## County of El Paso Medical Schedule of Benefits Buy-Up Plan January 11,2010

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Januar	y 11,2010	
OVERVIEW	In-Network/OOA	Out of network
<u>Please Note</u> : Out of Network deductible must be met be	fore benefits are paid	
Individual Annual Deductible	\$250 🖌	\$750
Family Annual Deductible	\$500	\$1,000
Maximum Individual Out-of-Pocket	\$2,000	NO LIMIT
Maximum Family Out-of-Pocket	\$4,000	NO LIMIT
Stop Loss Protection **		
Excludes co-payments, deductibles, any Out-of-		
Network mental health or any penalty (ies).		
Coinsurance	80%	65%
Maximum Lifetime Benefit	\$2,000,000	combined
Hospital Services	\$	
UNIVERSITY MEDICAL CENTER		
PREFERRED HOSPITAL		
Inpatient/Outpatient Coinsurance	95	%
Hospital Deductible (per admission)	\$100	
Outpatient Hospital Deductible (per year)	\$2	
Maximum Individual Out-of-Pocket	\$2,0	
Maximum Family Out-of-Pocket	. \$4,0	
Emergency Use of Emergency Room Co-pay	\$100 then 80%	
Non-Emergency Use of Emergency Room Co-pay	\$100 then 80%	
OTHER PPO HOSPITAL FACILITIES	80%	
UNDER ACN		
Hospital Deductible (per admission)	\$100	
Outpatient Hospital Deductible (per year)	\$200	
Maximum Individual Out-of-Pocket	\$2,000	
Maximum Family Out-of-Pocket	, \$4,000	
Emergency Use of Emergency Room Co-pay	\$100 then 80%	
Non Emergency Use of Emergency Room Co-pay	\$100 then 80%	
NON NETWORK HOSPITAL FACILITES	50%	
Hospital Deductible(per admission)	\$100	
Outpatient Hospital Deductible (per year)		00
Maximum Individual Out-of-Pocket	NO L	
Maximum Family Out-of-Pocket	NO L	
Emergency Use of Emergency Room Co-pay	\$100 th	
Non-Emergency Use of Emergency Room Co-pay	\$100 then 50%	after deductible

## \* Refer to PPO directory

If a procedure is not available at University Medical Center or other PPO hospital facilities then benefits will be covered at 80% coinsurance level when rendered at a Non-Network facility

<u>Please Note</u>: Emergency Room co-pay will be waived only in the case of a hospital admission

	In-Network/OOA	Out of Network
Professional Services		
Office Visit *	\$30 Co-payment	65%
	Office Visit then	0070
A dult Proting Developed anomalimit to	covered @100%	
Adult Routine Physical exams limit to:		
• Routine annual physical exam (one per year)	\$30 Co-payment	not covered
	Office Visit then	
	covered @100%	
• One well woman exam to include pap smear	\$30 Co-payment	not covered
(one per year)	Office Visit then	
	covered @100%	
• Immunizations (all ages)	100%	not covered
• Mammography (one per year)**	100%	not covered
• DXA Bone Density Test (one per year)**	100% not to exceed \$300	not covered
• Colonoscopy (age 50 & older, not to exceed	100%	not covered
one per 10 years)**		
<ul> <li>Colorectal and Prostate exams (one per year)</li> </ul>	100%	not covered
	100%	not covered
• Labs		
• EKG (one per year)	100%	not covered
	m and do not require a co-pay	
	80%	65%
Surgeon Assistant Surgeon Office Visits	80% 80%	65% 65%
Assistant Surgeon Office Visits	80% 80% 80%	65% 65% 65%
Assistant Surgeon Office Visits All Other Office <b>Services/Procedures</b>	80% 80% 80% 80%	65% 65% 65%
Assistant Surgeon Office Visits All Other Office <b>Services/Procedures</b> Hospital Visits	80% 80% 80% 80%	65% 65% 65% 65% 65%
Assistant Surgeon Office Visits All Other Office <b>Services/Procedures</b> Hospital Visits Allergy Tests and Treatments	80% 80% 80% 80%	65% 65% 65%
Assistant Surgeon Office Visits All Other Office <b>Services/Procedures</b> Hospital Visits Allergy Tests and Treatments Chiropractic Care	80% 80% 80% 80% 80%	65% 65% 65% 65% 65%
Assistant Surgeon Office Visits All Other Office <b>Services/Procedures</b> Hospital Visits Allergy Tests and Treatments Chiropractic Care Office Visit	80% 80% 80% 80% 80% 80% \$30 co-pay then 100%	65% 65% 65% 65% 65% 65%
Assistant Surgeon Office Visits All Other Office <b>Services/Procedures</b> Hospital Visits Allergy Tests and Treatments Chiropractic Care Office Visit	80% 80% 80% 80% 80% \$30 co-pay then 100% 80%	65% 65% 65% 65% 65% 65%
Assistant Surgeon Office Visits All Other Office <b>Services/Procedures</b> Hospital Visits Allergy Tests and Treatments Chiropractic Care Office Visit Other Services	80% 80% 80% 80% 80% 80% \$30 co-pay then 100%	65% 65% 65% 65% 65% 65%
Assistant Surgeon Office Visits All Other Office <b>Services/Procedures</b> Hospital Visits <u>Allergy Tests and Treatments</u> Chiropractic Care Office Visit Other Services Mental Health	80% 80% 80% 80% \$30 co-pay then 100% 80% \$2000 maximu	65% 65% 65% 65% 65% 65% m combined
Assistant Surgeon Office Visits All Other Office <b>Services/Procedures</b> Hospital Visits Allergy Tests and Treatments Chiropractic Care Office Visit Other Services Mental Health Inpatient	80% 80% 80% 80% 80% \$30 co-pay then 100% 80%	65% 65% 65% 65% 65% 65%
Assistant Surgeon Office Visits All Other Office <b>Services/Procedures</b> Hospital Visits Allergy Tests and Treatments Chiropractic Care Office Visit Other Services Mental Health Inpatient Facility	80% 80% 80% 80% \$30 co-pay then 100% 80% \$2000 maximu 80%	65% 65% 65% 65% 65% 65% m combined 65%
Assistant Surgeon Office Visits All Other Office <b>Services/Procedures</b> Hospital Visits <u>Allergy Tests and Treatments</u> Chiropractic Care Office Visit Other Services Mental Health Inpatient Facility Physician	80% 80% 80% 80% \$30 co-pay then 100% 80% \$2000 maximu 80% 80%	65% 65% 65% 65% 65% <u>65%</u> 65% 65%
Assistant Surgeon Office Visits All Other Office <b>Services/Procedures</b> Hospital Visits Allergy Tests and Treatments Chiropractic Care Office Visit Other Services Mental Health Inpatient Facility Physician Outpatient	80% 80% 80% 80% \$30 co-pay then 100% 80% \$2000 maximu 80%	65% 65% 65% 65% 65% 65% m combined 65%
Assistant Surgeon Office Visits All Other Office <b>Services/Procedures</b> Hospital Visits Allergy Tests and Treatments Chiropractic Care Office Visit Other Services	80% 80% 80% 80% \$30 co-pay then 100% 80% \$2000 maximu 80% 80%	65% 65% 65% 65% 65% <u>65%</u> 65% 65%
Assistant Surgeon Office Visits All Other Office Services/Procedures Hospital Visits Allergy Tests and Treatments Chiropractic Care Office Visit Other Services Mental Health Inpatient Facility Physician Outpatient Physician Other Services	80% 80% 80% 80% 80% \$30 co-pay then 100% 80% \$2000 maximu 80% 80% 80%	65% 65% 65% 65% 65% m combined 65% 65% 65% 65%
Assistant Surgeon Office Visits All Other Office <b>Services/Procedures</b> Hospital Visits <u>Allergy Tests and Treatments</u> Chiropractic Care Office Visit Other Services Mental Health Inpatient Facility Physician Outpatient Physician	80% 80% 80% 80% 80% \$30 co-pay then 100% 80% \$2000 maximu 80% 80% 80%	65% 65% 65% 65% 65% m combined 65% 65% 65% 65%
Assistant Surgeon Office Visits All Other Office Services/Procedures Hospital Visits Allergy Tests and Treatments Chiropractic Care Office Visit Other Services Mental Health Inpatient Facility Physician Outpatient Physician Other Services Skilled Nursing Facility	80% 80% 80% 80% 80% 80% 80% 80% 80% 80%	65% 65% 65% 65% 65% 65% 65% 65% 65% 65%
Assistant Surgeon Office Visits All Other Office Services/Procedures Hospital Visits Allergy Tests and Treatments Chiropractic Care Office Visit Other Services Mental Health Inpatient Facility Physician Outpatient Physician Other Services Skilled Nursing Facility Preferred Lab	80% 80% 80% 80% 80% 80% \$2000 maximu 80% 80% 80% 80% 80% 80% 80% 80%	65% 65% 65% 65% 65% 65% 65% 65% 65% 65%
Assistant Surgeon Office Visits All Other Office Services/Procedures Hospital Visits Allergy Tests and Treatments Chiropractic Care Office Visit Other Services Mental Health Inpatient Facility Physician Outpatient Physician Other Services Skilled Nursing Facility	80% 80% 80% 80% 80% 80% 80% 80% 80% 80%	65% 65% 65% 65% 65% 65% 65% 65% 65% 65%

	Prior appro	val required
Registered Private Duty Nursing	No Benefit	No Benefit
Hospice Care	80%	65%
Ambulance		
Emergency Use	80%	80%
Transports/Non-Emergency Use	80%	65%
Physical and Speech Therapy	80%	65%
Prosthetic	80%	65%
Durable Medical Equipment	80%	65%

OVERVIEW	In Network/OOAN	Out of Network
Prescription Drugs * (30 day Retail supply)	\$5 co-pay/Generic Drugs	65% after deductible
	\$20 co-pay Preferred Brand Name Drugs	
	\$35 go-pay Non-Preferred Brand Name Drugs	
Mail Order Drugs *	\$10 co-pay/Generic	no coverage
(90 day supply)	\$40 co-pay Preferred Brand Name Drugs	
	\$70 co-pay Non-Preferred Brand Name Drugs	

Pre-admission and Concuwent Review	Included	Required
Large Case Management	Included	Included

## County of El **Paso** Medical Schedule of Benefits Core Plan January 11,2010

OVERVIEW	In-Network/OOA	Out of network
<u>Please Note</u> : Out & Network deductible must be met bef	fore benefits are paid	
Individual Annual Deductible	\$1000	\$2000
Family Annual Deductible	\$2000	\$4,000
Maximum Individual Out-of-Pocket	\$2,500	NO LIMIT
Maximum Family Out-of-Pocket	\$5,000	<b>NO</b> LIMIT
Stop Loss Protection **		
** Excludes co-payments, deductibles, any Out-of- Network mental health or any penalty (ies).		
Coinsurance	80%	65%
Maximum Lifetime Benefit	\$2,000,000 combined	
Hospitnl Services		
UNIVERSITY MEDICAL CENTER PREFERRED HOSPITAL		
Inpatient/Outpatient Coinsurance	95	5%
Hospital Deductible (per admission)	\$100	
Outpatient Hospital Dcductible (per year)	\$200	
Maximum Individual Out-of-Pocket	\$2,500	
Maximum Family Out-of-Pocket	\$5,000	
Emergency Use of Emergency Koom Co-pay	\$100 then 80%	
Non-Emergency Use of Emergency Room Co-pay	\$100 then 80%	
OTHER PPO HOSPITAL FACILITIES	80%	
UNDER ACN		
Hospital Deductible (per admission)	\$100	
Outpatient Hospital Deductible (per year)	\$200	
Maximum Individual Out-of-Pocket	\$2,500	
Maximum Family Out-of-pocket	\$5,000	
Emergency Use of Emergency Room Co-pay	\$100 then 80%	
Non Emergency Use of Emergency Room Co-pay	\$100 then 80%	
NON NETWORK HOSPITAL FACILITES	50%	
Hospital Deductible (per admission)	\$100	
Outpatient Hospital Deductible (per year)	•	200
Maximum Individual Out-of-Pocket		JMIT
Maximum Family Out-of-Pocket		IMIT
Emergency Use of Emergency Room Co-pay	\$100 th	
Non-Emergency Use of Emergency Room Co-pay	\$100 then 50%	after deductible

## \* Refer to PPO directory

If a procedure is not available at University Modical Center or other PPO hospital fueillities then benefits will be covered at 80% coinsurance level when rendered at a Non-Network facility

<u>Please Note</u>: Emergency Room co-pay will be waived only in the case of a hospital admission

OVERVIEW	In-Network/OOA	Out of Network
Professional Services		
Office Visit *	\$35 Co-payment	65%
	Office Visit then	
	covered $(\hat{a})100\%$	
Adult Routine Physical exams limit to:		
• Routine annual physical exam (one per year)	\$35 Co-payment	not covered
- Routine unitur physical exam (one per year)	Office Visit then	not covered
	covered @100%	
	covered wrown	
Well woman exam to include pap smear (one	\$35 Co-payment	not covered
per year)	Office Visit then	
por jour,	covered @100%	
	0010104 (4910070	
• Immunizations (all ages)	100%	not covered
Mammography (onc pcr ycar)**	100%	not covered
• DXA Bone Density Tesl (one per year)**	100% not to exceed	not covered
	\$300	
• Colonoscopy (age 50 & older, not to exceed	100%	not covered
one per 10 years)** ***		
• Colorcctal and Prostate exams (one per year)	100%	not covered
• Labs	100%	not covered
• EKG (one per year)	100%	not covered
*Excludes any procedures such as labs, x-ray, etc.		
**'These services are considered a part of the annual example.	m and do not require a co-pay	vment
Surgeon	80%	65%
Assistant Surgeon	80%	65%
Office Visits	80%	65%
All Other Office Services/Procedures	80%	65%
Iospital Visits	80%	65%
Allergy Tests and Treatments	80%	65%
Chiropractic Care		
Office Visit	\$35 co-pay then 100%	65%
Other Services	80%	65%
	\$2000 maximu	
Mental Health		
npatient	80%	65%
Facility	6670	0570
Physician	80%	65%
Dutpatient	80%	65%
hysician		
ther Services		
killed Nursing Facility	80%	65%
	60 days co	
Preferred Lab	100%	N/A
Diagnostic X-ray & Lab Chemo/Radiation Thcrapy	80%	65%
Home Hcalth Carc	80%	65%
	80%	65%
	Prior approva	1

Registered Private Duty Nursing	No Benefit	No Benefit
Hospice Care	80%	G5%
Ambulance		
Emergency Use	80%	80%
Transports/Non-Emergency IJse	80%	65%
Physical ond Speech Therapy	80%	65%
Prosthetic	80%	G5%
Durable Medical Equipment	80%	65%

OVERVIEW	In Network/OOAN	Out of Network	
Prescription Drugs *	\$10 co-pay/Generic Drugs	65% after deductible	
(30 day Retail supply)	\$25 co-pay Preferred Brand Name Drugs		
	\$40 co-pay Non-Preferred Brand Name Drugs		
Mail Order <b>Drugs</b> *	\$20 co-pay/Generic	no coverage	
(90 day supply)	\$50 co-pay Preferred Brand Name Drugs		
	\$80 co-pay Non-Preferred Brand Name Drugs		

\* Please see "Prescription Drug Expense Coverage" section for details on Drug Benefits