EAGLE PASS ISD

2021-2022 **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	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	**$0**	**$0**	**$590 ($1,770 Family)**
Annual Out-of-Pocket Maximum (Excluding Deductible and Copays)	**$1,180 Ind (No Family limit)**	**$1,180 Ind (No Family Limit)**	**$3,540 Ind (No Family Limit)**
BENEFITS			
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**	60% 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**

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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/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
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**		

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.