PLAN SUMMARY OF BENEFITS - 2017-2018

	EPO PLAN	BASIC PLAN		HRA FUND		*****COPAY Plan- Transparent Pricing Arrangement
	IN-NETWORK ONLY (BAPTIST/ST. FRANCIS, LEBONHEUR HOSPTIALS)	IN-NETWORK (BAPTIST/ST. FRANCIS, LEBONHEUR HOSPITALS)	****OUT-OF-NETWORK	IN-NETWORK (BAPTIST/ST. FRANCIS, LEBONHEUR HOSPITALS)	****OUT-OF-NETWORK	(BAPTIST/ST. FRANCIS, LEBONHEUR HOSPITALS)
***WELLNESS (Routine Care)						
Physical Exams (per ACA)	100% (no Ded.)	100% (no Ded.)	Not Covered	100% (no Ded.)	Not Covered	100% (no Ded.)
Well Child Care (Including Immunizations)	100% (no Ded.)	100% (no Ded.)	Not Covered	100% (no Ded.)	Not Covered	100% (no Ded.)
Mammogram (Test and Reading)	100% (no Ded.)	100% (no Ded.)	50% (after Ded.)	100% (no Ded.)	50% (after Ded.)	100% (no Ded.)
Pap Smears (Test and Reading)	100% (no Ded.)	100% (no Ded.)	50% (after Ded.)	100% (no Ded.)	50% (after Ded.)	100% (no Ded.)
Prostate Blood Test/Colonoscopy (Test and Reading)	100% (no Ded.)	100% (no Ded.)	50% (after Ded.)	100% (no Ded.)	50% (after Ded.)	100% (no Ded.)
Fecal Occult Screening (Test and Reading)	100% (no Ded.)	100% (no Ded.)	50% (after Ded.)	100% (no Ded.)	50% (after Ded.)	100% (no Ded.)
**Annual Health Fund Provided to Employees and Dependents	Not Applicable	Not Applicable		$500 Indv. $750 Indv. +1 $1,000 Fam (Please note: the "Fund" is applied to the back end of the Deductible)		Not Applicable
MAJOR MEDICAL						
*Deductible (Ded.)	$500/Indv. $750/Indv.+1 $1,000/Fam.	$500/Indv. $1000/Indv. + 1 $1,500/Fam.	$1,000/ Indv. $2,000/ Indv. + 1 $3,000/ Fam.	$1,500/Indv. $3,000/Indv. + 1 $4,500/Fam.	$3,000/ Indv. $6,000/ Indv. + 1 $9,000/ Fam.	N/A
Plan Paymt (Coinsurance)	100%	80%	50%	80%	50%	100%
Out-of-Pocket Max.* (Including Ded.)	$2,000/Indv. $3,750/Indv. + 1 $5,500/Fam.	$4,000/Indv. $8,000/Indv. + 1 $12,000/Fam.	$9,000/ Indv. $18,000/Indv. + 1 $27,000/ Fam.	$5,000/Indv. $10,000/Indv. + 1 $13,700/Fam.	$12,000/ Indv. $24,000/ Indv. + 1 $34,700/ Fam.	$2,000/Indv. $3,750/Indv. + 1 $5,500/Fam.
Lifetime Max. per Fam Mbr.	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
HOSPITAL BENEFITS						
In-Patient	$500 Copay (then Ded.) per admission	80% (after Ded.)	50% (after Ded.)	80% (after Ded.)	50% (after Ded.)	$500 per admission
Out-Patient	$250 Copay (then Ded.) per visit	80% (after Ded.)	50% (after Ded.)	80% (after Ded.)	50% (after Ded.)	$250 Copay
Emergency Room	$150 Copay (then Ded.) per visit	$150 Copay, then Ded., then 100%		80% (after Ded.)		$150 Copay
Non-Emergency	Not Covered	$150 Copay, then Ded. , then 100%	50% (after Ded.)	80% (after Ded.)	50% (after Ded.)	$500 Copay
	Copay Waived if admitted due to Medical Emergency					
SURGICAL / PHYSICIAN BENEFITS						
In-Patient/Out-Patient	100% (no Ded.)	80% (after Ded.)	50% (after Ded.)	80% (after Ded.)	50% (after Ded.)	100%
PHYSICIAN'S OFFICE VISIT						
Primary Care	100%; after $20 Copay	100%; after $25 Copay	50% (after Ded.)	80% (after Ded.)	50% (after Ded.)	$20 Copay
Specialist	100%; after $35 Copay	100%; after $35 Copay	50% (after Ded.)	80% (after Ded.)	50% (after Ded.)	$35 Copay
DIAGNOSTIC SERVICES						
Routine X-Ray & LAB Services (outpatient)	100% (no Ded.)	80% (no Ded.)	50% (after Ded.)	80% (after Ded.)	50% (after Ded.)	100%
(MRI, MRA, CAT and Pet Scan are subject to Deductible)	100% (after Ded.)	80% (after Ded.)	50% (after Ded.)	80% (after Ded.)	50% (after Ded.)	CAT Scans - ($150 Copay) MRI/MRA/PET Scans- ($250 Copay)
PRESCRIPTIONS						
GENERIC	$10	$10	50% (after $100 Ded.)	$10	50% (after $100 Ded.)	$10
PREFERRED	$25	$25	50% (after $100 Ded.)	$25	50% (after $100 Ded.)	$25
NON-PREFERRED	$50	$50	50% (after $100 Ded.)	$50	50% (after $100 Ded.)	$50
MENTAL/NERVOUS & SUBSTANCE ABUSE						
In-Patient	$500 Copay (then Ded.) per admission	80% (after Ded.)	50% (after Ded.)	80% (after Ded.)	50% (after Ded.)	$500 per admission
Physician's Ofc. Visit	100%; after $20 Copay	100%; after $25 Copay	50% (after Ded.)	80% (after Ded.)	50% (after Ded.)	$20 Copay
ADDITIONAL MEDICAL BENEFITS						
Physical Therapies/ Chiropractic (60 visits max)	100%; after $35 Copay	100%; after $35 Copay	50% (after Ded.)	80% (after Ded.)	50% (after Ded.)	$20 Copay - (15 visits)
Home Health Care (Precertification) (60 visits max)	100% (after Ded.)	80% (after Ded.)	50% (after Ded.)	80% (after Ded.)	50% (after Ded.)	100%
Extended Care Facility (60 visits max)	100% (after Ded.)	80% (after Ded.)	50% (after Ded.)	80% (after Ded.)	50% (after Ded.)	$100 Copay
Hospice (Precertification)	100% (after Ded.)	80% (after Ded.)	50% (after Ded.)	80% (after Ded.)	50% (after Ded.)	100%
Urgent Care	$75 Copay, (then Ded.)	$75 Copay, (then Ded.)	$75 Copay, (then Ded.)	80% (after Ded.)	50% (after Ded.)	$40 Copay
Ambulance Services	100% (after Ded.)	80% (after Ded.)	80% (after Ded.)	80% (after Ded.)	50% (after Ded.)	$50 Copay
Medical Supplies & DME	100% (after Ded.)	80% (after Ded.)	50% (after Ded.)	80% (after Ded.)	50% (after Ded.)	$50 Copay

***Deductibles and Out of Pocket Expenses Accumulate on a calendar year basis.**

**The HRA Fund pays at the back end of the deductible and is funded 50% for enrollments beginning September 1. On January 1, the fund will be funded the full amount listed in this summary and any funds remaining at the end of the calendar year will be added to it. Please note that the fund cannot exceed 100% of the in-network Deductible.

***For a detailed listing of preventive services, please visit the U.S. Department of Health and Human Services website at: https://www.healthcare.gov/what-are-my-preventive-care-benefits.

The plan document is the governing document; therefore any discrepancies which may be found in this summary are not binding. The Plan Document may be found by going to your district's Employee Portal and looking under "Documents/Links".

**** Out of Network providers may bill for amounts above the Usual and Customary charges, which the Member may also be charged on top of the deductibles and coinsurance amounts.

***** **Transparent Pricing Arrangement (COPAY Plan)** uses direct contracts with hospital networks to reduce costs to the plan. All services are assigned a copay. Balance billing received from non-contracted facilities will be negotiated by HealthSCOPE

Revised 03-25-2017