

# FIRSTCARE

## SCHEDULE OF COPAYMENTS EMPLOYEES RETIREMENT SYSTEM OF TEXAS TEXAS EMPLOYEES GROUP BENEFITS PROGRAM

The following is a summary of the Copayment amounts You and any Dependents must pay when receiving the services listed below. These services must be performed, prescribed, or directed by Your Primary Care Physician or designated OB/GYN Physician. Please refer to Your Evidence of Coverage for a detailed explanation of covered and non-covered services.

Benefit Description	Member Copayments FY2007
<b>Physicians and Lab Services</b>	
Physician Office Visit - Primary Care Physician (PCP)	\$30
Specialist Office Visit	\$40
Routine physicals – One per plan year for adults; periodic for children, or as directed by the Primary Care Physician	\$30 to the PCP or \$40 to the specialist
Diagnostic x-rays, mammography, and lab tests	No Copayment
Immunizations – For children 0 to 6 years of age	No Copayment
Immunizations – For children 7 years and older, and adults	\$30
Well Woman exam – One per plan year	\$30 to the PCP or \$40 to the specialist
Vision, speech, and hearing screenings – For all enrolled Participants	\$40
Speech & hearing testing (covered for all Participants)	\$40
Speech therapy and rehabilitative therapy, including physical and occupational therapy. Covered as any other illness and not subject to any maximum.	\$40
Allergy testing	\$40
Allergy serum	50% of the Allowable Amount
Allergy serum administration - When allergy shot is administered <b>without</b> an office visit.	No Copayment
Routine eye exam - One per plan year	\$40
Office surgery & diagnostic procedures (all office surgeries, excluding vasectomies and tubal ligations)	\$30 to the PCP or \$40 to the specialist
Maternity care – Physician services, including diagnosis of pregnancy, pre & post-natal care, and delivery (including delivery by C-section) – see “Hospital Services” for Inpatient charges.	No Copayment
Family planning	\$40
Vasectomy & tubal ligation	No Copayment
Infertility benefits	50% of the Allowable Amount
<b>Hospital Services</b>	
Inpatient hospital - Semi - private room & board or intensive care units.	\$100 per day per admission; 5 day maximum; \$1,500 max. per person per year
Outpatient day surgery	\$100
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.	No Copayment
Blood and blood products - Inpatient & outpatient	No Copayment
Private Duty Nursing, based on medical necessity	No Copayment
Outpatient facilities, including pre-admission testing and/or treatment room	No Copayment

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Emergency care – <b>ER Copayment waived if admitted - Hospital stay of at least 24 hours; Inpatient Copayment will apply.</b>	\$100
Urgent care – Includes Physician's after-hours care or services provided at an urgent care facility	\$50
<b>Extended Care Services (Based on medical necessity)</b>	
Skilled Nursing facility – Covered up to 60 days per plan year	No Copayment
Hospice Care - Inpatient and outpatient	No Copayment
Home health	No Copayment
Private duty nursing	No Copayment
<b>Other Medical Services</b>	
Hearing aids (Repairs not covered)	Plan pays \$500 per ear every 3 years
Hearing aid batteries – Not subject to any maximum amounts	No Copayment
Dental – Restoration & correction of damage caused by external violent accidental injury to healthy, natural teeth, occurring while covered under the plan for services provided within 24 months of the date of the accident. Certain oral surgeries are covered.	\$40
Durable Medical Equipment – 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 as specified in Section 1358.051(2), Tex.Ins.Code.	20% of the Allowable Amount
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 up to a \$10,000 maximum per occurrence.	20% of the Allowable Amount
Organ Transplants – Covered as any other illness for kidney, cornea, liver, heart, heart-lung, pancreatic-kidney, bone marrow, and other organ transplants that the HMO determines to be non-experimental and/or investigational according to current medical policy guidelines. Artificial organs (e.g. heart) not covered. Donor expenses are covered.	No Copayment (Hospital Copayments will apply)
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.	No Copayment
<b>Behavioral Health</b>	
Inpatient mental health – Covered up to 30 days per Plan Year. \$1500 Copayment maximum per person per Plan year for any hospital inpatient confinement (including behavioral health).	\$100 per day; not to exceed \$500 Copayment per admission; \$1,500 max. per person per year
Inpatient serious mental illness – Covered as any other illness. \$1500 Copayment maximum per person per Plan Year for any hospital inpatient confinement (including behavioral health).	\$100 per day; not to exceed \$500 Copayment per admission; \$1,500 max. per person per year
Inpatient chemical dependency – Covered as any other illness, based on medical necessity	\$100 per day; not to exceed \$500 Copayment per admission; \$1,500 max. per person per year

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**SCHEDULE OF COPAYMENTS  
EMPLOYEES RETIREMENT SYSTEM OF TEXAS  
TEXAS EMPLOYEES GROUP BENEFITS PROGRAM**

Benefit Description	Member Copayments FY2007
Inpatient chemical dependency – Covered as any other illness, based on medical necessity	\$100 per day; not to exceed \$500 Copayment per admission; \$1,500 max. per person per year
Outpatient mental health – 25 visits per Plan Year	\$40
Outpatient serious mental illness – Covered as any other illness	\$40
Outpatient chemical dependency – Same as any other illness and not subject to any maximums	\$40
<b>Prescription Drugs*</b>	
<b>Pharmacy deductible per person per Plan Year</b>	\$50
Up to a 30-day supply of non-maintenance medication for one Copayment	\$10/\$25/\$40
Up to a 30-day supply of maintenance medication for one Copayment	\$15/\$35/\$55
Infertility drugs	50% of the Allowable Amount
Up to a 30-day supply of insulin and diabetic oral agent(s) for one Copayment	\$10/\$25/\$40
The supply of necessary disposable syringes for the insulin supply for one Copayment	\$10/\$25/\$40
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. Limited up to a 30-day supply.	20%
<b>Mail Order Pharmacy-Generic, Preferred and Non-Preferred</b>	
Up to a 90 day supply per prescription or refill for one mail order copayment	\$30/\$75/\$120
Oral Contraceptives up to a 90-day supply for one mail order copayment	\$30/\$75/\$120
Infertility drugs	50%
Up to a 90-day supply of insulin and diabetic oral agent(s) for one mail order copayment.	\$30/\$75/\$120
The supply of necessary disposable syringes for the insulin supply for one mail order copayment	\$30/\$75/\$120
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. Limited up to a 90-day supply.	20% of the Allowable Amount

**\*Generic medications will be dispensed unless the medication required does not have a Generic Equivalent. If a Brand Name medication is dispensed when a Generic is available, You will be responsible for the Generic Copayment plus the cost difference between the Generic and the Brand Name medication**