

EAGLE PASS ISD

2024-2025

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 - Office Surgery - Allergy Testing, Serum, and Injections	N/A N/A N/A	80% after Deductible 80% after Deductible 80% after Deductible	60% after Deductible 60% after Deductible 60% after Deductible
Urgent Care Facility (Minor Emergency Medical Clinic)	N/A	80% after Deductible	60% 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	80% after Deductible (Facility and interpretation) 80% after Deductible	80% after Deductible 100% of PPO Rate; Copay/Deductible waived	60% after Deductible 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 - Outpatient Therapy - Day Treatment - Office Visit Serious Mental Illness paid SAAOI	80% after Deductible 80% after Deductible 80% after Deductible N/A	80% after Deductible 80% after Deductible 80% after Deductible 80% 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.

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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 Rehabilitation	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 – Annual Well Woman Exam – Annual Mammogram/PSA – Well Baby/Well Child Care – Routine Immunizations – Routine Vision Exam – Routine Hearing Exam – Lab/X-ray and routine diagnostic testing and other medical screenings	N/A N/A 100%; Deductible waived N/A N/A N/A N/A 100%; Deductible waived	100%; Deductible waived 100%; Deductible waived 100%; Deductible waived 100%; Deductible waived 100%; Deductible waived 100%; Deductible waived 100%; Deductible waived 100%; Deductible waived	60% after Deductible 60% after Deductible 60% after Deductible 60% after Deductible 60% after Deductible 60% after Deductible 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 Discount Card included-30 day supply	\$0 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.