Benefits Fact Sheet

ERS
Employees Retirement System of Texas

Plan Year 2019

Scott&White HEALTH PLAN

1 (800) 321-7947
ers.swhp.org

Part of BaylorScott&White HEALTH

SWADMIN_240_2018

BENEFIT DESCRIPTION	MEMBER PAYS
Total plan year* out-of-pocket maximum per person (Including coinsurance and copayments, not mutually exclusive from other out-of-pocket limits.)	$6,650
Total plan year* out-of-pocket maximum per family (Including coinsurance and copayments, not mutually exclusive from other out-of-pocket limits.)	$13,300
Plan year* out-of-pocket coinsurance maximum per person	$2,000
Lifetime maximum	None
PHYSICIANS AND LAB SERVICES	**MEMBER PAYS**
Physician office visit – Primary care physician	$25
Specialist office visit	$40
Routine preventive care – Once per calendar year or as directed by the primary care physician • Children and Well-Baby periodic exams • Men's and Women's health exams	No charge
*Diagnostic X-rays, mammography, lab tests	20%
High-tech radiology (CT Scan, MRI and Nuclear Medicine) – Outpatient testing only	$100 copayment plus 20%
Immunizations – For children and adults	No charge
Vision– For all enrolled Participants	20% without office visit; $40 plus 20% with office visit
Colorectal cancer screening – Subject to language in 13.4.13.2 of the Description of Benefits in your EOC (zero cost sharing for certain preventive services under the Affordable Care Act)	No charge
Exam for detection and prevention of osteoporosis – Subject to language in 13.4.13.3 of the Description of Benefits in your EOC (zero cost sharing for certain preventive services under the Affordable Care Act)	No charge
Cervical cancer screening – Subject to language in 13.4.13.5 of the Description of Benefits in your EOC (zero cost sharing for certain preventive services under the Affordable Care Act)	No charge
Tubal ligation – (zero cost sharing for certain preventive services under the Affordable Care Act)	No charge
Speech and hearing testing – For all enrolled participants	20% without office visit; $40 plus 20% with office visit
Speech therapy and rehabilitative therapy, including physical and occupational therapy – Covered as any other illness and not subject to any maximum	20% without office visit; $40 plus 20% with office visit
Allergy testing	20%
Allergy serum	20%
Allergy serum administration – When allergy shot is administered without an office visit	20%
Routine eye exam – One per plan year	$40
Office surgery and procedures (all office surgeries, excluding vasectomies and tubal ligations)	20%
Maternity care (physician services only) – Prenatal and postnatal care, and network obstetrician delivery charges (including delivery by C-section) – see "Hospital Services" for inpatient charges (Does not include complications of pregnancy.)	Prenatal office visit and obstetrician delivery: No charge Postnatal office visit: $25 copayment primary care physician; $40 copayment specialist
Family planning	$40
Vasectomy	20%
Infertility benefits	50%

*Plan Year 2019 is from September 1, 2018 through August 31, 2019

**Under the Affordable Care Act, certain preventive and women's health services are paid at 100% (i.e., at no cost to the member) dependent upon physician billing and diagnosis. In some cases, you will be responsible for payment of some services.

HOSPITAL SERVICES	MEMBER PAYS
Inpatient hospital – Semi-private room and board or intensive care units	$150 per day copayment per admission, up to $750 copayment max. per admission, $2,250 copayment max. per person per year plus 20%
Outpatient day surgery	$100 copayment plus 20%
Other inpatient charges, including medically necessary surgical procedures. Includes orthognathic surgery. Guest trays, cots, telephone, maternity kits, paternity kits and other personal items not covered.	$150 per day copayment per admission, up to $750 copayment max. per admission, $2,250 copayment max. per person per year plus 20%
Blood and blood products – Inpatient and outpatient	20%
Private duty nursing – Based on medical necessity	20%
Outpatient facilities, including pre-admission testing and/or treatment room	20%
Emergency care – In-area and out-of-area covered at listed copayment. If hospitalized, copayment is applied to hospital confinement.	$150 copayment plus 20%
Urgent care	$50 copayment plus 20%
Skilled nursing facility (based on medical necessity)	20%
Hospice care – Inpatient and outpatient (based on medical necessity)	20%
Home health	20%
OTHER MEDICAL SERVICES	**MEMBER PAYS**
Chiropractic care (refer to Manipulative Therapy benefit for specifics)	20% without office visit; $40 plus 20% with office visit. Maximum number of manipulative therapy visits: 35 per plan year*
Hearing aids (repairs not covered)	Plan pays $1,000 per ear every 3 years
Hearing aid batteries – Not subject to any maximum amounts	20%
Accidental dental – Restoration or replacement of dental work that was in place at the time of the injury, including, but not limited to, crowns, veneers, bridges, and implants, occurring while covered under the plan for services provided within 24 months of the date of the accident. Certain oral surgeries are covered.	20%
Durable Medical Equipment (DME) – Includes medically necessary purchase and/or rental. Benefits for rental are limited to, and will not exceed, the purchase price of the equipment. (Repairs are covered if not due to neglect or abuse.) This benefit also includes diabetic supplies other than insulin, diabetic oral agent(s) and syringes as specified in Section 1358.051(2), Tex. Ins. Code.	20%
Prostheses – Artificial devices, surgical or non-surgical, which replace body parts, including arms, legs, eyes and cochlear implants are covered. Replacements and repairs are covered as required by medical necessity. Prosthetic devices, orthotic devices, and professional services related to the fitting and use of these devices are included, if services are pre-authorized and provided by a contracted provider.	20%
Organ transplants – Covered as any other illness for kidney, cornea, liver, heart, heart-lung, lung, pancreatic-kidney, bone marrow and other organ transplants that the HMO determines to be not experimental and/or not investigational according to current medical plan guidelines. Donor expenses are covered. Artificial organs (e.g., heart) not covered.	$150 per day copayment per admission, up to $750 copayment max. per admission, $2,250 copayment max. per person per year plus 20%
Ambulance – Professional local ground or air ambulance transportation services to the nearest hospital, appropriately equipped and staffed for the treatment of the participant's condition	20%

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BEHAVIORAL HEALTH CARE BENEFITS	MEMBER PAYS
Inpatient mental health	$150 per day copayment per admission, up to $750 copayment max. per admission, $2,250 copayment max. per person per year plus 20%
Inpatient serious mental illness – Covered as any other illness	$150 per day copayment per admission, up to $750 copayment max. per admission, $2,250 copayment max. per person per year plus 20%
Inpatient chemical dependency – Covered as any other illness (based on medical necessity)	$150 per day copayment per admission, up to $750 copayment max. per admission, $2,250 copayment max. per person per year plus 20%
OUTPATIENT MENTAL HEALTH THERAPY	**MEMBER PAYS**
Outpatient serious mental illness therapy – Covered as any other illness	$25
Outpatient chemical dependency therapy – Same as any other illness and not subject to any maximums	$25
PRESCRIPTION DRUGS	**MEMBER PAYS**
Plan year* deductible	$50
If a brand name medication is dispensed when a generic is available, member will be responsible for the generic copayment plus the cost difference between the generic and the brand name medication.	
PARTICIPATING RETAIL PHARMACY	**MEMBER PAYS** (Tier 1 / Tier 2 / Tier 3)
Up to a 30-day supply per prescription or refill of Non-Maintenance medication	$10 / $35 / $60
Up to a 30-day supply per prescription or refill of Maintenance medication	$10 / $45 / $75
Infertility drugs	50%
Up to a 30-day supply of insulin for one copayment	$10 / $35 / $60
Up to a 30-day supply of each diabetic oral agent for one copayment	$10 / $35 / $60
The supply of necessary disposable syringes for the insulin for one copayment	$35
Diabetic supplies other than insulin, diabetic oral agent(s) and syringes as specified in Section 1358.051(2), Tex. Ins. Code. Up to a 30-day supply.	20%
MAIL ORDER PHARMACY	**MEMBER PAYS** (Tier 1 / Tier 2 / Tier 3)
Up to a 90-day supply per prescription or refill for one mail order copayment	$30 / $105 / $180
Infertility drugs	50%
Up to a 90-day supply of insulin for one mail order copayment	$30 / $105 / $180
Up to a 90-day supply of each diabetic oral agent for one mail order copayment	$30 / $105 / $180
The supply of necessary disposable syringes for the insulin for one mail order copayment	$105
Diabetic supplies other than insulin, diabetic oral agent(s) and syringes as specified in Section 1358.051(2), Tex. Ins. Code. Up to a 90-day supply.	20%

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