FirstCare – Health Plans that Work for Texans

SUMMARY OF BENEFITS
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's Copayment PY 2009
Physicians and Lab Services	
Physician Office Visit Primary Care Physician Specialist Office Visit	$30 $40
Routine physicals-One per plan year for adults; periodic for children, or as directed by the primary care physician	$30 or $40
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 or $40
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%
Allergy serum administration-When allergy shot is administered **without** an office visit	No copayment
Routine eye exam-one per plan year	$40
Office surgery & procedures (all office surgeries, excluding vasectomies and tubal ligations)	$30 or $40
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%
Hospital Services	
Inpatient hospital-Semi-private room & board or intensive care units	$100 per day copayment per admission, 5 day max. $1500 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 - In-area and out-of-area covered at listed copayment. If hospitalized, copayment is waived	$100
Urgent care - Includes physician's after-hours care or at an urgent care facility	$50
Extended Care Services (Based on medical necessity)	
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
Other Medical Services	
Hearing aids - $500.00 per ear every 3 years (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 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.	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	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
Behavioral Health	
Inpatient mental health-Covered in full up to 30 days per plan year	$100 per day copayment per admission, 5 day max. $1500 max. per person per year
Inpatient serious mental illness-Covered as any other illness	$100 per day copayment per admission, 5 day max. $1500 max. per person per year
Inpatient chemical dependency-Covered as any other illness, based on medical necessity	$100 per day copayment per admission, 5 day max. $1500 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

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Benefit Description	Member's Copayment PY 2009
Prescription Drugs **Plan Year Deductible**	**$50**
If a Brand Name medication is dispensed when a Generic is available, member shall be responsible for the Generic Copayment plus the cost difference between the Generic and the Brand Name medication	
Participating Retail Pharmacy-Tier 1, Tier 2 & Tier 3 Up to a 30-day supply per prescription or refill of **Non-Maintenance** medication	$10/$25/$40
Up to a 30-day supply per prescription or refill of **Maintenance** medication	$15/$35/$55
Infertility drugs are paid at 50% copayment	50%
Up to a 30-day supply of insulin for one copayment	$10/$25/$40
Up to a 30-day supply of each diabetic oral agent for one copayment	$10/$25/$40
The supply of necessary disposable syringes for the insulin supply for one copayment	$25
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. Up to a 30-day supply for a 20% copayment	20%
Mail Order Pharmacy-Tier 1, Tier 2 & Tier 3	
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 are paid at 50% copayment	50%
Up to a 90-day supply of insulin for one mail order copayment	$30/$75/$120
Up to a 90-day supply of each diabetic oral agent for one mail order copayment	$30/$75/$120
The supply of necessary disposable syringes for the insulin supply for one mail order copayment	$75
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. Up to a 90-day supply for a 20% copayment	20%

VALUE-ADDED SERVICES

Preferred Glucose Meters .... No Co-pay
Preferred Diabetic Test Strips (30 day supply) .... 10% Coinsurance per item

ERS cannot and does not guarantee the length of time that a specific type of "Value-Added" product shall be offered. Any questions or concerns about these products, should be directed to the sponsoring HMO.