

ST. CHARLES COMMUNITY UNIT SCHOOL DISTRICT 303

2020 BENEFITS AT A GLANCE

	PPO PLAN		Consumer Driven Health Plan (CDHP)		HMOI
	In-Network	Out-of-Network	In-Network	Out-of-Network	
Deductible					
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
Out-of-Pocket					
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
Lifetime Maximum	Unlimited		Unlimited		Unlimited
Hospital/Surgical Services (incl. mental health)					
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%*
Hospital Copay	\$0	\$300	\$0	\$0	\$200/3 days
Emergency Room	\$100 copay then 80% after regular ded.		80% after regular ded.		100% after \$100 copay
Chiropractic	\$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 \$50 copay referral required
Physical Therapy	\$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 \$25 copay
Occupational Therapy	\$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 \$25 copay
Speech Therapy	\$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 \$25 copay
Physician Services (incl. mental health)					
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 \$25 copay for primary care/mental health and \$50 for specialist
Out of Area	80% after ded.		80% after ded.		N/A
Private Duty Nursing	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
Other Services					
Outpatient	80% after ded.	70% after ded.	80% after ded.	70% after ded.	100%
Out of Area	80% after ded.		80% after ded.		0%*
Maternity Authorization	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
Pre-certification Penalty**	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. A \$200 additional deductible will be applied. 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 (GDHP)		HMOI
	In-Network	Out-of-Network	In-Network	Out-of-Network	
WELLNESS BENEFITS					
Well Baby/Child Care	100%	90%	100%	90%	100% less \$25 copay per visit for primary care
Preventive & Wellness Services	100%	90%	100%	90%	100% less \$25 copay per visit for primary care \$50 for specialist
PRESCRIPTION DRUG BENEFITS (included in all medical plans) – Advantage Pharmacy Network (excludes CVS), Performance Drug List					
Retail (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
Mail Order (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
Non-Participating Pharmacy Payment Level	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: D303 participates in Prior Authorization, Step Therapy, Mandatory Specialty Pharmacy, and Member-Pay-the-Difference programs. Compound drugs are excluded. All prescriptions for maintenance medications but be filled in a 90 day supply. Call BCBS or see your Summary Plan Description for more details on the Medical and Prescription Drug programs.					
VISION BENEFITS – VISION SERVICE PLAN (VSP) (included with all medical plans)					
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.					
	VSP Participating Provider			Non-Participating Provider	
WellVision Exam Once every 12 months	100% after \$10 copay			Reimbursed up to \$25	
Lenses					
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	
Once every 12 months					
Frames Once every 24 months	Covered up to \$130 allowance			Reimbursed up to \$45	
Elective Contact Lenses	Covered up to \$130 allowance 15% off contact lens exam (fitting and evaluation)			Reimbursed up to \$105	
Non-Covered Glasses	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	
Laser Vision Correction	Average of 15% off regular price or 5% off promotional price. Discounts only available from contracted facilities.			N/A	
DENTAL BENEFITS – MetLife (must be elected separately)					
	In-Network			Out-of-Network	
Reimbursement	Negotiated Fee Schedule			R&C 90 th Percentile	
Deductible Applies to B & C	\$50 per individual (up to family maximum of \$150)			\$50 per individual (up to family maximum of \$150)	
Calendar Year Max	\$1,750			\$1,750	
Coverage A Preventive	100%			75%	
Coverage B Minor Restorative	85%			60%	
Coverage C Major Restorative	55%			30%	
Orthodontia	50%			50%	
\$1,500 Lifetime Maximum					
Note: A separate calendar year maximum of \$1,000 applies to dental implants. Dental implants are covered under Coverage C, Major Restorative.					