SCHEDULE OF BENEFITS

The following is a summary of the benefit options available to each participant during a qualified enrollment period. Descriptions below summarize participant cost sharing, prior authorization requirements, limitations and exclusions.
The Plan utilizes a preferred provider network for professional and facility services, effective 12/1/22 through the PHCS preferred provider network.

PLAN FEATURES		"New" Low Utilizer Plan		QHDHP / HSA		Basic "Mid Plan"		Choice		Select	
S&S Plan Code:		TEX5		TEX3		TEX1		TEX2		TEX4	
Type of Coverage		Point of Service		Point of Service		Point of Service		Point of Service		Point of Service	
Professional & Anciliary - Preferred Network		PHCS/Multiplan		PHCS/Multiplan		PHCS/Multiplan		PHCS/Multiplan		PHCS/Multiplan	
Inpatient & Outpatient - Facility		Open Access Multiple Texas Hospital & Provider Systems		Open Access Multiple Texas Hospital & Provider Systems		Open Access Multiple Texas Hospital & Provider Systems		Open Access Multiple Texas Hospital & Provider Systems		Open Access Multiple Texas Hospital & Provider Systems	
PCP Requirement		None		None		None		None		None	
DEDUCTIBLE & COINSURANCE		In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
Deductible - Individual		$6,000	$12,000	$3,000	$6,000	$3,000	$6,000	$1,500	$3,000	$1,500	$3,000
Deductible - Family		$12,000	$24,000	$6,000	$12,000	$6,000	$12,000	$3,000	$6,000	$3,000	$6,000
Coinsurance		80% after Deductible	70% after Deductible	80% after Deductible	70% after Deductible	80% after Deductible	70% after Deductible	80% after Deductible	70% after Deductible	80% after Deductible	70% after Deductible
Out of Pocket Maximum		In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
Individual		$7,500	$15,000	$7,050	$14,100	$7,500	$15,000	$7,500	$15,000	$7,500	$15,000
Family		$15,000	$30,000	$14,100	$28,200	$15,000	$30,000	$15,000	$30,000	$15,000	$30,000
Maximum Plan Year Benefits		Unlimited		Unlimited		Unlimited		Unlimited		Unlimited	
MEDICAL BENEFITS	**Prior Auth Required[3]**	**Member Pays**		**Member Pays**		**Member Pays**		**Member Pays**		**Member Pays**	
PHYSICIAN SERVICES		In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
Primary Care Office Visit *(applies to visit only)*	No	$30 Copay	30% after deductible	20% after deductible	30% after deductible	$30 Copay	30% after deductible	$30 Copay	30% after deductible	$30 Copay	30% after deductible
Specialist Office Visit	No	$70 Copay	30% after deductible	20% after deductible	30% after deductible	$70 Copay	30% after deductible	$70 Copay	30% after deductible	$70 Copay	30% after deductible
Services provided in a Physicians Office (other than the office visit ~~copay~~)	No	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible
Urgent Care	No	$50 Copay	30% after deductible	20% after deductible	30% after deductible	$50 Copay	30% after deductible	$50 Copay	30% after deductible	$50 Copay	30% after deductible
Telemedicine Services (1 800 MD)	No	$0	no coverage	$0	no coverage	$0	no coverage	$0	no coverage	$0	no coverage
PREVENTIVE & WELLNESS SERVICES *(ACA required preventive services only)*		In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
Services at **Physician Office**	No	$0 Copay	30% after deductible	$0 Copay	30% after deductible	$0 Copay	30% after deductible	$0 Copay	30% after deductible	$0 Copay	30% after deductible
Outpatient Hospital Free Standing Facility Services	Yes	$0 Copay	30% after deductible	$0 Copay	30% after deductible	$0 Copay	30% after deductible	$0 Copay	30% after deductible	$0 Copay	30% after deductible
HOSPITAL/FACILITY SERVICES		In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
Inpatient Hospitalization	Yes	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible
Inpatient Visits - Physician	Incl in Hospital	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible
Inpatient Surgery (Second surgical opinion may be required)	Yes	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible
Inpatient Diagnostic Services *(Lab, x-ray, CT, MRI, MRA, PET scan)*	Incl in Hospital	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible
Outpatient Hospital Free Standing Facility Services and Surgery	Yes	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible
Anesthesia	No	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible
Emergency Room Services (Life threatening Services)	No	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible
Emergency Room Services (Non-Emergent Care)	No	Not Covered / 100% paid by Member		Not Covered / 100% paid by Member		Not Covered / 100% paid by Member		Not Covered / 100% paid by Member		Not Covered / 100% paid by Member	
***DIAGNOSTIC SERVICES* (Outpatient)**		In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
Laboratory Services	**No**	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible	$70 Copay	30% after deductible
Radiology (x-ray, ultrasound)	**No**	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible	$70 Copay	30% after deductible
CT / MRI / MRA / PET Scan	**Yes**	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible	$500 Copay	30% after deductible
PREGNANCY BENEFITS		In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
Physician Visits	**No**	$30 Copay	30% after deductible	20% after deductible	30% after deductible	$30 Copay	30% after deductible	$30 Copay	30% after deductible	$30 Copay	30% after deductible
Testing/Childbirth/Delivery	**No**	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible
MENTAL & NERVOUS; CHEMICAL DEPENDENCY		In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
Office Visits *(outpatient)*	**No**	$30 Copay	30% after deductible	20% after deductible	30% after deductible	$30 Copay	30% after deductible	$30 Copay	30% after deductible	$30 Copay	30% after deductible
Inpatient *(Facility)*	**Yes**	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible
Outpatient *(Facility)*	**Yes**	$30 Copay	30% after deductible	20% after deductible	30% after deductible	$30 Copay	30% after deductible	$30 Copay	30% after deductible	$30 Copay	30% after deductible
OTHER SERVICES; Network requirements		In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
Allergy Office visits (The copay applies for the office visit only)	**No**	$100 Copay	30% after deductible	20% after deductible	30% after deductible	$100 Copay	30% after deductible	$100 Copay	30% after deductible	$100 Copay	30% after deductible
Allergy Services Testing / injections	**Yes**	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible
Air Ambulance Transportation - NON Emergency	**Yes**	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible
Home Health Care (Limited to 30 visits per plan year)	**Yes**	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible
Hospice Care *(Outpatient/Home)*	**Yes**	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible
Rehabilitation/Habilitation Services *(limited to 30 visits per plan year)*	**No**	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible
Second Surgical Opinion (may be required)	**No**	$0 Copay	30% after deductible	$0 Copay	30% after deductible	$0 Copay	30% after deductible	$0 Copay	30% after deductible	$0 Copay	30% after deductible
OTHER SERVICES: Open Access		In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network	In-Network	Non-Network
Hospice Care *(Inpatient)*	**Yes**	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible
Emergency Medical Transportation	**No**	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible
Air Ambulance Transportation - Emergency *(Pre-cert as soon as reasonably possible)*	**Yes**	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible	20% after deductible	30% after deductible

PHARMACY BENEFITS	Participating Pharmacies	Participating Pharmacies	Participating Pharmacies	Participating Pharmacies	Participating Pharmacies
PREVENTIVE Prescriptions ONLY *(Subject to Formulary & ACA requirements)*	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**
Pharmacy Retail – up to a 30 day supply	Generic ONLY $0 Copay Brand Drugs - Not Covered	Generic ONLY $0 Copay Brand Drugs - Not Covered	Generic ONLY $0 Copay Brand Drugs - Not Covered	Generic ONLY $0 Copay Brand Drugs - Not Covered	Generic ONLY $0 Copay Brand Drugs - Not Covered
Pharmacy Mail Order – up to a 90 day supply	Generic ONLY $0 Copay Brand Drugs - Not Covered	Generic ONLY $0 Copay Brand Drugs - Not Covered	Generic ONLY $0 Copay Brand Drugs - Not Covered	Generic ONLY $0 Copay Brand Drugs - Not Covered	Generic ONLY $0 Copay Brand Drugs - Not Covered
NON-PREVENTIVE Prescriptions - (Subject to Formulary)	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**
Retail Pharmacy– (up to a 30 day supply)	Generic – $10 Copay Preferred Brand - $35 Copay Non Preferred Brand - Not Covered; Member pays 100%	Generic – 30% after deductble Preferred Brand - 30% after deductible Non Preferred Brand - 30% after deductible	Generic – $10 Copay Preferred Brand - $35 Copay Non Preferred Brand - 30% to $125 Max	Generic – $10 Copay Preferred Brand - $35 Copay Non Preferred Brand - 30% to $125 Max	Generic – $10 Copay Preferred Brand - $35 Copay Non Preferred Brand - 30% to $125 Max
Mail Order Pharmacy (90 day supply)	Generic – $25 Copay Preferred Brand - $87.50 Copay Non Preferred Brand - Not Covered; Member pays 100%	Generic – 30% after deductble Preferred Brand - 30% after deductible Non Preferred Brand - 30% after deductible	Generic – $25 Copay Preferred Brand - $87.50 Copay Non Preferred Brand - 30% to $125 Max	Generic – $25 Copay Preferred Brand - $87.50 Copay Non Preferred Brand - 30% to $125 Max	Generic – $25 Copay Preferred Brand - $87.50 Copay Non Preferred Brand - 30% to $125 Max
SPECIALTY MEDICATIONS	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**	**Member Pays**
Rx Contain Program	$0 Copay[1]	50% after deductible; $500 Maximum	$0 Copay[1]	$0 Copay[1]	$0 Copay[1]
Retail Pharmacy– (up to a 30 day supply)	50% Copay; $500 Maximum	50% after deductible; $500 Maximum	50% after deductible; $500 Maximum	50% after deductible; $500 Maximum	50% after deductible; $500 Maximum
Mail Order Pharmacy (90 day supply)	50% Copay; $500 Maximum	50% after deductible; $500 Maximum	50% Copay; $500 Maximum	50% Copay; $500 Maximum	50% Copay; $500 Maximum

[1] RXContain Program provides certain specialty medications at a $0 copay if the participants family income is below $100,000 annually.

Renewal Rates	EE	**$401.30**	**$431.30**	**$446.02**	**$566.19**	**$644.10**
Renewal Rates	ES	**$1,096.40**	**$1,151.00**	**$1,167.72**	**$1,329.98**	**$1,359.98**
Renewal Rates	EC	**$688.83**	**$728.44**	**$753.30**	**$905.57**	**$1,072.77**
Renewal Rates	FAM	**$1,351.52**	**$1,414.40**	**$1,445.36**	**$1,709.40**	**$1,958.40**