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

| | ECISD Health Plan | |
|---|---|---|
| **2018 Benefits** | In-Network Benefit | Out-Of-Network Benefit |
| **Basic Medical Care** | | |
| Primary Doctor | $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 Dr's. Perscription)** | 100% | 100% |
| Colonoscopy -Physician charges ***Preventive** | 100% | %50 after Deductible |
| Mammography Screens ***** **Preventive (Once a Year)** | 100% | %50 after Deductible |
| Osteoporosis Screening ***** **Preventive (Once a Year)** | 100% | %50 after Deductible |
| Prostate Cancer Screening ***** **Preventive (Once a Year)** | 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** | | |
| Prescription Drug Annual Deductible | $50 per Calendar Year | |
| Generic Drug Annual Deductible | Waived | |
| **Retail Prescriptions After Deductible:** | | |
| Generic Drugs | $10 Co-pay | 50% Co-Insurance |
| Brand Name Drugs | $45 Co-pay | 50% Co-Insurance |
| Non-Preferred Brand | $65 Co-pay | 50% Co-Insurance |
| Compound **(Maximum paid $300 Per Prescription)** | $45 Co-pay | 50% Co-Insurance |
| Specialty | $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, Toxid 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 |
| Impatient Hosptial Daily Fee | $300 | $900 |
| Outpatient Facility/Physcian Services | 70% | 50% |
| Out of Pocket Limit- Individual/ Family | $5,000 | $14,700 |

## Blue Cross Blue Shield 2018 Plan Year Rates

| Coverage Tier | ECISD Monthly Contribution | Employee Monthly Rate |
|---|---|---|
| Employee Only | $464.00 | $90.00 |
| Employee/Spouse | $464.00 | $468.00 |
| Employee/Children | $464.00 | $352.00 |
| Family | $464.00 | $604.00 |

Board Approved 10/10/17

# 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)**<br>-Virtual Visit<br>Medical ☐ *Yes/* ☒ *No* | *% of Allowable Amount after Copayment*<br>***Or***<br>*of Allowable Amount after Deductible* | *Same as OON OV* |
| -Virtual Visit<br>Behavioral Health ☐ *Yes/* ☒ *No*<br>**Note: Behavioral Health Virtual Visit Applies to MHP** | *% of Allowable Amount after Copayment*<br>***Or***<br>*% of Allowable Amount after Deductible* | *Same as OON MH* |
| -Telemedicine Vendor (Specific procedures and providers)<br>☒ Does not apply<br>☐ TeleDoc<br>☐ Doctor on Demand | *100% of Amount after $ Deductible*<br>**Note: Claims will be paid at billed charge** | |
| In Vitro Fertilization Services | ☒ *Decline* | |

| Extended Care Expenses | | |
|---|---|---|
| ***Extended Care Expenses***<br>*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**<br>*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<br>*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***<br>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* |