AGENDA ITEM

BOARD OF TRUSTEES
AGENDA

[ ] Workshop	[X] Regular	[ ] Special

(A) [ ] **Report Only** [ ] **Recognition**

Presenter(s):

Briefly describe the subject of the report or recognition presentation.

(B) [X] **Action Item**

Presenter(s): ISMAEL MIJARES, DEPUTY SUPERINTENDENT FOR BUSINESS & FINANCE
LUIS VELEZ, PURCHASING DIRECTOR

Briefly describe the action required.

CONSIDER AND TAKE APPROPRIATE ACTION ON THE REQUEST TO APPROVE THE SERVICE AGREEMENT FOR FORT DUNCAN MEDICAL CENTER, LP RETROACTIVE TO SEPTEMBER 1, 2025 AND THE BOARD DELEGATES THE SUPERINTENDENT OR DESIGNEE THE AUTHORITY TO MAKE RELATED BUDGETED PURCHASES OF GOODS OR SERVICES AS PER BOARD POLICY CH.

(C) Funding source: Identify the source of funds if any are required.

BUDGETED FUNDS

(D) Clarification: Explain any question or issues that might be raised regarding this item.

SEE ATTACHED

AMENDMENT TO THE
HOSPITAL SERVICE AGREEMENT
BETWEEN
EAGLE PASS INDEPENDENT SCHOOL DISTRICT
AND
FORT DUNCAN MEDICAL CENTER

This Amendment to the Hospital Agreement (hereinafter the "Amendment") is made and entered into by and between Eagle Pass Independent School District (collectively "Company") and Fort Duncan Medical Center, LP d/b/a Fort Duncan Regional Medical Center ("Hospital"), (together referred to as the "Parties" and individually as a "Party"). This Agreement shall go into effect on the "Effective Date" specified on the signature page.

WHEREAS, the Parties have previously entered into a Hospital Services Agreement effective September 1, 2015 whereby Hospital agree to provide service to Company for the benefit of Members; and

WHEREAS the Parties now wish to amend the Hospital Service Agreement

NOW, THEREFORE, in consideration of the mutual covenants and agreements set forth in this Agreement and other good and valuable consideration, the Parties hereto, intending to be legally bound, hereby agree as follows:

1. Notice given to terms and provisions of Agreement sent to Hospital, shall be amended to state:

   and to Hospital at:

   Fort Duncan Regional Medical Center
   Attn: CFO
   3333 N Foster Maldonado Blvd
   Eagle Pass, TX 78852

   With a copy to:

   UHS of Delaware, Inc.
   Attn: Payer Strategies
   367 South Gulph Rd
   King of Prussia, PA 19406

2. Paragraph A of the **TERM AND TERMINATION** section of the Agreement shall be amended to state

   A. **Term**. The Term of the Agreement shall be September 1, 2015 to August 31, 2028.

3. Exhibit A is hereby deleted in its entirety and replaced by **Exhibit A** attached hereto.

4. Exhibit B is hereby deleted in its entirety and replaced by **Exhibit B** attached hereto.

5. Paragraph E of the **COMPENSATION** section of the Agreement shall be amended to state

   E. **Charge Master Increases**. Hospital agrees that it will not increase its weighted charge master greater than the Charge Master Limit (identified in Exhibit A) in aggregate in a contract year. Hospital will notify Company thirty (30) days in advance of a pending increase. In the event that Hospital increases its Charge Master in aggregate by more than the Charge Master Limit for a given contract

year, then the Paid Percent of Charges rates shall be adjusted and rounded to the nearest one tenth of a percent according to the following formula:

Prior Paid Percent of Charges * (1 + CDM Limit)/(1 + Charge Master Increase) = Adjusted Paid Percent of Charges.

6. All other terms and conditions of the Agreement and any amendments thereto, if any, shall remain in full force and effect. If the terms of this Amendment conflict with any of the terms of the Agreement, the terms of this Amendment shall prevail.

IN WITNESS WHEREOF, the undersigned, with the intent to be legally bound, have caused this Amendment to be dully executed and effective as of the Effective date.

COMPANY	**HOSPITAL**
By:_____	By: Melanie Schoof (Sep 5, 2025 11:20:22 EDT)
Print Name: Samuel Mijares	Print Name: Melanie Schoof
Title: Superintendent/ Eagle Pass ISD	Title: Vice President, Payer Strategies
Date:_____	Date: 09/05/2025

EFFECTIVE DATE: 09/01/2025

Exhibit A

Eagle Pass ISD Rates Effective 9/1/2025 - 8/31/2028
Fort Duncan Regional Medical Center

Table 1: Compensation					
Service	MS-DRG/ Revenue Code	Payment Method	eff. 9.1.25	eff. 9.1.26	eff. 9.1.27
Inpatient Services					
Medical		Per Diem	$4,331	$4,450	$4,584
Surgical		Per Diem	$5,380	$5,528	$5,694
ICU/CCU	RC 200-300, 207-212,219	Per Diem	$6,035	$6,201	$6,387
Psychiatric/Chemical Dependency	RC 114,116, 124,126	Per Diem	$1,522	$1,564	$1,611
Normal Delivery 1-2 days	MS-DRG 796-798, 805-807	Per Diem	$6,560	$6,740	$6,942
Additional Delivery Days		Per Diem	$1,574	$1,617	$1,666
Normal Delivery with OR Procedures except Sterilization and/or D&C	MS-DRG 768	Per Diem	$6,560	$6,740	$6,942
Additional Delivery Days with MS-DRG 768		Per Diem	$1,574	$1,617	$1,666
C-Section Delivery	MS-DRG 783-788	Per Diem	$8,659	$8,897	$9,164
Additional Delivery Days		Per Diem	$1,640	$1,685	$1,736
Newborn	MS-DRG 795	Per Diem	$1,286	$1,321	$1,361
Sick Baby	MS-DRG 789-794	Per Diem	$1,968	$2,022	$2,083
Inpatient Rehabilitation	MS-DRG 945-946	Per Diem	$2,585	$2,656	$2,736
Bariatric Surgery 1-5 days	MS-DRG 616-621	Per Diem	$31,148	$32,005	$32,965
Additional Bariatric Days		Per Diem	$4,986	$5,123	$5,277
Cardiology/Cardiac Surgery	MS-DRG 215-218	Per Case	$140,393	$144,254	$148,582
	MS-DRG 219-221	Per Case	$86,597	$88,978	$91,647
	MS-DRG 275-277	Per Case	$42,861	$44,040	$45,361
	MS-DRG 228-230	Per Case	$50,515	$51,904	$53,461
	MS-DRG 231-232	Per Case	$55,108	$56,623	$58,322
	MS-DRG 233-234	Per Case	$100,638	$103,406	$106,508
	MS-DRG 235-236	Per Case	$79,251	$81,430	$83,873
	MS-DRG 266-274	Per Case	$64,030	$65,791	$67,765
	MS-DRG 242	Per Case	$21,911	$22,514	$23,189
	MS-DRG 243-244	Per Case	$18,894	$19,414	$19,996
	MS-DRG 321 - 322	Per Case	$33,546	$34,469	$35,503
	MS-DRG 250	Per Case	$35,427	$36,401	$37,493
	MS-DRG 251	Per Case	$20,075	$20,627	$21,246
	MS-DRG 252	Per Case	$48,153	$49,477	$50,961
	MS-DRG 253	Per Case	$40,109	$41,212	$42,448
	MS-DRG 258-259	Per Case	$14,434	$14,831	$15,276
	MS-DRG 260-262	Per Case	$24,405	$25,076	$25,828
	MS-DRG 286-287	Per Case	$24,930	$25,616	$26,384

Exhibit A

Service	MS-DRG/ Revenue Code	Payment Method	eff. 9.1.25	eff. 9.1.26	eff. 9.1.27
Cardiac/Cardiology Cases where LOS exceeds 5 days		Per Diem beginning on Day 6 paid in addition to case rate	$5,117	$5,258	$5,416
Orthopedic/Spine Cases	MS-DRG 402, 426-430, 447-448, 450-451	Per Case	$28,131	$28,905	$29,772
	MS-DRG 456-458	Per Case	$33,458	$34,378	$35,409
	MS-DRG 461-462	Per Case	$17,057	$17,526	$18,052
	MS-DRG 466-468	Per Case	$24,930	$25,616	$26,384
	MS-DRG 469-470	Per Case	$11,809	$12,134	$12,498
	MS-DRG 471-473	Per Case	$28,866	$29,660	$30,550
	MS-DRG 518-519	Per Case	$24,930	$25,616	$26,384
	MS-DRG 520	Per Case	$18,370	$18,875	$19,441
	MS-DRG 492	Per Case	$12,203	$12,539	$12,915
	MS-DRG 493	Per Case	$9,709	$9,976	$10,275
	MS-DRG 494	Per Case	$7,872	$8,088	$8,331
Orthopedic/Spine Cases where LOS exceeds 5 days		Per Diem beginning on Day 6 paid in addition to case rate	$5,117	$5,258	$5,416
Outpatient Services		Payment Method	eff. 9.1.25	eff. 9.1.26	eff. 9.1.27
Outpatient Services		Paid Percent of Charges	38.0%	38.0%	38.0%
Exclusions for both IP and OP Services		Payment Method	eff. 9.1.25	eff. 9.1.26	eff. 9.1.27
Implants with combined billed charges over $500	RC 274-276, 278	Paid Percent of Charges	26.0%	26.0%	26.0%
High-Cost Drugs with combined billed charges over $500	RC 343,344,636	Paid Percent of Charges	26.0%	26.0%	26.0%

Exhibit A

Service	MS-DRG/ Revenue Code	Payment Method	eff. 9.1.25	eff. 9.1.26	eff. 9.1.27
Stop Loss					
Stop Loss Percent		Paid Percent of Charges	28.0%	28.0%	28.0%
Stop Loss Threshold			$273,732	$273,732	$273,732
If Hospital's Billed Charges for a single inpatient admission exceed the Stop Loss Threshold, then Hospital's reimbursement shall be the Total Billed Charges multiplied by the Stop Loss Percent in lieu of the Per Diem, Per Case, Implant and High Cost Drug reimbursement rates.					
Charge Master					
Charge Master Limit			2.5%	2.75%	3.0%

Hospital agree that it will not increase its weighted Charge Master greater than the Charge Master Limit in aggregeate in a contract year. Hospital will notify Company thirty (30) days in advance of a pending increase. In the event that the Hospital increases its Charge Master in aggregate by more than the Charge Master Limit for a given contract year, then the Paid Percent of Charges rates shall be adjusted and rounded to the nearest one tenth of a percent according to the following formula:
Prior Paid Percent of Charges * (1+ CDM Limit)/(1+ Charge Master Increase) = Adjusted Paid Percent of Charges

Adjusted Rates Example:
Charge Master Limit = 2.5%
Charge Master Increase = 8.0%
Prior Paid Percent of Charges = 38.0%
Adjusted Paid Percent of Charges = 36.1%
38.0% * (1.025/1.08) = 36.06481%
Rounded to the nearest one tenth of a percent

The Stop Loss Threshold will be adjusted by the full amount of the Charge Master Increase rounded to the nearest whole dollar amount according to the following formula:
Stop Loss Threshold * (1+ Charge Master Increase) = Adjusted Stop Loss Threshold

Stop Loss Threshold Example:
Stop Loss Threshold: $273,732
Charge Master Increase = 8.0%
Adjusted Stop Loss Threshold: $295,631
$273,732 * 1.08 = $295,630.56
Rounded to the nearest whole dollar amount

Exhibit B

The attached benefit schedule applies to Eligible Employees and their Beneficiaries of Eagle Pass Independent School District Group Health Plan.

EAGLE PASS INDEPENDENT SCHOOL DISTRICT

Marked for Excellence

Benefits & Risk Management Department
IMAGINE360
HEALTH INSURANCE RATES FORM FOR EMPLOYEES
Effective September 1, 2025

PLATINUM OPTION

POLICY	MONTHLY PREMIUM	EMPLOYER'S CONTRIBUTION	EMPLOYEE'S COST PER MONTH	EMPLOYEE'S COST PER PAY PERIOD
EMPLOYEE ONLY	$1,134.00	$992.00	$142.00	$71.00
EMPLOYEE/SPOUSE	$1,748.00	$992.00	$756.00	$378.00
EMPLOYEE/CHILDREN	$1,420.00	$992.00	$428.00	$214.00
EMPLOYEE/FAMILY	$1,932.00	$992.00	$940.00	$470.00
EMPLOYEE/FAMILY BOTH EMPLOYED	$2,508.00	$1,984.00	$524.00	$262.00

HIGH OPTION

POLICY	MONTHLY PREMIUM	EMPLOYER'S CONTRIBUTION	EMPLOYEE'S COST PER MONTH	EMPLOYEE'S COST PER PAY PERIOD
EMPLOYEE ONLY	$1,062.00	$992.00	$70.00	$35.00
EMPLOYEE/SPOUSE	$1,336.00	$992.00	$344.00	$172.00
EMPLOYEE/CHILDREN	$1,206.00	$992.00	$214.00	$107.00
EMPLOYEE/FAMILY	$1,594.00	$992.00	$602.00	$301.00
EMPLOYEE/FAMILY BOTH EMPLOYED	$2,170.00	$1,984.00	$186.00	$93.00

LOW OPTION

POLICY	MONTHLY PREMIUM	EMPLOYER'S CONTRIBUTION	EMPLOYEE'S COST PER MONTH	EMPLOYEE'S COST PER PAY PERIOD
EMPLOYEE ONLY	$992.00	$992.00	$0.00	$0.00
EMPLOYEE/SPOUSE	$1,236.00	$992.00	$244.00	$122.00
EMPLOYEE/CHILDREN	$1,104.00	$992.00	$112.00	$56.00
EMPLOYEE/FAMILY	$1,500.00	$992.00	$508.00	$254.00
EMPLOYEE/FAMILY BOTH EMPLOYED	$2,078.00	$1,984.00	$94.00	$47.00

This Health Insurance Rates Form is for your information and in NO WAY constitutes a change made to your health insurance plan. If you wish to make changes to your health insurance coverage- adding/dropping dependents, changing options, etc- you must enroll online via www.mybenefitshub.com/eaglepassisd or complete an Imagine360 Health Insurance Change Form at the Benefits Dept during the months of June through August. NO CHANGES WILL BE ACCEPTED AFTER AUGUST 31, 2025

EAGLE PASS ISD

2025-2026 **Low Plan Summary of Benefits** **Plan # S860032**

LEVEL I PROVIDERS: Hospitals (Inpatient/Outpatient), Inpatient facilities (i.e., Rehabilitation Facilities, Skilled Nursing Facilities and Hospice), Inpatient and Outpatient facilities for Treatment of Mental and Nervous Disorders, Chemical Dependency, Drug and Substance Abuse, Ambulatory Surgery Centers, Dialysis Clinics and other Inpatient or freestanding facilities.
LEVEL II PROVIDERS: Physicians and all other Providers of service. The "Level II PPO Benefit" also applies in the following exception: If a Covered Person seeks treatment in a Hospital or Ambulatory Surgery Center, and required services are rendered by a Non-PPO radiologist, anesthesiologist, pathologist, assistant surgeon, on-call Physician/specialist or emergency room Physician.

MEDICAL CARE			
Plan Lifetime Maximum Benefit	Unlimited		
Annual Maximum Benefit	Unlimited		
Calendar Yr Deductible (In-Network)	$590 Individual ($1,770 Family)		
Calendar Yr Deductible (Out-of-Network)	$1,180 Individual ($3,540 Family)		
Annual Out-of-Pocket Maximum for In and Out of Network (Excluding Deductible and Copays)	$2,360 Individual ($7,080 Family)		
BENEFITS	**Level I Benefit (Hospital/Facility Services)**	**Level II PPO Benefit (Physician Services)**	**Level II Non-PPO Benefit (Physician Services)**
ELAP Exclusive Providers	80% after Deductible	N/A	N/A
Inpatient Hospital Expenses Notification to HealthWatch is required within 48 hours of hospital admission or $250 penalty	80% after Deductible (Facility charges)	80% after Deductible	60% after Deductible
Hospital Emergency Room -Medical Emergency/Accidental Injury (Copay waived if admitted)	80% after **$105 Copay:** Deductible waived	80% Deductible waived (All related charges)	80% Deductible waived (All related charges)
Ambulance	80% after Deductible	80% after Deductible	60% after Deductible
Physician Office Visit	N/A	80% after Deductible	60% after Deductible
- Office Surgery	N/A	80% after Deductible	60% after Deductible
- Allergy Testing, Serum, and Injections	N/A	80% after Deductible	60% after Deductible
Urgent Care Facility (Minor Emergency Medical Clinic)	N/A	80% after Deductible	80% after Deductible
Preferred Lab Card	N/A	100%; Deductible waived	100%; Deductible waived
Lab/X-ray (Physician Office, Outpatient Hospital, Independent Lab)			
- Select Diagnostic Medical Procedures (MRIs, CT Scans, Ultrasounds, etc.)	80% after Deductible (Facility and interpretation)	80% after Deductible	60% after Deductible
- Other Lab/X-ray	80% after Deductible	100% of PPO Rate; Copay/Deductible waived	100% of U&C Fee; Deductible waived
Outpatient Hospital/Ambulatory Surgical Facility (All related charges)	80% after Deductible (Facility charges)	80% after Deductible	60% after Deductible
Maternity	80% after Deductible (Facility charges)	80% after Deductible (Office Visit Copay doesn't apply)	60% after Deductible
Routine Newborn Care (Pediatric care to date of baby's discharge.)	80% after Deductible (Facility charges)	80% after Deductible	60% after Deductible
Mental & Nervous Conditions, Chemical Dependency (Internal Plan Maximums Apply)			
- Inpatient	80% after Deductible	80% after Deductible	60% after Deductible
- Outpatient Therapy	80% after Deductible	80% after Deductible	60% after Deductible
- Day Treatment	80% after Deductible	80% after Deductible	60% after Deductible
- Office Visit	N/A	80% after Deductible	60% after Deductible
Serious Mental Illness paid SAAOI			

The Calendar Year Deductible and Annual Out-of-Pocket Maximum are determined by combining both Level I (Hospital/Facility) and Level II (PPO and Non-PPO) Covered Charges. Lifetime and Calendar Year Maximum Benefits are determined by combining Level I (Hospital/Facility) and Level II (PPO and Non-PPO) Covered Charges.

+ Office Visit Copay covers exam, treatment, allergy testing and supplies provided in the Physician's office except chemotherapy, speech therapy, occupational therapy, physical therapy, surgery, infusion therapy, orthotics, chiropractic, maternity, second surgical opinion, and radiation therapy.

EAGLE PASS ISD

2025-2026 **Low Plan Summary of Benefits** **Plan # S860032**

BENEFITS	Level I Benefit (Hospital/Facility Services)	Level II PPO Benefit (Physician Services)	Level II Non-PPO Benefit (Physician Services)
Physical Therapy/Occupational Therapy/Chiropractic Services Combined Calendar Year Maximum Number of Therapies/Visits	80% after Deductible 30	80% after Deductible 30	60% after Deductible 30
Speech Therapy (Restorative)	80% after Deductible	80% after Deductible	60% after Deductible
Sleep Disorders - Covered Services (Including sleep studies/ diagnostic testing, Surgery, devices and equipment)	80% after Deductible	80% after Deductible	60% after Deductible
Home Health Care Calendar Year Maximum	100%; Deductible waived 120 visits	100%; Deductible waived 120 visits	60% after Deductible 120 visits
Home Infusion Therapy	N/A	80% after Deductible	60% after Deductible
Skilled Nursing Facility Calendar Year Maximum	100%; Deductible waived 100 days	100%; Deductible waived 100 days	60% after Deductible 100 days
Chemotherapy, Dialysis, Radiation Therapy/Infusion Therapy/Cardiac Rehabillitation	80% after Deductible	80% after Deductible	60% after Deductible
Hospice Lifetime Maximum Benefit	100%; Deductible waived $20,000	100%; Deductible waived $20,000	60% after Deductible $14,000
DME, Medical Supplies	80% after Deductible	80% after Deductible	60% after Deductible
Prosthetic Devices	80% after Deductible	80% after Deductible	60% after Deductible
All Other Covered Charges	80% after Deductible	80% after Deductible	60% after Deductible
WELLNESS BENEFITS			
Routine Preventive Care			
– Routine Physical Exam	N/A	100%; Deductible waived	**60**% after Deductible
– Annual Well Woman Exam	N/A	100%; Deductible waived	**60**% after Deductible
– Annual Mammogram/PSA	100%; Deductible waived	100%; Deductible waived	**60**% after Deductible
– Well Baby/Well Child Care			
– Routine Immunizations	N/A	100%; Deductible waived	**60**% after Deductible
– Routine Vision Exam	N/A	100%; Deductible waived	**60**% after Deductible
– Routine Hearing Exam	N/A	100%; Deductible waived	**60**% after Deductible
– Lab/X-ray and routine diagnostic testing and other medical screenings	N/A 100%; Deductible waived	100%; Deductible waived 100%; Deductible waived	**60**% after Deductible **60**% after Deductible
Bone Density Test (age 65 and older or individuals who are at risk)	100%; Deductible waived	100%; Deductible waived	60% after Deductible
Routine Colonoscopy (age 50 and older or family history every 5 years)	100%; Deductible waived	100%; Deductible waived	60% after Deductible
Prescription Drug Expense Benefit			
Calendar Year Deductible Per Covered Person	$0		
Discount Card included-30 day supply	Generic: 80% No Deductible Brand: 80% No Deductible		

PLEASE CONTACT IMAGINE360 OR THE PPO NETWORK AT THE PHONE NUMBER OR WEBSITE SHOWN ON YOUR PLAN I.D. CARD FOR INFORMATION ABOUT WHICH PROVIDERS ARE INCLUDED AS LEVEL I OR LEVEL II PROVIDERS.

EAGLE PASS ISD

2025-2026 **High Plan Summary of Benefits** **Plan # S860032**

LEVEL I PROVIDERS: Hospitals (Inpatient/Outpatient), Inpatient facilities (i.e., Rehabilitation Facilities, Skilled Nursing Facilities and Hospice), Inpatient and Outpatient facilities for Treatment of Mental and Nervous Disorders, Chemical Dependency, Drug and Substance Abuse, Ambulatory Surgery Centers, Dialysis Clinics and other Inpatient or freestanding facilities

LEVEL II PROVIDERS: Physicians and all other Providers of service. The "Level II PPO Benefit" also applies in the following exception: If a Covered Person seeks treatment in a Hospital or Ambulatory Surgery Center, and required services are rendered by a Non-PPO radiologist, anesthesiologist, pathologist, assistant surgeon, on-call Physician/specialist or emergency room Physician.

MEDICAL CARE	
Plan Lifetime Maximum Benefit	Unlimited
Annual Maximum Benefit	Unlimited
Calendar Yr Deductible (In-Network)	$295 Individual ($885 Family)
Calendar Yr Deductible (Out-of-Network)	$590 Individual ($1,770 Family)
Annual Out-of-Pocket Maximum for In and Out of Network (Excluding Deductible and Copays)	$2,360 Individual ($7,080 Family)

BENEFITS	Level I Benefit (Hospital/Facility Services)	Level II PPO Benefit (Physician Services)	Level II Non-PPO Benefit (Physician Services)
ELAP Exclusive Providers	90% after Deductible	N/A	N/A
Inpatient Hospital Expenses Notification to HealthWatch is required within 48 hours of hospital admission or $250 penalty	90% after Deductible (Facility charges)	90% after Deductible	60% after Deductible
Hospital Emergency Room -Medical Emergency/Accidental Injury (Copay waived if admitted)	90% after **$105 Copay:** Deductible waived	90% Deductible waived (All related charges)	90% Deductible waived (All related charges)
Ambulance	90% after Deductible	90% after Deductible	60% after Deductible
Physician Office Visit † - Office Surgery - Allergy Testing, Serum, and Injections	N/A N/A N/A	100% after **$30 Copay** 90% after Deductible 100% after **$30 Copay**	60% after Deductible 60% after Deductible 60% after Deductible
Urgent Care Facility (Minor Emergency Medical Clinic)	N/A	100% after **$30 Copay**	100% after Deductible
Preferred Lab Card	N/A	100%; Deductible waived	100%; Deductible waived
Lab/X-ray (Physician Office, Outpatient Hospital, Independent Lab) - Select Diagnostic Medical Procedures (MRIs, CT Scans, Ultrasounds, etc.) - Other Lab/X-ray	90% after Deductible (Facility and interpretation) 100%; Deductible waived	90% after Deductible 100% of PPO rate; Copay/Ded waived	60% after Deductible 100% of U&C fee; Deductible waived
Outpatient Hospital/Ambulatory Surgical Facility (All related charges)	90% after Deductible (Facility charges)	90% after Deductible	60% after Deductible
Maternity	90% after Deductible (Facility charges)	90% after Deductible (Office Visit Copay doesn't apply)	60% after Deductible
Routine Newborn Care (Pediatric care to date of baby's discharge.)	90% after Deductible (Facility charges)	90% after Deductible	60% after Deductible
Mental & Nervous Conditions, Chemical Dependency (Internal Plan Maximums Apply) - Inpatient - Outpatient Therapy - Day Treatment - Office Visit Serious Mental Illness paid SAAOI	 90% after Deductible 90% after Deductible 90% after Deductible N/A	 90% after Deductible 90% after Deductible 90% after Deductible 90% after Deductible	 60% after Deductible 60% after Deductible 60% after Deductible 60% after Deductible

The Calendar Year Deductible and Annual Out-of-Pocket Maximum are determined by combining both Level I (Hospital/Facility) and Level II (PPO and Non-PPO) Covered Charges. Lifetime and Calendar Year Maximum Benefits are determined by combining Level I (Hospital/Facility) and Level II (PPO and Non-PPO) Covered Charges.

†Office Visit Copay covers exam, treatment, allergy testing and supplies provided in the Physician's office except chemotherapy, speech therapy, occupational therapy, physical therapy, surgery, infusion therapy, orthotics, chiropractic, maternity, second surgical opinion, and radiation therapy.

EAGLE PASS ISD

2025-2026 **High Plan Summary of Benefits** **Plan # S860032**

BENEFITS	Level I Benefit (Hospital/Facility Services)	Level II PPO Benefit (Physician Services)	Level II Non-PPO Benefit (Physician Services)
Physical Therapy/Occupational Therapy/Chiropractic Services Combined Calendar Year Maximum Number of Therapies/Visits	90% after Deductible 30	90% after Deductible 30	60% after Deductible 30
Speech Therapy (Restorative)	90% after Deductible	90% after Deductible	60% after Deductible
Sleep Disorders - Covered Services (Including sleep studies/ diagnostic testing, Surgery, devices and equipment)	90% after Deductible	90% after Deductible	60% after Deductible
Home Health Care Calendar Year Maximum	100%; Deductible waived 120 visits	100%; Deductible waived 120 visits	60% after Deductible 120 visits
Home Infusion Therapy	N/A	90% after Deductible	60% after Deductible
Skilled Nursing Facility Calendar Year Maximum	100%; Deductible waived 100 days	100%; Deductible waived 100 days	60% after Deductible 100 days
Chemotherapy, Dialysis, Radiation Therapy/Infusion Therapy/Cardiac Rehabillitation	90% after Deductible	90% after Deductible	60% after Deductible
Hospice Lifetime Maximum Benefit	100%; Deductible waived $20,000	100%; Deductible waived $20,000	60% after Deductible $14,000
DME, Medical Supplies	90% after Deductible	90% after Deductible	60% after Deductible
Prosthetic Devices	90% after Deductible	90% after Deductible	60% after Deductible
All Other Covered Charges	90% after Deductible	90% after Deductible	60% after Deductible
WELLNESS BENEFITS			
Routine Preventive Care			
– Routine Physical Exam	N/A	100%; Copay/Ded waived	60% after Deductible
– Annual Well Woman Exam	N/A	100%; Copay/Ded waived	60% after Deductible
– Annual Mammogram/PSA	100%; Deductible waived	100%; Copay/Ded waived	60% after Deductible
– Well Baby/Well Child Care			
– Routine Immunizations	N/A	100%; Copay/Ded waived	60% after Deductible
– Routine Vision Exam	N/A	100%; Copay/Ded waived	60% after Deductible
– Routine Hearing Exam	N/A	100%; Copay/Ded waived	60% after Deductible
– Lab/X-ray and routine diagnostic testing and other medical screenings	N/A 100%; Deductible waived	100%; Copay/Ded waived 100%; Copay/Ded waived	60% after Deductible 60% after Deductible
Bone Density Test (age 65 and older or individuals who are at risk)	100%; Deductible waived	100%; Deductible waived	60% after Deductible
Routine Colonoscopy (age 50 and older or family history every 5 years)	100%; Deductible waived	100%; Deductible waived	60% after Deductible
PRESCRIPTION DRUG PLAN	**Express Scripts Retail/Specialty Pharmacy**		
Calendar Year Deductible Per Covered Person	**$0**		
Prescription Drug Card Co-pay 30/60/90-day supply limit	**Generic: $5/$10/$15 No Deductible** **Brand: $30/$60/$90 No Deductible**		
Express Scripts Mail Order Service Co-pay 90-day supply limit	**Generic: $10 No Deductible** **Brand: $55 No Deductible**		

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EAGLE PASS ISD

2025-2026 **Platinum Plan Summary of Benefits** **Plan # S860032**

LEVEL I PROVIDERS: Hospitals (Inpatient/Outpatient), Inpatient facilities (i.e., Rehabilitation Facilities, Skilled Nursing Facilities and Hospice), Inpatient and Outpatient facilities for Treatment of Mental and Nervous Disorders, Chemical Dependency, Drug and Substance Abuse, Ambulatory Surgery Centers, Dialysis Clinics and other Inpatient or freestanding facilities.
LEVEL II PROVIDERS: Physicians and all other Providers of service. The "Level II PPO Benefit" also applies in the following exception: If a Covered Person seeks treatment in a Hospital or Ambulatory Surgery Center, and required services are rendered by a Non-PPO radiologist, anesthesiologist, pathologist, assistant surgeon, on-call Physician/specialist or emergency room Physician.

MEDICAL CARE	
Plan Lifetime Maximum Benefit	Unlimited
Annual Maximum Benefit	Unlimited
Calendar Yr Deductible (In-Network)	$0
Calendar Yr Deductible (Out-of-Network)	$590 Individual ($1,770 Family)
Annual Out-of-Pocket Maximum (In-Network)	$1,180 Individual (No Family Limit)
Annual Out-of-Pocket Maximum (Out-of-Network) (Excluding Deductible and Copays)	$3,540 Individual (No Family Limit)

BENEFITS	Level I Benefit (Hospital/Facility Services)	Level II PPO Benefit (Physician Services)	Level II Non-PPO Benefit (Physician Services)
ELAP Exclusive Providers	80%	N/A	N/A
Inpatient Hospital Expenses Notification to HealthWatch is required within 48 hours of hospital admission or $250 penalty	80% (Facility charges)	80%	60% after Deductible
Hospital Emergency Room (Copay waived is admitted)	80% after **$105 Copay**	80% (All related charges)	80% Deductible waived (All related charges)
Ambulance	80%	80%	60% after Deductible
PCP Physician Office Visit	N/A	100% after **$25 Copay**	60% after Deductible
Specialist Physician Office Visit	N/A	100% after **$35 Copay**	60% after Deductible
- Office Surgery	N/A	80%	60% after Deductible
- Allergy Testing, Serum and Injections	N/A	100% after Applicable Copay*	60% after Deductible
_Other office Services (w/o Office Visit billed)	N/A	100% after Applicable Copay*	60% after Deductible
Urgent Care Facility (Minor Emergency Medical Clinic)	N/A	100% after **$35 Copay**	100% after Deductible
Preferred Lab Card	N/A	100%	100%; Deductible waived
Lab/X-ray (Physician Office, Outpatient Hospital, Independent Lab)	100% (Facility and interpretation)	100%	60% after Deductible
- Lab/X-ray (All related charges)	80%	100% of PPO Rate	100% of U&C Fee
Outpatient Hospital/Ambulatory Surgical Facility (All related charges)	80% (Facility charges)	80%	60% after Deductible
Maternity	80% (Facility charges)	80% (Office Visit Copay does not apply)	60% after Deductible
Routine Newborn Care (Pediatric care to date of baby's discharge.)	80% Facility charges)	80%	60% after Deductible
Mental & Nervous Conditions, Chemical Dependency (Internal plan maximums apply)			
- Inpatient	80%	80%	60% after Deductible
- Outpatient Therapy	80%	80%	60% after Deductible
- Day Treatment	80%	80%	60% after Deductible
- Office Visit (Serious Mental Illness Paid SAAOI)	80%	80%	60% after Deductible

The Calendar Year Deductible and Annual Out-of-Pocket Maximum are determined by combining both Level I (Hospital/Facility) and Level II (PPO and Non-PPO) Covered Charges. Lifetime and Calendar Year Maximum Benefits are determined by combining Level I (Hospital/Facility) and Level II (PPO and Non-PPO) Covered Charges.

*** Office Visit Copay covers exam, treatment, allergy testing and supplies provided in the Physician's office except chemotherapy, speech therapy, occupational therapy, physical therapy, surgery, infusion therapy, orthotics, chiropractic, maternity, second surgical opinion, and radiation therapy**

EAGLE PASS ISD

2025-2026 **Platinum Plan Summary of Benefits** **Plan # S860032**

BENEFITS	Level I Benefit (Hospital/Facility Services)	Level II PPO Benefit (Physician Services)	Level II Non-PPO Benefit (Physician Services)
Physical Therapy/Occupational Therapy/Speech Therapy/Cardiac Rehabilitation	80%	80%	60% after Deductible
Chiropractic Services Calendar Year Maximum Benefit	N/A	80% after Deductible $1,500	60% after Deductible $1,500
Sleep Disorders - Covered Services (Including sleep studies/ diagnostic testing, Surgery, devices and equipment)	80%	80%	60% after Deductible
Home Health Care Calendar Year Maximum	100% 120 visits	100% 120 visits	60% after Deductible 120 visits
Home Infusion Therapy	N/A	80%	60% after Deductible
Skilled Nursing Facility Calendar Year Maximum	100% 100 Days	100% 100 Days	60% after Deductible 100 Days
Chemotherapy, Dialysis, Radiation Therapy/Infusion Therapy	80%	80%	60% after Deductible
Hospice Lifetime Maximum Benefit	100% $10,000	100% $10,000	60% after Deductible $10,000
DME, Medical Supplies	80%	80%	60% after Deductible
Prosthetic Devices	80%	80%	60% after Deductible
All Other Covered Charges	80%	80%	60% after Deductible
WELLNESS BENEFITS			
Routine Preventive Care			
– Routine Physical Exam	N/A	100%; after applicable copay	60% after Deductible
– Annual Well Woman Exam	N/A	100%; after applicable copay	60% after Deductible
– Annual Mammogram/Bone Density Test/PSA	100%; Deductible waived	100%; Copay/Ded waived	60% after Deductible
– Well Baby/Well Child Care	N/A	100%; after applicable copay	60% after Deductible
– Routine Immunizations	N/A	100%; Copay/Ded waived	60% after Deductible
– Routine Vision Exam	N/A	100%; after applicable copay	60% after Deductible
– Routine Hearing Exam	N/A	100%; after applicable copay	60% after Deductible
– Lab/X-ray and routine diagnostic testing and other medical screenings	100%; Deductible waived	100%; Copay/Ded waived	60% after Deductible
Bone Density Test (age 65 and older or individuals who are at risk)	100%	100%	60% after Deductible
Routine Colonoscopy (age 50 and older every 5 yrs or family history)	100%	100%	60% after Deductible
PRESCRIPTION DRUG PLAN	**Express Scripts Retail/Specialty Pharmacy**		
Calendar Year Deductible Per Covered Person	**$0**		
Prescription Drug Card Co-pay 30/60/90-day supply limit	**Generic: $5/$10/$15 No Deductible** **Brand: $30/$60/$90 No Deductible**		
Express Scripts Mail Order Service Co-pay 90-day supply limit	**Generic: $10 No Deductible** **Brand: $55 No Deductible**		

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MS-DRG	Description		Yr 1	Yr 2	Yr 3	Notes on previous codes description	SMD Notes
MS-DRG 796-798, 805-807	796-VAGINAL DELIVERY WITH STERILIZATION AND/OR D&C WITH MCC 797-VAGINAL DELIVERY WITH STERILIZATION AND/OR D&C WITH CC 798- VAGINAL DELIVERY WITH STERILIZATION AND/OR D&C WITHOUT CC/MCC 805-VAGINAL DELIVERY WITHOUT STERILIZATION OR D&C WITH MCC 806-VAGINAL DELIVERY WITHOUT STERILIZATION OR D&C WITH CC 807-VAGINAL DELIVERY WITHOUT STERILIZATION OR D&C WITHOUT CC/MCC	Per Case	$ 6,560	$ 6,740	$ 6,942	New	DRG 796-798 added in FY19
MS-DRG 768	768-VAGINAL DELIVERY WITH O.R. PROCEDURES EXCEPT STERILIZATION AND/OR D&C	Per Case	$ 6,560	$ 6,740	$ 6,942		No changes
MS-DRG 783-788	783-CESAREAN SECTION WITH STERILIZATION WITH MCC 784-CESAREAN SECTION WITH STERILIZATION WITH CC 785- CESAREAN SECTION WITH STERILIZATION WITHOUT CC/MCC 786-CESAREAN SECTION WITHOUT STERILIZATION WITH MCC 787-CESAREAN SECTION WITHOUT STERILIZATION WITH CC 788-CESAREAN SECTION WITHOUT STERILIZATION WITHOUT CC/MCC	Per Case	$ 8,659	$ 8,897	$ 9,164	New	DRG 783-784 added in FY19, DRG 785-788 DRG added in FY20
MS-DRG 795	795-NORMAL NEWBORN	Per Case	$ 1,286	$ 1,321	$ 1,361		No Changes
MS-DRG 789-794	789-NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY 790-EXTREME IMMATURITY OR RESPIRATORY DISTRESS SYNDROME, NEONATE 791-PREMATURITY WITH MAJOR PROBLEMS 792-PREMATURITY WITHOUT MAJOR PROBLEMS 793-FULL TERM NEONATE WITH MAJOR PROBLEMS 794-NEONATE WITH OTHER SIGNIFICANT PROBLEMS	Per Case	$ 1,968	$ 2,022	$ 2,086		No Changes
MS-DRG 945-946	945-REHABILITATION WITH CC/MCC 946-REHABILITATION WITHOUT CC/MCC	Per Case	$ 2,585	$ 2,656	$ 2,736		No Changes
MS-DRG 616-621	616-AMPUTATION OF LOWER LIMB FOR ENDOCRINE, NUTRITIONAL AND METABOLIC DISORDERS WITH MCC 617-AMPUTATION OF LOWER LIMB FOR ENDOCRINE, NUTRITIONAL AND METABOLIC DISORDERS WITH CC 618-AMPUTATION OF LOWER LIMB FOR ENDOCRINE, NUTRITIONAL AND METABOLIC DISORDERS WITHOUT CC/MCC 619-O.R. PROCEDURES FOR OBESITY WITH MCC 620-O.R. PROCEDURES FOR OBESITY WITH CC 621-O.R. PROCEDURES FOR OBESITY WITHOUT CC/MCC	Per Case	$ 31,148	$ 32,005	$ 32,965		No Changes
MS-DRG 215-218	215-OTHER HEART ASSIST SYSTEM IMPLANT 216- CARDIAC VALVE AND OTHER MAJOR CARDIOTHORACIC PROCEDURES WITH CARDIAC CATHETERIZATION WITH MCC 217- CARDIAC VALVE AND OTHER MAJOR CARDIOTHORACIC PROCEDURES WITH CARDIAC CATHETERIZATION WITH CC 218- CARDIAC VALVE AND OTHER MAJOR CARDIOTHORACIC PROCEDURES WITH CARDIAC CATHETERIZATION WITHOUT CC/MCC	Per Case	$ 140,393	$ 144,254	$ 148,582		No Changes
MS-DRG 219-221	219-CARDIAC VALVE AND OTHER MAJOR CARDIOTHORACIC PROCEDURES WITHOUT CARDIAC CATHETERIZATION WITH MCC 220-CARDIAC VALVE AND OTHER MAJOR CARDIOTHORACIC PROCEDURES WITHOUT CARDIAC CATHETERIZATION WITH CC 221- CARDIAC VALVE AND OTHER MAJOR CARDIOTHORACIC PROCEDURES WITHOUT CARDIAC CATHETERIZATION WITHOUT CC/MCC	Per Case	$ 86,597	$ 88,978	$ 91,647		No Changes
MS-DRG 228-229	228-OTHER CARDIOTHORACIC PROCEDURES WITH MCC 229-OTHER CARDIOTHORACIC PROCEDURES WITHOUT MCC	Per Case	$ 50,515	$ 51,904	$ 53,461		No Changes
MS-DRG 231-232	231-CORONARY BYPASS WITH PTCA WITH MCC 232-CORONARY BYPASS WITH PTCA WITHOUT MCC	Per Case	$ 55,108	$ 56,623	$ 58,322		No Changes
MS-DRG 233-234	233-CORONARY BYPASS WITH CARDIAC CATHETERIZATION OR OPEN ABLATION WITH MCC 234- CORONARY BYPASS WITH CARDIAC CATHETERIZATION OR OPEN ABLATION WITHOUT MCC	Per Case	$ 100,638	$ 103,406	$ 106,508		No Changes
MS-DRG 235-236	235-CORONARY BYPASS WITHOUT CARDIAC CATHETERIZATION WITH MCC 236-CORONARY BYPASS WITHOUT CARDIAC CATHETERIZATION WITHOUT MCC	Per Case	$ 79,251	$ 81,430	$ 83,873		No Changes
MS-DRG 242	242-PERMANENT CARDIAC PACEMAKER IMPLANT WITH MCC	Per Case	$ 21,911	$ 22,514	$ 23,189		No Changes
MS-DRG 243-244	243-PERMANENT CARDIAC PACEMAKER IMPLANT WITH CC 244- PERMANENT CARDIAC PACEMAKER IMPLANT WITHOUT CC/MCC	Per Case	$ 18,894	$ 19,414	$ 19,996		No Changes
MS-DRG 250	250-PERCUTANEOUS CARDIOVASCULAR PROCEDURES WITHOUT INTRALUMINAL DEVICE WITH MCC	Per Case	$ 35,427	$ 36,401	$ 37,493		No Changes
MS-DRG 251	251-PERCUTANEOUS CARDIOVASCULAR PROCEDURES WITHOUT INTRALUMINAL DEVICE WITHOUT MCC	Per Case	$ 20,075	$ 20,627	$ 21,246		No Changes
MS-DRG 252	252-OTHER VASCULAR PROCEDURES WITH MCC	Per Case	$ 48,153	$ 49,477	$ 50,961		No Changes
MS DRG 253	253-OTHER VASCULAR PROCEDURES WITH CC	Per Case	$ 40,109	$ 41,212	$ 42,448		No Change
MS-DRG 258-259	258-CARDIAC PACEMAKER DEVICE REPLACEMENT WITH MCC 259-CARDIAC PACEMAKER DEVICE REPLACEMENT WITHOUT MCC	Per Case	$ 14,434	$ 14,831	$ 15,276		No Changes
MS-DRG 260-262	260-CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT WITH MCC 261-CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT WITH CC 262-CARDIAC PACEMAKER REVISION EXCEPT DEVICE REPLACEMENT WITHOUT CC/MCC	Per Case	$ 24,405	$ 25,076	$ 25,828		No Changes
MS-DRG 268-269	268-AORTIC AND HEART ASSIST PROCEDURES EXCEPT PULSATION BALLOON WITH MCC 269-AORTIC AND HEART ASSIST PROCEDURES EXCEPT PULSATION BALLOON WITHOUT MCC	Per Case	$ 64,030	$ 65,791	$ 67,765	Previous DRG 237-MAJOR CARDIOVASC PROCEDURES W MCC OR THORACIC AORTIC ANEURYSM REPAIR	268 and 269 were added in FY16. 237 was deleted in FY16.
MS DRG 266-267	266-ENDOVASCULAR CARDIAC VALVE REPLACEMENT AND SUPPLEMENT PROCEDURES WITH MCC 267-ENDOVASCULAR CARDIAC VALVE REPLACEMENT AND SUPPLEMENT PROCEDURES WITHOUT MCC	Per Case	$ 64,030	$ 65,791	$ 67,765	New	266 and 267 were created in FY15 for more descriptive DRG Used DRG 270-272 rates.
MS-DRG 270-272	270-OTHER MAJOR CARDIOVASCULAR PROCEDURES WITH MCC 271-OTHER MAJOR CARDIOVASCULAR PROCEDURES WITH CC 272-OTHER MAJOR CARDIOVASCULAR PROCEDURES WITHOUT CC/MCC	Per Case	$ 64,030	$ 65,791	$ 67,765	Previous 238 MAJOR CARDIOVASC PROCEDURES W/O MCC	270 and 271 were added in FY16. Drg 238 was deleted in FY16
MS-DRG 273-274	273-PERCUTANEOUS AND OTHER INTRACARDIAC PROCEDURES WITH MCC 274-PERCUTANEOUS AND OTHER INTRACARDIAC PROCEDURES WITHOUT MCC	Per Case	$ 64,030	$ 65,791	$ 67,765	New	273-274 were created in FY16 for a more descriptive DRG. Used DRG 270-272 rates
MS-DRG 275-277	275-CARDIAC DEFIBRILLATOR IMPLANT WITH CARDIAC CATHETERIZATION 276-CARDIAC DEFIBRILLATOR IMPLANT WITH MCC OR CAROTID SINUS NEUROSTIMULATOR 277-CARDIAC DEFIBRILLATOR IMPLANT WITHOUT MCC	Per Case	$ 42,861	$ 44,040	$ 45,361	Previous 222- CARDIAC DEFIBRILLATOR IMPLANT WITH CARDIAC CATHETERIZATION WITH AMI, HF OR SHOCK WITH MCC 223- CARDIAC DEFIBRILLATOR IMPLANT WITH CARDIAC CATHETERIZATION WITH AMI, HF OR SHOCK WITHOUT MCC	275 was added in FY24. 222 and 223 were deleted in FY24. Blended DRG 222-227 rates
MS-DRG 286-287	286-CIRCULATORY DISORDERS EXCEPT AMI, WITH CARDIAC CATHETERIZATION WITH MCC 287-CIRCULATORY DISORDERS EXCEPT AMI, WITH CARDIAC CATHETERIZATION WITHOUT MCC	Per Case	$ 24,930	$ 25,616	$ 26,384		No Changes
MS DRG 321-322	321-PERCUTANEOUS CARDIOVASCULAR PROCEDURES WITH INTRALUMINAL DEVICE WITH MCC OR 4+ ARTERIES/INTRALUMINAL DEVICES- 322-PERCUTANEOUS CARDIOVASCULAR PROCEDURES WITH INTRALUMINAL DEVICE WITHOUT MCC	Per Case	$ 33,546	$ 34,469	$ 35,503	prev 246 and 248 246-PERCUTANEOUS CARDIOVASCULAR PROCEDURES WITH DRUG-ELUTING STENT WITH MCC OR 4+ ARTERIES OR STENTS 248- PERCUTANEOUS CARDIOVASCULAR PROCEDURES WITH NON-DRUG-ELUTING STENT WITH MCC OR 4+ ARTERIES OR	321 was add in FY24, 246 and 248 were deleted in FY24 322 was added in FY 24, 247 and 249 were deleted in FY24 Blended 246-249 rates

MS-DRG 402, 426-430, 447-448, 450-451	402-SINGLE LEVEL COMBINED ANTERIOR AND POSTERIOR SPINAL FUSION EXCEPT CERVICAL 426-MULTIPLE LEVEL COMBINED ANTERIOR AND POSTERIOR SPINAL FUSION EXCEPT CERVICAL WITH MCC OR CUSTOM-MADE ANATOMICALLY DESIGNED INTERBODY FUSION DEVICE 427-MULTIPLE LEVEL COMBINED ANTERIOR AND POSTERIOR SPINAL FUSION EXCEPT CERVICAL WITH CC 428- MULTIPLE LEVEL COMBINED ANTERIOR AND POSTERIOR SPINAL FUSION EXCEPT CERVICAL WITHOUT CC/MCC 429-COMBINED ANTERIOR AND POSTERIOR CERVICAL SPINAL FUSION WITH MCC 430-COMBINED ANTERIOR AND POSTERIOR CERVICAL SPINAL FUSION WITHOUT MCC 447-MULTIPLE LEVEL SPINAL FUSION EXCEPT CERVICAL WITH MCC OR CUSTOM-MADE ANATOMICALLY DESIGNED INTERBODY FUSION DEVICE 448-MULTIPLE LEVEL SPINAL FUSION EXCEPT CERVICAL WITHOUT MCC 450- SINGLE LEVEL SPINAL FUSION EXCEPT CERVICAL WITH MCC OR CUSTOM-MADE ANATOMICALLY DESIGNED INTERBODY FUSION DEVICE 451-SINGLE LEVEL SPINAL FUSION EXCEPT CERVICAL WITHOUT MCC	Per Case	$ 28,131	$ 28,905	$ 29,772		402 and 426-428 were add in FY25. 429-430 were added in FY 25. Use blended rate of 453-460 calculation= DRG453X3+459DRG+460DRG /5
MS-DRG 456 - 458	456-SPINAL FUSION EXCEPT CERVICAL WITH SPINAL CURVATURE, MALIGNANCY, INFECTION OR EXTENSIVE FUSIONS WITH MC 457-SPINAL FUSION EXCEPT CERVICAL WITH SPINAL CURVATURE, MALIGNANCY, INFECTION OR EXTENSIVE FUSIONS WITH CC 458-SPINAL FUSION EXCEPT CERVICAL WITH SPINAL CURVATURE, MALIGNANCY, INFECTION OR EXTENSIVE FUSIONS WITHOUT CC/MCC	Per Case	$ 33,458	$ 34,378	$ 35,409		No Changes
MS-DRG 461-462	461-BILATERAL OR MULTIPLE MAJOR JOINT PROCEDURES OF LOWER EXTREMITY WITH MCC 462-BILATERAL OR MULTIPLE MAJOR JOINT PROCEDURES OF LOWER EXTREMITY WITHOUT MCC	Per Case	$ 17,057	$ 17,526	$ 18,052		No Changes
MS-DRG 466-468	466-REVISION OF HIP OR KNEE REPLACEMENT WITH MCC 467-REVISION OF HIP OR KNEE REPLACEMENT WITH CC 468-REVISION OF HIP OR KNEE REPLACEMENT WITHOUT CC/MCC	Per Case	$ 24,930	$ 25,616	$ 26,384		No Changes
MS-DRG 469-470	469-MAJOR HIP AND KNEE JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY WITH MCC OR TOTAL ANKLE REPLACEMENT 470-MAJOR HIP AND KNEE JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY WITHOUT MCC	Per Case	$ 11,809	$ 12,134	$ 12,498		No Changes
MS-DRG 471-473	471-CERVICAL SPINAL FUSION WITH MCC 472-CERVICAL SPINAL FUSION WITH CC 473-CERVICAL SPINAL FUSION WITHOUT CC/MCC	Per Case	$ 28,866	$ 29,660	$ 30,550		No Changes
MS-DRG 492	492-LOWER EXTREMITY AND HUMERUS PROCEDURES EXCEPT HIP, FOOT AND FEMUR WITH MCC	Per Case	$ 12,203	$ 12,539	$ 12,915		No Changes
MS-DRG 493	493-LOWER EXTREMITY AND HUMERUS PROCEDURES EXCEPT HIP, FOOT AND FEMUR WITH CC	Per Case	$ 9,709	$ 9,976	$ 10,275		No Changes
MS-DRG 494	494-LOWER EXTREMITY AND HUMERUS PROCEDURES EXCEPT HIP, FOOT AND FEMUR WITHOUT CC/MCC	Per Case	$ 7,872	$ 8,088	$ 8,331		No Changes
MS-DRG 518-519	518-BACK AND NECK PROCEDURES EXCEPT SPINAL FUSION WITH MCC OR DISC DEVICE OR NEUROSTIMULATOR 519-BACK AND NECK PROCEDURES EXCEPT SPINAL FUSION WITH CC	Per Case	$ 24,930	$ 25,616	$ 26,384	prev 490 490-BACK & NECK PROC EXC SPINAL FUSION W CC/MCC OR DISC DEVICE/NEUROSTIM	519-519 were added in FY15, 490 was deleted in FY15
MS-DRG 520	520-BACK AND NECK PROCEDURES EXCEPT SPINAL FUSION WITHOUT CC/MCC	Per Case	$ 18,370	$ 18,875	$ 19,441	prev 491 491-BACK & NECK PROC EXC SPINAL FUSION W/O CC/MCC	520 was added in FY15, 491 was deleted in FY15