<br>• deductible waived | 60% of usual, customary and reasonable fees<br>• deductible applies | |
| Office Visit – *Mental or Nervous Disorder* and *Substance Abuse Treatment* | 100 % of PPO rate after a copayment of $35 per visit<br>• deductible waived | 60% of usual, customary and reasonable fees<br>• deductible applies | |
| Additional Covered Services During Office Visit Including:<br>• Surgery in Doctor office<br>• Lab or X-rays<br>• Allergy Care<br>• Injections<br>• Other Covered Services **Provided treatments listed above are provided on the day of the office visit or within 3 days of the office visit** | Covered expenses payable at 100% up to $500<br><br>thereafter reimbursed at 80% of the PPO rate<br>• deductible applies | 60% of usual, customary and reasonable fees<br>• deductible applies | |
| Routine Preventive Care | 100 % of PPO rate<br>• deductible waived | 60% of usual, customary and reasonable fees<br>• deductible applies | First $750 covered at 100% charges above subject to deductible per plan year* |
| Chiropractic Care | 80% of PPO rate<br>• deductible applies | 60% of usual, customary and reasonable fees<br>• deductible applies | Limited to $1,500 per plan year maximum |

| Physician Services – Inpatient and Outpatient (other than office) | | | |
|---|---|---|---|
| **Percentage Payable For:** | **PPO Network Providers** | **Non-PPO Network Providers** | **Limits** |
| Medical/Surgical Visits | 80% of PPO rate<br>• deductible applies | 60% of usual, customary and reasonable fees<br>• deductible applies | |

| Physician Services – Inpatient and Outpatient (other than office) | | | |
|---|---|---|---|
| **Percentage Payable For:** | **PPO Network Providers** | **Non-PPO Network Providers** | **Limits** |
| *Mental or Nervous Disorder* and *Substance Abuse Treatment* Visits | 80% of PPO rate<br>• deductible applies | 60% of usual, customary and reasonable fees<br>• deductible applies | |
| Surgeon | 80% of PPO rate<br>• deductible applies | 60% of usual, customary and reasonable fees<br>• deductible applies | |
| Assistant Surgeon | 80% of PPO rate<br>• deductible applies | 60% of usual, customary and reasonable fees<br>• deductible applies | Limited to 25% of surgical fee allowance |

| Other Covered Services | | | |
|---|---|---|---|
| **Percentage Payable For:** | **PPO Network Providers** | **Non-PPO Network Providers** | **Limits** |
| Ambulance — Air or Ground Transportation | 80% of PPO rate<br>• deductible applies | 60% of usual, customary and reasonable fees<br>• deductible applies | |
| Therapy<br>• Physical<br>• Occupational<br>• Speech<br>• IV and Infusion<br>• Cardiac Rehabilitation | 80% of PPO rate<br>• deductible applies | 60% of usual, customary and reasonable fees<br>• deductible applies | |
| Chemotherapy and Radiation Therapy | 80% of PPO rate<br>• deductible applies | 60% of usual, customary and reasonable fees<br>• deductible applies | |
| Durable Medical Equipment | 80% of PPO rate<br>• deductible applies | 60% of usual, customary and reasonable fees<br>• deductible applies | |
| Home Health Services | 80% of PPO rate<br>• deductible applies | 60% of usual, customary and reasonable fees<br>• deductible applies | Limited to 60 visits per plan year maximum |
| Hospice | 100% of PPO rate<br>• deductible waived | 100% of usual, customary and reasonable fees<br>• deductible waived | Limited to $5,000 per lifetime maximum benefit |
| Diagnostic Laboratory and X-Ray, and Pathologist Fees and Radiologist Fees | 80% of PPO rate<br>• deductible applies | 60% of usual, customary and reasonable fees<br>• deductible applies | |
| Prosthetic Devices and Medical Supplies | 80% of PPO rate<br>• deductible applies | 60% of usual, customary and reasonable fees<br>• deductible applies | |
| Prescription Drugs – Pharmacy Purchase | 100% of usual, customary and reasonable fees, deductible waived, subject to copayments as follows:<br>• $5 per prescription or refill for generic drugs<br>• $25 per prescription or refill for brand name drug preferred copayment*<br>• $40 per prescription or refill for brand name drug non-preferred copayment* | | Limited to 30-day supply per purchase |
| Prescription Drugs – Mail Order Purchase | 100% of usual, customary and reasonable fees, deductible waived, subject to copayments as follows: | | Limited to 90-day supply per purchase |

| | | | |
|---|---|---|---|
| | • $12.50 per prescription or refill for generic drugs<br>• $62.50 per prescription or refill for brand name drugs preferred copayment*<br>• $100 per prescription or refill for brand name drugs non preferred copayment | | |
| *Unless a brand name drug is ordered "dispense as written" by your physician, you must also pay the difference in cost between a generic drug and its brand name equivalent. | | | |
| Other Covered Expenses | 80% of PPO rate<br>• deductible applies | 60% of usual, customary and reasonable fees<br>• deductible applies | |
| **Vision Benefits**<br>Eye Exam (including refractions)<br>Lenses, Frames and Contact Lenses | 100% deductible waived<br><br>100% deductive waived | | 1 exam per plan year<br>$200 per plan year maximum benefit |

*Preventive care benefit of up to $750 covered at 100% applies to any facility charges and/or physician charges, any charges above $750 are subject to deductible and coinsurance