

# MID-VALLEY/ST. CHARLES COMMUNITY UNIT SCHOOL DISTRICT 303

## 2019 BENEFITS AT A GLANCE

	PPO PLAN		Consumer Driven Health Plan (CDHP)		HMOI
	In-Network	Out-of-Network	In-Network	Out-of-Network	
<b>Deductible</b>					
Single	\$400	\$800	\$1,500	\$3,000	\$0
Single + 1	\$800	\$1,600	n/a	n/a	\$0
Family	\$1,200	\$2,400	\$3,000	\$6,000	\$0
<b>Out-of-Pocket</b>					
Single	\$4,000	\$8,000	\$6,000	\$12,000	\$1,000
Single + 1	\$8,000	\$16,000	n/a	n/a	n/a
Family	\$12,000	\$24,000	\$12,000	\$24,000	\$2,000
<b>Lifetime Maximum</b>	Unlimited		Unlimited		Unlimited
<b>Hospital/Surgical Services (incl. mental health)</b>					
Inpatient	80% after ded.	70% after ded.	80% after ded.	70% after ded.	100%
Outpatient	80% after ded.	70% after ded.	80% after ded.	70% after ded.	100%
Out of Area	80% after ded.	70% after ded.	80% after ded.	70% after ded.	0%*
<b>Hospital Copay</b>	\$0	\$300	\$0	\$0	\$200/3 days
<b>Emergency Room</b>	\$100 copay then 80% after regular ded.		80% after regular ded.		100% after \$75 copay
<b>Chiropractic</b>	\$50 copay 12 visit maximum/calendar year for muscle manipulations/spinal adjustments	70% after ded.	80% after ded. 12 visit maximum/calendar year for muscle manipulations/spinal adjustments	70% after ded.	100% after \$40 copay referral required
<b>Physical Therapy</b>	\$50 copay 65 visits/calendar year/therapy maximum	70% after ded.	80% after ded. 65 visits/calendar year/therapy maximum	70% after ded.	100% after \$20 copay
<b>Occupational Therapy</b>	\$50 copay 70 visits/calendar year/therapy maximum	70% after ded.	80% after ded. 70 visits/calendar year/therapy maximum	70% after ded.	100% after \$20 copay
<b>Speech Therapy</b>	\$50 copay 45 visits/calendar year/therapy maximum	70% after ded.	80% after ded. 45 visits/calendar year/therapy maximum	70% after ded.	100% after \$20 copay
<b>Physician Services (incl. mental health)</b>					
Inpatient	80% after ded.	70% after ded.	80% after ded.	70% after ded.	100%
Outpatient	\$25 copay for primary care/mental health and \$50 for specialist	70% after ded.	80% after ded.	70% after ded.	100% after \$20 copay for primary care/mental health and \$40 for specialist
Out of Area	80% after ded.		80% after ded.		N/A
<b>Private Duty Nursing</b>	80% after ded. 10 visits/calendar year maximum	70% after ded.	80% after ded. 10 visits/calendar year maximum	70% after ded.	100% referral required
<b>Other Services</b>					
Outpatient	80% after ded.	70% after ded.	80% after ded.	70% after ded.	100%
Out of Area	80% after ded.		80% after ded.		0%*
<b>Maternity Authorization</b>	Only required for hospital stays longer than 48 hours for a vaginal delivery or 96 hours for a cesarean section.		Only required for hospital stays longer than 48 hours for a vaginal delivery or 96 hours for a cesarean section.		physician will authorize
<b>Pre-certification Penalty**</b>	<b>Pre-certification is required before all hospital admissions (or within two working days following an emergency admission) and before all scheduled surgeries performed outside the doctor's office.</b> <b>A \$200 additional deductible will be applied.</b> Utilization Management can be reached at: 1-800-572-3089				physician will authorize
*	Except when emergency treatment is required. You must call your Primary care Physician (PCP) for follow-up care.				
**	All inpatient hospital admissions or any surgeries must be pre-certified for both PPO plans.				

	PPO Plan		Consumer Driven Health Plan (CDHP)		HMOI
	In-Network	Out-of-Network	In-Network	Out-of-Network	
<b>WELLNESS BENEFITS</b>					
<b>Well Baby/Child Care</b>	100%	90%	100%	90%	100% less \$20 copay per visit for primary care
<b>Preventive &amp; Wellness Services</b>	100%	90%	100%	90%	100% less \$20 copay per visit for primary care \$40 for specialist
<b>PRESCRIPTION DRUG BENEFITS (Included in all medical plans) – Advantage Pharmacy Network (excludes CVS)</b>					
<b>Retail</b> (34 day supply)			Subject to deductible than copays apply*		
Generic	\$10 copay		\$10 copay		\$10 copay
Brand	\$25 copay		\$25 copay		\$25 copay
Non-Preferred Brand	\$60 copay		\$60 copay		\$60 copay
Self-Injectables	\$65 copay		\$65 copay		\$65 copay
<b>Mail Order</b> (90 day supply)			Subject to deductible than copays apply*		
Generic	\$20 copay		\$20 copay		\$20 copay
Brand	\$50 copay		\$50 copay		\$50 copay
Non-Preferred Brand	\$120 copay		\$120 copay		\$120 copay
<b>Non-Participating Pharmacy Payment Level</b>	75% of the eligible charge, minus the applicable copay				Not Covered
*Approved preventive medications are paid prior to deductible at the listed copays. Call BCBS at the number listed on the back of your ID card for a complete list. Notes: MV/D303 participates in Prior Authorization, Step Therapy, Mandatory Specialty Pharmacy, and Member-Pay-the-Difference programs. Compound drugs are excluded.					
<b>Call BCBS or see your Summary Plan Description for more details on the Medical and Prescription Drug programs.</b>					
<b>VISION BENEFITS – VISION SERVICE PLAN (VSP) (included with all medical plans)</b>					
<i>Eligible members and/or dependents may select any licensed provider for vision care services. Members who choose to receive services from a Non-Participating provider will be reimbursed up to the maximum allowance.</i>					
	<b>VSP Participating Provider</b>			<b>Non-Participating Provider</b>	
<b>WellVision Exam</b> <i>Once every 12 months</i>	100% after \$10 copay			Reimbursed up to \$25	
<b>Lenses</b>					
Single Vision	100% after \$25 copay			Reimbursed up to \$30	
Lined Bifocal	100% after \$25 copay			Reimbursed up to \$35	
Lined Trifocal	100% after \$25 copay			Reimbursed up to \$45	
Standard Progressive	100% after \$50 copay			Reimbursed up to \$45	
Premium Progressive	100% after \$80-\$90 copay			Reimbursed up to \$45	
Custom Progressive	100% after \$120-\$160 copay			Reimbursed up to \$45	
<i>Once every 12 months</i>					
<b>Frames</b> <i>Once every 24 months</i>	Covered up to \$130 allowance			Reimbursed up to \$45	
<b>Elective Contact Lenses</b>	Covered up to \$130 allowance 15% off contact lens exam (fitting and evaluation)			Reimbursed up to \$105	
<b>Non-Covered Glasses</b>	30% off additional glasses or sunglasses, including lens options, from the same VSP doctor on the same day as your WellVision exam. 20% off from any VSP doctor within 12 months of your last WellVision exam.			N/A	
<b>Laser Vision Correction</b>	Average of 15% off regular price or 5% off promotional price. Discounts only available from contracted facilities.			N/A	
<b>DENTAL BENEFITS – MetLife (must be elected separately)</b>					
	<b>In-Network</b>			<b>Out-of-Network</b>	
<b>Reimbursement</b>	Negotiated Fee Schedule			R&C 90 <sup>th</sup> Percentile	
<b>Deductible</b> <i>Applies to B &amp; C</i>	\$50 per individual (up to family maximum of \$150)			\$50 per individual (up to family maximum of \$150)	
<b>Calendar Year Max</b>	\$1,750			\$1,750	
<b>Coverage A</b> <i>Preventive</i>	100%			80%	
<b>Coverage B</b> <i>Minor Restorative</i>	80%			70%	
<b>Coverage C</b> <i>Major Restorative</i>	50%			40%	
<b>Orthodontia</b>	50%			50%	
\$1,500 Lifetime Maximum					
<i>Note: A separate calendar year maximum of \$1,000 applies to dental implants. Dental implants are covered under Coverage C, Major Restorative.</i>					

Please Refer to your Summary Plan Description for Further Details  
The MV HR/Payroll Assistant can be reached at 331-228-5964.

Plan Year 2019