Whiteface CISD 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 does not include 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 • Family Unit	 $1,500 $3,000	 $4,500 $9,000
Percentage Payable (unless otherwise stated)	80%	60%
Out-of Pocket Expense Limit • Individual • Family Unit	 $2,000 $4,000	 $6,000 $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 • **subject to a $1000 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 • **subject to a $1000 copayment per hospital treatment***	
*The Plan has arranged for a special negotiated discount arrangement at the following facilities. **The $1000 copayment requirement is waived for all of these hospital providers:** • Covenant Hospital, Lubbock Texas • 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 • deductible applies	
Hospital Emergency Room Services		
Hospital Emergency Room - Accident or Illness	80% of allowable claim limits • deductible applies subject to a $500 copayment per hospital confinement*	
Facility Outpatient Diagnostic Services		
Diagnostic X-ray and Laboratory	80% of allowable claim limits • deductible applies	
Facility Charges for Routine Preventive Care	100% of allowable claim limits • deductible waived	First $750 covered at 100% charges over subject to deductible per plan year*
All Other Covered Facility Services and Supplies		
Home Health Care Facility Charges	80% of allowable claim limits • deductible applies	100 visits per plan year maximum
Hospice Facility Charges	100% of allowable claim limits • deductible waived	Limited to $10,000 per lifetime maximum benefit
Other Covered Expenses	80% of allowable claim limits • deductible applies	

Outpatient Dialysis Services: The Plan does not use a preferred provider organization for dialysis services. The in-network deductible and co-insurance will apply.

Reimbursement for Outpatient Dialysis will be subject to Outpatient Dialysis Service Max Allowable.

Limitations/Requirements: A Covered Person must: 1) Notify Spectrum Review when diagnosed with End Stage Renal Disease ("ESRD"); and 2) Notify Spectrum Review when dialysis treatment begins;

Outpatient Dialysis Max Allowable for outpatient dialysis services is 125% of Medicare allowable fees and the Plan will adjudicate the claims using in network co-insurance.

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/Surgical	100 % of PPO rate after a copayment of $35 per visit • deductible waived	60% of usual, customary and reasonable fees • deductible applies	
Office Visit – *Mental or Nervous Disorder* and *Substance Abuse Treatment*	100 % of PPO rate after a copayment of $35 per visit • deductible waived	60% of usual, customary and reasonable fees • deductible applies	
Additional Covered Services During Office Visit or within two days of an office visit Including: • Surgery • Lab or X-rays • Allergy Care • Injections • Other Covered Services	Covered expenses payable at 100% up to $500 thereafter reimbursed at 80% of the PPO rate • deductible applies	60% of usual, customary and reasonable fees • deductible applies	
Routine Preventive Care	100 % of PPO rate • deductible waived	60% of usual, customary and reasonable fees • deductible applies	First $750 covered at 100% charges over subject to deductible per plan year*
Chiropractic Care	50% of PPO rate deductible waived	50% of usual, customary and reasonable fees	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 • deductible applies	60% of usual, customary and reasonable fees • 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 • deductible applies	60% of usual, customary and reasonable fees • deductible applies	
Surgeon	80% of PPO rate • deductible applies	60% of usual, customary and reasonable fees • deductible applies	
Assistant Surgeon	80% of PPO rate • deductible applies	60% of usual, customary and reasonable fees • 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 • deductible applies	60% of usual, customary and reasonable fees • deductible applies	
Therapy • Physical • Occupational • Speech • IV and Infusion • Cardiac Rehabilitation	80% of PPO rate • deductible applies	60% of usual, customary and reasonable fees • deductible applies	
Chemotherapy and Radiation Therapy	80% of PPO rate • deductible applies	60% of usual, customary and reasonable fees • deductible applies	
Durable Medical Equipment	80% of PPO rate • deductible applies	60% of usual, customary and reasonable fees • deductible applies	
Home Health Services	80% of PPO rate • deductible applies	60% of usual, customary and reasonable fees • deductible applies	Limited to 60 visits per plan year maximum
Hospice	100% of PPO rate • deductible waived	100% of usual, customary and reasonable fees • 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 • deductible applies	60% of usual, customary and reasonable fees • deductible applies	
Prosthetic Devices and Medical Supplies	80% of PPO rate • deductible applies	60% of usual, customary and reasonable fees • deductible applies	
Prescription Drugs – Pharmacy Purchase	100% of usual, customary and reasonable fees, deductible waived, subject to copayments as follows: • $5 per prescription or refill for generic drugs • $25 per prescription or refill for brand name drug preferred copayment* • $40 per prescription or refill for brand name drug non-preferred copayment* • $80 per prescription or refill for brand name drug when a Generic Therapeutic Alternative is available		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: • $12.50 per prescription or refill for generic drugs • $62.50 per prescription or refill for brand name drugs preferred copayment* • $100 per prescription or refill for brand name drugs non preferred copayment • $200 per prescription or refill for brand name drug when a Generic Therapeutic Alternative is available		Limited to 90-day supply per purchase
*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 • deductible applies	60% of usual, customary and reasonable fees • deductible applies	
Vision Benefits Eye Exam (including Refreactions) Lenses, Frames, and Contact Lenses	100% deductible waived 100% deductible waived		1 exam per plan year $200 per plan year maximum

*Preventive care benefit of up to $750 covered at 100% applies to any facility charges and/or physician charges