## EAGLE PASS ISD
### 2017-2018
#### 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

<table>
<thead>
<tr>
<th></th>
<th>Level I Benefit (Hospital/Facility Services)</th>
<th>Level II PPO Benefit (Physician Services)</th>
<th>Level II Non-PPO Benefit (Physician Services)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Lifetime Maximum Benefit</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Annual Maximum Benefit</td>
<td>Unlimited</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Calendar Year Deductible</td>
<td>$590 ($1,770 Family)</td>
<td>$590 ($1,770 Family)</td>
<td>$1,180 ($3,540 Family)</td>
</tr>
<tr>
<td>Annual Out-of-Pocket Maximum (Excluding Deductible and Copays)</td>
<td>$2,360 ($7,080 Family)</td>
<td>$2,360 ($7,080 Family)</td>
<td>$2,360 ($7,080 Family)</td>
</tr>
</tbody>
</table>

### BENEFITS

**ELAP Exclusive Providers**
- **Inpatient Hospital Expenses**
  - Notification to HealthWatch is required within 48 hours of hospital admission or $250 penalty
  - 80% after Deductible
  - N/A
  - N/A
- **Hospital Emergency Room**
  - Medical Emergency/Accidental Injury (Copay waived is admitted)
    - Deductible waived
    - 80% after Deductible
    - 80% Deductible waived (All related charges)
    - 60% after Deductible
  - None Medical Emergency
    - 80% after Deductible
    - 80% after Deductible
    - 60% after Deductible
- **Ambulance**
  - 80% after Deductible
  - 80% after Deductible
  - 60% after Deductible
- **Physician Office Visit**
  - 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
    - 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.)
    - 80% after Deductible
    - 80% after Deductible
    - 60% after Deductible
  - Other Lab/X-ray
    - 80% after Deductible (Facility and interpretation)
    - 80% after Deductible
    - 60% after Deductible
- **Outpatient Hospital/Ambulatory Surgical Facility**
  - All related charges
    - 80% after Deductible (Facility charges)
    - 80% after Deductible
    - 60% after Deductible
- **Maternity**
  - Facility charges
    - 80% after Deductible (Office Visit Copay doesn’t apply)
    - 80% after Deductible
    - 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.*
**MEDICAL CARE**

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Level I Benefit (Hospital/Facility Services)</th>
<th>Level II PPO Benefit (Physician Services)</th>
<th>Level II Non-PPO Benefit (Physician Services)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Therapy/Occupational Therapy/Chiropractic Services</td>
<td>80% after Deductible</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td>Combined Calendar Year Maximum Number of Therapies/Visits</td>
<td>30</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>Speech Therapy (Restorative)</td>
<td>80% after Deductible</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td>Sleep Disorders</td>
<td>80% after Deductible</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td>- Covered Services (including sleep studies/diagnostic testing, Surgery, devices and equipment)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Health Care</td>
<td>100%; Deductible waived</td>
<td>100%; Deductible waived</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td>Calendar Year Maximum</td>
<td>120 visits</td>
<td>120 visits</td>
<td>120 visits</td>
</tr>
<tr>
<td>Home Infusion Therapy</td>
<td>N/A</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>100%; Deductible waived</td>
<td>100%; Deductible waived</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td>Calendar Year Maximum</td>
<td>100 days</td>
<td>100 days</td>
<td>100 days</td>
</tr>
<tr>
<td>Chemotherapy, Dialysis, Radiation Therapy/Infusion Therapy/Cardiac Rehabilitation</td>
<td>80% after Deductible</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td>Hospice</td>
<td>100%; Deductible waived</td>
<td>100%; Deductible waived</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td>Lifetime Maximum Benefit</td>
<td>$20,000</td>
<td>$20,000</td>
<td>$14,000</td>
</tr>
<tr>
<td>DME, Medical Supplies</td>
<td>80% after Deductible</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td>Prosthetic Devices</td>
<td>80% after Deductible</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
</tr>
<tr>
<td>All Other Covered Charges</td>
<td>80% after Deductible</td>
<td>80% after Deductible</td>
<td>60% after Deductible</td>
</tr>
</tbody>
</table>

**WELLNESS BENEFITS**

**Routine Preventive Care**
- Routine Physical Exam: N/A
- Annual Well Woman Exam: N/A
- Annual Mammogram/Bone Density Test/PSA: 100%; Deductible waived
- Well Baby/Well Child Care: N/A
- Routine Immunizations: N/A
- Routine Vision Exam: N/A
- Routine Hearing Exam: N/A
- Lab/X-ray and routine diagnostic testing and other medical screenings: 100%; Deductible waived

- Routine Colonoscopy (age 50 and older or family history every 5 years): 100%; Deductible waived

**Prescription Drug Expense Benefit**
- Calendar Year Deductible: $0
- Per Covered Person
- Discount Card included-30 day supply: Generic: 80% No Deductible
- Brand: 80% No Deductible

**PLEASE CONTACT GROUP & PENSION ADMINISTRATORS 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.**

The Eagle Pass ISD Group Health Plan believes this plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at (830) 773-5181 ext. 1056/1088.