PEARLAND INDEPENDENT SCHOOL DISTRICT
TEXAS PISD HDHP MEDICAL COVERAGE SUMMARY

In-Network Providers will submit claims to Marpai Health on the patient's behalf.
All claims must be filed no later than 12 months after the claim was incurred or the claim will be denied.

TopCare

If you need a medical procedure/diagnostic imaging and/or surgery, our Health Pro can help you through the process. Contact your Health Pro at (888) 721-0497 for more information and assistance in selecting a provider.

Submit Medical Claims to: Marpai Health
PO Box 3610, Brandon, FL 33509-3610
Electronic Claims Submission for Medical Claims: Payer ID # 35245
For a list of Preferred Providers: www.aetna.com/asa
Submit Pharmacy Claims to: CapRx; www.caprx.com; 1-844-722-7798
Electronic Claims Submission for Pharmacy Claims: RxBIN: 610852; PCN: CHM; Rx Grp: JD85

Pre-Certification: American Health Holdings – (800) 641-5566

Inpatient Hospital admissions (including Mental Illness and Substance Abuse admissions); Skilled Nursing Facility and Rehabilitation Facility admissions; Routine and high risk maternity (routine only if inpatient stay exceeds 48/96 hours); Long term acute care; Outpatient surgeries including, but not limited to, back surgeries, hysterectomy, transplants, sleep apnea surgeries, etc.; Non-emergency CT Scan, MRI, PET Scan, capsule endoscopy and genetic testing, including BRCA; Dialysis; Chemotherapy; Radiation therapy; Hyperbaric oxygen; Home Health Care; Durable Medical Equipment, limited to electric/motorized scooters or wheelchairs; Ambulance – fixed wing aircraft (plane).

Pre-Certification Penalty: Services may be denied if Pre-Certification is not obtained. The penalty will be assessed to the provider if the services are rendered by an in-network provider and Pre-Certification is not obtained. If services are rendered by an out-of-network provider, the penalty will be assessed to the Participant if Pre-Certification is not obtained.

MEDICAL PLAN DEDUCTIBLES AND MAXIMUMS

Benefits and cost sharing accumulate on a Benefit Plan Year basis from 9/1 through 8/31 each year.

TYPE OF SERVICE	IMPORTANT PROVISIONS	IN-NETWORK PROVIDER The Allowable Expense is limited to the Preferred Provider Reimbursement Schedule. The Deductible applies to all services prior to benefit payment, except where noted.	OUT-OF-NETWORK PROVIDER The Allowable Expense is limited to the Maximum Allowable Charge or other amount determined by the Plan Administrator. The Deductible applies to all services prior to benefit payment, except where noted.
DEDUCTIBLE	Per Benefit Plan Year (Carryover does not apply) In-network and out-of-network deductibles are not combined. Medical and Prescription deductibles are combined. The Deductible is embedded.	$6,750 Individual $13,500 Family	$13,500 Individual $27,000 Family
MEDICAL OUT-OF-POCKET MAXIMUM	Per Benefit Plan Year (Carryover does not apply) Includes medical deductible, coinsurance, Copays and prescription drug out-of-pocket expenses. The Out-of-Pocket Maximum is embedded.	$7,900 Individual $15,800 Family	$15,800 Individual $31,600 Family
ANNUAL/LIFETIME MAXIMUM		Unlimited	

Radiologist, Anesthesiologists, Pathologists and Emergency Care: If you have a covered outpatient surgical procedure or inpatient stay at a Participating Hospital or facility, services by the associated physician, radiologist, anesthesiologist or pathologist, will be payable at the in-network benefit level. Emergency care, including ambulance services, and associated professional fees (E.g. anesthesiologist, pathologist, radiologist, etc.) rendered in a Hospital Emergency room will be payable at the in-network benefit level when rendered by either a non-preferred or Preferred Provider. The treatment must be for an Emergency as defined in the Plan. Follow-up care will be payable according to the Coverage Summary.

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ACUPUNCTURE		Not covered	Not covered
ALLERGY CARE			
-Office Visit		$100 Copay per visit	60% after deductible
-Treatment (Injections)		80% after deductible	60% after deductible
-Serum		80% after deductible	60% after deductible
-Laboratory & Scratch Testing		80% after deductible	60% after deductible
AMBULANCE	Pre-Certification required for air ambulance. Penalty listed above applies if not obtained. Air ambulance is covered if Medically Necessary for true emergency.		
-Emergency		80% after deductible	Same as in-network
-Non-Emergency		Not covered	Not covered
ANESTHESIA			
-Inpatient		80% after deductible	60% after deductible
-Outpatient		80% after deductible	60% after deductible
-Office		80% after deductible	60% after deductible
AUTISM SPECTRUM DISORDERS	Covered when Medically Necessary	Covered as described under type of service rendered	Covered as described under type of service rendered
APPLIED BEHAVIOR ANALYSIS (ABA) THERAPY	Covered when Medically Necessary	Covered as described under type of service rendered	Covered as described under type of service rendered
BIOFEEDBACK		Not covered	Not covered
CARDIAC REHABILITATION			
-Office		80% after deductible	60% after deductible
-Any Other Place of Service		80% after deductible	60% after deductible
CHEMOTHERAPY	Pre-Certification required. Penalty listed above applies if not obtained.		
-Outpatient Hospital		80% after deductible	60% after deductible
-Office		80% after deductible	60% after deductible
-Any Other Place of Service		80% after deductible	60% after deductible
CHIROPRACTOR	Maximum of 30 visits per Benefit Plan Year	$100 Copay per visit	60% after deductible
DENTAL CARE COVERED UNDER MEDICAL PLAN	Routine care is not covered.		
-Accidental Injury to Teeth	Covers treatment started within 1 year of the accident.	Covered as described under type of service rendered	Covered as described under type of service rendered
-Dental Oral Surgery	Removal of wisdom teeth is covered.	Covered as described under type of service rendered	Covered as described under type of service rendered

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DIABETIC TREATMENT			
-Education		PCP: $30 Copay per visit Specialist: $100 Copay per visit	60% after deductible
-Supplies and Equipment		80% after deductible	60% after deductible
DIAGNOSTIC X-RAYS AND IMAGING TESTS	Pre-Certification required for certain diagnostic tests. Penalty listed above applies if not obtained.		
-Independent Facility		80% after deductible	60% after deductible
-Outpatient Hospital		80% after deductible	60% after deductible
-Physician's Office		80% after deductible	60% after deductible
HIGH TECH IMAGING ***(SUCH AS MRI, MRA, PET AND CAT SCANS)***	Pre-Certification required for certain imaging. Penalty listed above applies if not obtained.	80% after deductible	60% after deductible
DIALYSIS OR HEMODIALYSIS	Pre-Certification required. Penalty listed above applies if not obtained.	80% after deductible	60% after deductible
DURABLE MEDICAL EQUIPMENT (DME) ***Including, but not limited to:***	Pre-Certification required for certain DME and prosthetics. Penalty listed above applies if not obtained.		
-Durable Medical Equipment		80% after deductible	60% after deductible
-Disposable Medical Supplies		80% after deductible	60% after deductible
-Prosthetics (Internal)		80% after deductible	60% after deductible
-Prosthetics (External)		80% after deductible	60% after deductible
-Foot Orthotics		80% after deductible	60% after deductible
-Orthotics (Braces)		80% after deductible	60% after deductible
ENTERAL FORMULA		Not covered	Not covered
FAMILY PLANNING SERVICES			
-Elective Sterilization Procedures			
Tubal Ligation		100%, deductible waived	60% after deductible
Vasectomy		Covered as described under type of service rendered	Covered as described under type of service rendered
-Contraceptive Devices		100%, deductible waived	60% after deductible
-Contraceptive Management Office Visit		100%, deductible waived	60% after deductible
-Infertility Treatment		Not Covered	Not Covered
GENDER REASSIGNMENT SERVICES	Pre-Certification required for surgery. Penalty listed above applies if not obtained.	Covered as described under type of service rendered	Covered as described under type of service rendered

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GENETIC TESTING AND COUNSELING	Pre-Certification required for genetic testing, including BRCA tests. Penalty listed above applies if not obtained.		
-Genetic Testing		80% after deductible	60% after deductible
-Genetic Counseling	Maximum 3 visits per Benefit Plan Year	$100 Copay per visit	60% after deductible
HEARING AIDS AND EXAMS			
-Hearing Aids	Maximum of $1,000 every 36 months.	80% after deductible	60% after deductible
-Hearing Exam		$100 Copay per visit	60% after deductible
HOME HEALTH CARE	Pre-Certification required. Penalty listed above applies if not obtained. Private Duty Nursing covered as a part of Home Health Care. Maximum of 30 visits per Benefit Plan Year	80% after deductible	60% after deductible
HOSPICE CARE	Includes coverage for bereavement counseling.		
-Inpatient		80% after deductible	60% after deductible
-Home		80% after deductible	60% after deductible
HOSPITAL FACILITY			
Inpatient Hospital	Pre-Certification required for inpatient admissions. Penalty listed above applies if not obtained.	80% after deductible	60% after deductible
Outpatient Hospital			
-Emergency Room for a medical Emergency	Emergency room services will also be covered if rendered by an out-of-network Provider.	80% after deductible	60% after deductible
-Emergency Room for non-Emergency care		Not Covered	Not Covered
-Outpatient Surgical Center	Pre-Certification required on certain surgical procedures. Penalty listed above applies if not obtained.	80% after deductible	60% after deductible
INFUSION THERAPY	Pre-Certification required on home infusion therapy. Penalty listed above applies if not obtained.	80% after deductible	60% after deductible

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LABORATORY	Pre-Certification required for genetic testing, including BRCA tests. Penalty listed above applies if not obtained.		
-Independent Facility		80% after deductible	60% after deductible
-Outpatient Hospital		80% after deductible	60% after deductible
-Physician's Office		80% after deductible	60% after deductible
MASSAGE THERAPY		Not Covered	Not Covered
MATERNITY CARE-MOTHER	Post-Certification required if stay exceeds 48 hours for vaginal delivery or 96 hours for cesarean section. Penalty listed above applies if not obtained.		
-Inpatient Hospital or Birthing Center		80% after deductible	60% after deductible
-Physician for Prenatal Care and Delivery		80% after deductible	60% after deductible
-Office Visits		$100 Copay per visit	60% after deductible
MENTAL ILLNESS SERVICES	Pre-Certification required on inpatient admissions. Penalty listed above applies if not obtained. Includes coverage for residential care.		
-Inpatient		80% after deductible	60% after deductible
-Inpatient Physician		80% after deductible	60% after deductible
-Outpatient		80% after deductible	60% after deductible
-Office		$100 Copay per visit	60% after deductible
MODIFIED FOOD PRODUCT		Not Covered	Not Covered
NEWBORN CARE (Prior to Discharge)	Post-Certification required if stay exceeds 48 hours for vaginal delivery or 96 hours for cesarean section. Penalty listed above applies if not obtained.		
-Hospital		80% after deductible	60% after deductible
-Physician		80% after deductible	60% after deductible
NUTRITIONAL COUNSELING	Maximum of 6 visits per Benefit Plan Year	$100 Copay per visit	60% after deductible
OBESITY TREATMENT			
-Non-surgical treatment		Covered as described under type of service rendered	Covered as described under type of service rendered
-Surgical treatment		Not covered	Not covered
OCCUPATIONAL THERAPY	Maximum of 30 visits per Benefit Plan Year.		
-Office		80% after deductible	60% after deductible
-Any Other Place of Service		80% after deductible	60% after deductible

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ORGAN TRANSPLANTS Guidelines apply – Refer to your Plan Document for more information on this benefit	Pre-Certification required. Penalty listed above applies if not obtained. The transplant must be performed at an approved designated facility.	80% after deductible Transplant-related travel, lodging and meals are covered at 100% after deductible with a lifetime maximum of $10,000.	60% after deductible Transplant-related travel, lodging and meals are covered at 60% after deductible with a lifetime maximum of $10,000.
PHYSICAL THERAPY	Maximum of 30 visits per Benefit Plan Year.		
-Office		80% after deductible	60% after deductible
-Any Other Place of Service		80% after deductible	60% after deductible
PHYSICIAN			
-Inpatient	PCP includes Family Practitioner, General Practitioner, Internist, Pediatrician, OBGYN, Physician's Assistant, and Nurse Practitioner	80% after deductible	60% after deductible
-Office/Clinic (PCP)		$30 Copay per visit Other services provided in the Physician's Office are covered at 80% after deductible	60% after deductible
Consultation (Specialist)			60% after deductible
-Inpatient		80% after deductible	60% after deductible
-Outpatient		80% after deductible	60% after deductible
-Office/Clinic		$100 Copay per visit Other services provided in the Physician's Office are covered at 80% after deductible	60% after deductible
Second Medical Opinion		100%, deductible waived	60% after deductible
PREADMISSION TESTING		Refer to Laboratory and Diagnostic Tests benefits	Refer to Laboratory and Diagnostic Tests benefits

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PREVENTIVE/WELL CARE	Preventative/Well Care is covered as defined in the Patient Protection and Affordable Care Act and CARES Act as amended.		
-Physician Office Services		100%, deductible waived	60% after deductible
-Lab, X-ray or other preventive tests		100%, deductible waived	60% after deductible
-Immunizations		100%, deductible waived	60% after deductible
-Women's Preventive Care	Covered as defined by the Health Resources and Services Administration (HRSA)	100%, deductible waived	60% after deductible
-Mammograms (Routine) Includes coverage for routine 3D mammograms		100%, deductible waived	60% after deductible
-Routine Vision Exam	Except for visual acuity screenings for children as defined under the Patient Protection and Affordable Care Act.	Not covered	Not covered
-Routine Hearing Screening	Except for newborn hearing screenings as defined under the Patient Protection and Affordable Care Act.	Not covered	Not covered
PRIVATE DUTY NURSING	Covered under the Home Health Care Benefit	Not covered	Not covered
RADIATION THERAPY	Pre-Certification required for radiation therapy. Penalty listed above applies if not obtained.		
-Outpatient Hospital		80% after deductible	60% after deductible
-Office		80% after deductible	60% after deductible
-Any Other Place of Service		80% after deductible	60% after deductible
REHABILITATION FACILITY	Pre-Certification required. Penalty listed above applies if not obtained.	80% after deductible	60% after deductible
RESPIRATORY THERAPY			
-Outpatient Hospital		80% after deductible	60% after deductible
-Any Other Place of Service		80% after deductible	60% after deductible
SLEEP STUDIES AND TREATMENT	Pre-Certification required on sleep studies. Penalty listed above applies if not obtained.	80% after deductible	60% after deductible
SPEECH THERAPY	Maximum of 30 visits per Benefit Plan Year		
-Office		80% after deductible	60% after deductible
-Any Other Place of Service		80% after deductible	60% after deductible

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SKILLED NURSING FACILITY	Pre-Certification required. Penalty listed above applies if not obtained. Maximum of 60 days per Benefit Plan Year	80% after deductible	60% after deductible
SUBSTANCE ABUSE TREATMENT	Pre-Certification required on inpatient admissions. Penalty listed above applies if not obtained. Includes coverage for residential care.		
-Inpatient Rehabilitation		80% after deductible	60% after deductible
-Inpatient Physician		80% after deductible	60% after deductible
-Outpatient		80% after deductible	60% after deductible
-Office		$100 Copay per visit	60% after deductible
SURGERY (Refer to Hospital Facility, Surgery Center or Anesthesia for benefits related to surgery)	Pre-Certification required on certain surgical procedures. Penalty listed above applies if not obtained. Abortions are only covered when carrying the fetus to full term would seriously endanger the life of the mother or in the case of rape or incest.		
Surgeon			
-Inpatient		80% after deductible	60% after deductible
-Outpatient		80% after deductible	60% after deductible
-Office		80% after deductible	60% after deductible
Assistant Surgeon		80% after deductible	60% after deductible
Second Surgical Opinion		100%, deductible waived	60% after deductible
SURGERY CENTER (Freestanding Surgical Facility)	Pre-Certification required on certain surgical procedures. Penalty listed above applies if not obtained.	80% after deductible	60% after deductible
TELEMEDICINE			
-MDLive Virtual Visits		100%, deductible waived	Not Covered
-Virtual Visits (Non-MDLive Providers)		80% after deductible	60% after deductible
TEMPOROMANDIBULAR JOINT DISORDER (TMJ)		Not Covered	Not Covered
TOBACCO CESSATION	Except for services covered as defined under the Patient Protection and Affordable Care Act.	Not Covered	Not Covered
URGENT CARE FACILITY		80% after deductible	60% after deductible
VISION CARE	Except for services covered as defined under the Patient Protection and Affordable Care Act.	Not Covered	Not Covered
WIGS		80% after deductible	60% after deductible

PRESCRIPTION DRUG EXPENSE BENEFIT

TYPE OF PROGRAM	IMPORTANT PROVISIONS	IN-NETWORK BENEFITS
PRESCRIPTION DEDUCTIBLE	Per Benefit Plan Year	$6,750 Individual $13,500 Family Applies only to specialty drugs. Combined with the Medical Deductible The Deductible is embedded.
PRESCRIPTION DRUG OUT-OF-POCKET MAXIMUM	Per Benefit Plan Year	$7,900 Individual $15,800 Family Combined with the Medical Out-of-Pocket Maximum. The Out-of-Pocket Maximum is embedded.
RETAIL	Up to 30-day supply	$10 Copay – Generic Brand Drug $50 Copay – Preferred Brand Name Drug 50% coinsurance (max copay $200) – Non-Preferred Brand Generic Drug
MAIL ORDER MAINTENANCE DRUGS	Up to a 90-day supply	$25 Copay – Generic Brand Drug $125 Copay – Preferred Brand Name Drug 50% coinsurance (max copay $200) – Non-Preferred Brand Generic Drug
SPECIALTY DRUGS		80% after deductible
DIABETIC SUPPLIES AND INSULIN		See Benefits Above
Prior authorization may be required for some drugs. **Drugs purchased at out-of-network pharmacies are not covered.** Certain preventive drugs, including oral contraceptives are covered in full, not subject to deductible. See www.healthcare.gov for more information. Contact your Pharmacy Benefit Manager for prescription drug coverage inquiries. Your Pharmacy Benefit Manager's contact information is located on your Benefit Identification Card.		

Note: This Coverage Summary is intended to be a general description of benefits only. Some limitations, conditions, or exclusions may apply. The benefits listed above are subject to change at any time. If there is a discrepancy between this overview and the Plan Document, the Plan Document will prevail. Services must be Medically Necessary treatment of Sickness or Injury, unless otherwise stated. The fact that a Physician may prescribe, order, recommend or approve a service or supply does not, in and of itself, make it Medically Necessary even though it is not specifically listed as an exclusion. All of the facts and circumstances surrounding the claim must be considered.