EAGLE PASS ISD

2021-2022 **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	Level I Benefit (Hospital/Facility Services)	Level II PPO Benefit (Physician Services)	Level II Non-PPO Benefit (Physician Services)
Plan Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited
Annual Maximum Benefit	Unlimited	Unlimited	Unlimited
Calendar Year Deductible	**$295 ($885 Family)**	**$295 (885 Family)**	**$590 ($1,770 Family)**
Annual Out-of-Pocket Maximum (Excluding Deductible and Copays)	**$2,360 ($7,080 Family)**	**$2,360 ($7,080 Family)**	**$2,360 ($7,080 Family)**
BENEFITS			
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 †	N/A	100% after **$30 Copay**	60% after Deductible
- Office Surgery	N/A	90% after Deductible	60% after Deductible
- Allergy Testing, Serum, and Injections	N/A	100% after **$30 Copay**	60% after Deductible
Urgent Care Facility (Minor Emergency Medical Clinic)	N/A	100% after **$30 Copay**	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.)	90% after Deductible (Facility and interpretation)	90% after Deductible	60% after Deductible
- Other Lab/X-ray	100%; Deductible waived	100% of PPO rate; Copay/Ded waived	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	90% after Deductible	90% after Deductible	60% after Deductible
- Outpatient Therapy	90% after Deductible	90% after Deductible	60% after Deductible
- Day Treatment	90% after Deductible	90% after Deductible	60% after Deductible
- Office Visit	N/A	90% 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.

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MEDICAL CARE	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/Bone Density Test/PSA	100%; Deductible waived	100%; Copay/Ded waived	60% after Deductible
– Well Baby/Well Child Care	N/A	100%; Copay/Ded waived	60% after Deductible
– 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	100%; Deductible waived	100%; Copay/Ded 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**		

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.

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