

MARCH 1, 2008

**2007 – 2008 HEALTH CARE COVERAGE PLAN
COMPARABILITY PROGRAM COMPARISON**

San Elizario ISD

As required in the provisions of the Texas Education Code (TEC) Section 22.004 which was most recently amended by House Bill 2427 of the 80th Texas Legislature, San Elizario ISD has prepared this report to confirm the comparability of the health care coverage offered to its employees with the HealthSelect coverage offered by the State of Texas to its employees.

This report is available for review at the central administrative office of each campus within San Elizario ISD and is also available on the District's website.

TEC Section 22.004 (d) identifies six Requirements that must be satisfied in this report.

REQUIREMENT 1

The Board of Trustees of San Elizario ISD on August 8, 2001 adopted a resolution authorizing the District to self insure the group health coverage for the District's employees. On an annual basis, San Elizario ISD's external auditors confirm that the District is adequately able to cover the assumed liability of the self funded benefit plan. A copy of the most recent external auditor's report can be obtained by contacting:

RENA SEIFTS.

REQUIREMENT 2

On March 1, 2008 San Elizario ISD offered the following group health coverage benefit options. This is a summary description of benefits only. Refer to the actual benefit booklet for complete benefits, limitations and exclusions descriptions. The benefit offering are subject to change in the future.

(Core Medical Schedule of Benefits)

Features	In-Network		Out-of-Network
	Preferred Hospital/OOA	PPO	
	ACN With Sierra Medical/Providence/R.E Thomason	All other ACN Hospitals	
Individual calendar year deductible**	\$500	\$500	\$1,000
Family calendar year deductible**	\$1,000	\$1,000	\$2,000
Maximum calendar year individual out-of-pocket	\$2,500	\$2,500, Except Hospital	Unlimited
Maximum calendar year family out-of-pocket	\$7,500	\$7,500, Except Hospital	Unlimited
Maximum lifetime benefit	\$1,000,000 Combined		

**** Three Month Carryover Applies.**

***Allowables are based on eligible charges.**

Hospital Services	Preferred Hospital/OOA	PPO	Out-of-Network
Inpatient Hospital Deductible(Per admission)	\$100	\$250	\$750
Room & board (semi-private)	80%	50% Never increases to 100%	50% Never increases to 100%
Ancillary hospital charges	80%	50% Never increases to 100%	50% Never increases to 100%
Outpatient Services	80%	50% Never increases to 100%	50% Never increases to 100%
Skilled Nursing Facility	\$10,000 combined per calendar year		
Non-Emergency (ER) Copayment	\$50, then 50%	\$100, then 50% Never increases to 100%	\$100, then 50% Never increases to 100%
Emergency/Accident (ER) Copayment	\$50, then 80%	\$50, then 80% Never increases to 100%	\$50, then 80% Never increases to 100%
Pre-Admission and Continued Care Review Required	\$250 penalty if not obtained	\$250 penalty if not obtained	\$250 penalty if not obtained

***Allowables are based on eligible charges.**

Professional Services	In-Network	Out-of-Network
Physician Office Visits	\$25 Co pay, then 100%	50%
Urgent Care Centers	\$25 Co pay	50%
Routine Annual physical exams limited to:		
Office Visit (one per year)	\$25 Co pay, then 100%	50%
<ul style="list-style-type: none"> Routine Newborn Services (through 24 months) 	100%	50%
<ul style="list-style-type: none"> Immunizations 	100%	50%
<ul style="list-style-type: none"> Vision Exam (one per year) 	100%	50%

• Hearing Exam (one per year)	100%	50%
• Pap Smear (one per year)**	100%	50%
• Mammography (one per year)**	100%	50%
• Colorectal and Prostate Exams (one per year)**	100%	50%
• Bone Density (one per year)**	100%	50%

** These services are considered a part of an annual exam and do not require a Co payment.

All Other services	80%	50%
Preferred Labs	100%	N/A
Lab, X-ray	80%(no deductible)	50%
Physician Hospital Visits	80%	50%
Allergy tests & treatments	80%	50%
Surgeon	80%	50%
Assistant Surgeon	80%	50%
Anesthetist	80%	50%
Physical Medicine Services (in office setting) (\$ 1,500 combined maximum per year. CPT's 97010-97799.)	80%	50%
Emergency Room Physician	80%	50%

(Out of Network physicians practicing at In Network hospitals will be covered at In Network Benefits for Accidents and True Emergencies only)

***Allowables are based on eligible charges.**

Mental Health/Substance Abuse (except Serious Mental Illness)	In-Network	Out-of-Network
Inpatient facility (Combined	80%	50%

30 day maximum per calendar year)		
Physician for Inpatient Services (Combined 30 day maximum per calendar year)	80%	50%
Outpatient Physician (Combined 30 day maximum per calendar year)	\$25 Co payment then 100%	50%

***Allowables are based on eligible charges.**

Mental Health (Serious Mental Illness)	In-Network	Out-of-Network
Inpatient facility (Combined 45 day maximum per calendar year)	80%	50%
Physician for Inpatient Services (Combined 45 day maximum per calendar year)	80%	50%
Outpatient Physician (Combined 60 day maximum per calendar year)	\$25 Co payment then 100%	50%

***Allowables are based on eligible charges.**

Extended Care Expenses	In-Network	Out-of-Network
Home Health Care (\$10,000 combined per calendar year)	80%	50%
Hospice (\$20,000 combined lifetime maximum)	80%	50%

***Allowables are based on eligible charges.**

All Other Non Hospital Services	In-Network	Out-of-Network
Ambulance	80%	50%
X-ray & lab	80% (No Deductible)	50%
Chemo/radiation therapy	80%	50%
Physical & speech therapy (speech therapy under limited	80%	50%

conditions)		
Durable medical equipment (Total billed charges greater than \$500 must have prior approval of Plan Administrator.)	80%	50%
Second surgical opinion may be requested by Medical Case Manager	Applicable	Applicable

***Allowables are based on eligible charges.**

Prescription Drugs	
Retail (30-day supply)	
Generic Name	\$0 Co payment at Participating Pharmacies. No benefit for Non-Participating Pharmacies.
Preferred Brand Name (see list)	\$30 Co payment at Participating Pharmacies. No benefit for Non-Participating Pharmacies.
Other Brand Name	\$40 Co payment at Participating Pharmacies. No benefit for Non-Participating Pharmacies.
Brand Name Drugs not appearing on the "Preferred Brand Name" list are subject to the highest co pay.	
Mail Order (90-day supply)	
Generic Name	\$0 Co payment.
Preferred Brand Name (see list)	\$60 Co payment.
Other Brand Name	\$80 Co payment.
Brand Name Drugs not appearing on the "Preferred Brand Name" list are subject to the highest co pay.	

Buy Up Medical Schedule of Benefits

Features	In-Network		Out-of-Network
	Preferred Hospital/OOA	PPO	
	ACN With Sierra Medical/Providence/R.E Thomason	All other ACN Hospitals	

Individual calendar year deductible**	\$150	\$350	\$700
Family calendar year deductible**	\$300	\$1,000	\$2,000
Maximum calendar year individual out-of-pocket	\$2,000	\$2,000, Except Hospital	Unlimited
Maximum calendar year family out-of-pocket	\$6,000	\$6,000, Except Hospital	Unlimited
Maximum lifetime benefit	\$1,000,000 Combined		

**** Three Month Carryover Applies.**

***Allowables are based on eligible charges.**

Hospital Services	Preferred Hospital/OOA	PPO	Out-of-Network
Inpatient Hospital Deductible(Per admission)	\$100	\$250	\$750
Room & board (semi-private)	90%	50% Never increases to 100%	50% Never increases to 100%
Ancillary hospital charges	90%	50% Never increases to 100%	50% Never increases to 100%
Outpatient Services	90%	50% Never increases to 100%	50% Never increases to 100%
Skilled Nursing Facility	\$10,000 combined per calendar year		
Non-Emergency (ER) Co payment	\$50, then 50%	\$100, then 50% Never increases to 100%	\$100, then 50% Never increases to 100%
Emergency/Accident (ER) Co payment	\$50, then 90%	\$50, then 80% Never increases to 100%	\$50, then 80% Never increases to 100%
Pre-Admission and Continued Care Review Required	\$250 penalty if not obtained	\$250 penalty if not obtained	\$250 penalty if not obtained

***Allowables are based on eligible charges.**

Professional Services	In-Network	Out-of-Network
Physician Office Visits	\$20 Co pay, then 100%	50%

Urgent Care Centers	\$20 Co pay	50%
Routine Annual physical exams limited to:		
Office Visit (one per year)	\$20 Co pay, then 100%	50%
<ul style="list-style-type: none"> Routine Newborn Services (through 24 months) 	100%	50%
<ul style="list-style-type: none"> Immunizations 	100%	50%
<ul style="list-style-type: none"> Vision Exam (one per year) 	100%	50%
<ul style="list-style-type: none"> Hearing Exam (one per year) 	100%	50%
<ul style="list-style-type: none"> Pap Smear (one per year)** 	100%	50%
<ul style="list-style-type: none"> Mammography (one per year)** 	100%	50%
<ul style="list-style-type: none"> Colorectal and Prostate Exams (one per year)** 	100%	50%
<ul style="list-style-type: none"> Bone Density (one per year)** 	100%	50%
** These services are considered a part of an annual exam and do not require a Co payment.		
All Other services	90%	50%
Preferred Labs	100%	N/A
Lab, X-ray	90%(no deductible)	50%
Physician Hospital Visits	90%	50%
Allergy tests & treatments	90%	50%
Surgeon	90%	50%
Assistant Surgeon	90%	50%
Anesthetist	90%	50%
Physical Medicine Services (in office setting)	90%	50%

(\$ 1,500 combined maximum per year. CPT's 97010-97799.)		
Emergency Room Physician	90%	50%

(Out of Network physicians practicing at In Network hospitals will be covered at In Network Benefits for Accidents and True Emergencies only)

***Allowables are based on eligible charges.**

Mental Health/Substance Abuse (except Serious Mental Illness)	In-Network	Out-of-Network
Inpatient facility (Combined 30 day maximum per calendar year)	90%	50%
Physician for Inpatient Services (Combined 30 day maximum per calendar year)	90%	50%
Outpatient Physician (Combined 30 day maximum per calendar year)	\$20 Co payment then 100%	50%

***Allowables are based on eligible charges.**

Mental Health (Serious Mental Illness)	In-Network	Out-of-Network
Inpatient facility (Combined 45 day maximum per calendar year)	90%	50%
Physician for Inpatient Services (Combined 45 day maximum per calendar year)	90%	50%
Outpatient Physician (Combined 60 day maximum per calendar year)	\$20 Co payment then 100%	50%

***Allowables are based on eligible charges.**

Extended Care Expenses	In-Network	Out-of-Network
Home Health Care (\$10,000 combined per calendar year)	90%	50%
Hospice	90%	50%

(\$20,000 combined lifetime maximum)		
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***Allowables are based on eligible charges.**

All Other Non Hospital Services	In-Network	Out-of-Network
Ambulance	90%	50%
X-ray & lab	90%(no deductible)	50%
Chemo/radiation therapy	90%	50%
Physical & speech therapy (speech therapy under limited conditions)	90%	50%
Durable medical equipment (Total billed charges greater than \$500 must have prior approval of Plan Administrator.)	90%	50%
Second surgical opinion may be requested by Medical Case Manager	Applicable	Applicable

***Allowables are based on eligible charges.**

Prescription Drugs	
Retail (30-day supply)	
Generic Name	\$0 Co payment at Participating Pharmacies. No benefit for Non-Participating Pharmacies.
Preferred Brand Name (see list)	\$25 Co payment at Participating Pharmacies. No benefit for Non-Participating Pharmacies.
Other Brand Name	\$35 Co payment at Participating Pharmacies. No benefit for Non-Participating Pharmacies.
Brand Name Drugs not appearing on the "Preferred Brand Name" list are subject to the highest copay.	
Mail Order (90-day supply)	
Generic Name	\$0 Co payment.
Preferred Brand Name (see list)	\$50 Co payment.
Other Brand Name	\$70 Co payment.
Brand Name Drugs not appearing on the "Preferred Brand Name" list are subject to the highest co pay.	

REQUIREMENT 3

On March 1, 2008, the amount paid by San Elizario ISD and by the District's employees for the group health coverage options on this date are listed below. These amounts are subject to change in the future.

SAN ELIZARIO INDEPENDENT SCHOOL DISTRICT

&

ACCESS ADMINISTRATOR'S, INC.

MONTHLY HEALTH PLAN RATES

2007-2008

Core Plan

Employee Only	\$0.00	
Employee Spouse	\$187.00	{ \$500.00 Yearly Deductible-80%/20%
Employee Child(ren)	\$157.00	\$25.00 co-pay
Employee Family	\$368.00	

Buy up Plan

Employee Only	\$42.00	
Employee Spouse	\$260.00	{ \$150.00 Yearly Deductible-90%/10%
Employee Child(ren)	\$220.00	\$20.00 co-pay
Employee Family	\$470.00	

MONTHLY DENTAL PLAN RATES

Core Plan

Employee Only	\$21.00
Employee Child(ren)	\$47.50
Employee Spouse	\$37.75
Employee Family	\$56.00

Buy Up Plan

Employee Only	\$25.50
Employee Child(ren)	\$62.00
Employee Spouse	\$50.00
Employee Family	\$75.50

MONTHLY VISION PLAN RATES

Employee Only	\$7.15
Employee + 1	\$13.25
Employee Family	\$19.40

REQUIREMENT 4

On March 1, 2008, the estimated number of employees covered under the San Elizario ISD group health coverage plan is:

317 CORE PLAN

157 BUY UP PLAN

TOTAL EMPLOYEES 474

REQUIREMENT 5

As a prudent and conscientious employer and provider of employer sponsored benefits, San Elizario ISD was able to complete this report, as well as the required **2007-2008 Comparability Report Form** which is on file with the Teacher Retirement System with minimal staff involvement and without difficulty.

REQUIREMENT 6

In order to determine comparability with the State of Texas HealthSelect plan, San Elizario ISD used the following approach.

Recognizing that the costs of health care can vary by region with the great state of Texas, San Elizario ISD used the following frequencies of health claims utilization for a LOW, MEDIUM and HIGH Utilizer of health benefits and calculated the annual out of pocket expense for each of the benefit option available to San Elizario ISD's employees as well as the HealthSelect plan (a copy of this plan summary of benefits can be obtained at http://tlo2.tlc.state.tx.us/news/documents/health_expenses.pdf).

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The estimated annual out of pocket expense to each utilizer for each plan is summarized below.

LOW UTILIZER

Benefit Plan Option	Annual Out of Pocket Expense
San Elizario ISD Buy Up Plan	\$295.00
HealthSelect	\$350.00
San Elizario ISD Core Plan	\$360.00

MEDIUM UTILIZER

Benefit Plan Option	Annual Out of Pocket Expense
San Elizario ISD Buy Up Plan	\$1,355.00
San Elizario ISD Core Plan	\$2,030.00
HealthSelect	\$2,235.00

HIGH UTILIZER

Benefit Plan Option	Annual Out of Pocket Expense
San Elizario ISD Buy Up Plan	\$3,900.00
HealthSelect	\$4,600.00
San Elizario ISD Core Plan	\$5,050.00

Each of the benefit plan options listed above is based upon a Preferred Provider Organization network of preferred health care providers that represent comparable access to quality health care providers for the plan members. Each plan offers a comprehensive plan design with benefits provided for physician, hospital and prescription drug services. Each plan includes reasonable limitations and exclusions based upon standard industry provisions used within health care benefit plans.

San Elizario ISD is satisfied that it offers one or more benefit options that are comparable to or better than the HealthSelect plan which is used as a benchmark for comparison purposes.

TEACHER RETIREMENT SYSTEM OF TEXAS
1000 Red River Street, Austin, Texas 78701-2698
Telephone (512) 542-6400 or (800) 223-8778
www.trs.state.tx.us

2007-2008 Comparability Report Form

Please complete and mail no later than March 1, 2008 to:

Teacher Retirement System of Texas
Attention: 2007-2008 Comparability Report
1000 Red River Street
Austin, TX 78701-2698

District Name: SAN ELIZARIO INDEPENDENT SCHOOL DISTRICT

Does your district offer employee health coverage that is comparable to HealthSelect?

Yes No

Is your district in compliance with all other requirements of Section 22.004 of the Education Code?

Yes No

I certify that, based on my personal knowledge, the information provided above is true and accurate.


Signature of School Official

1/23/08
Date

LORENA G. RIOS
Name of School Official (Print or Type)

RISK MANAGEMENT COORDINATOR
Title (Print or Type)

(915) 872-3900
Phone number

Note: This form is the only documentation that should be submitted by your district to TRS. Do not provide any additional documentation such as the district's contract for group health coverage, schedule of benefits, premium rate sheet, etc.

For questions concerning the 2007-2008 Comparability Report Form, please contact Sunitha Downing at (512) 542-6435.

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