



CITY OF ENNIS

COST PLUS PLAN

Effective October 1, 2019

Group #H870922

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.

DEDUCTIBLE AND ANNUAL OUT-OF-POCKET MAXIMUM	IMAGINE HEALTH FACILITIES/PHYSICIANS	ENNIS REGIONAL FACILITY/PHYSICIANS AND HEALTHSMART PPO PHYSICIANS 2), 3)	NON IMAGINE/ENNIS REGIONAL FACILITIES AND NON- PPO PHYSICIANS 2), 3)
Lifetime Maximum	Unlimited		
Plan Year Deductible			
- Per Covered Person	\$200	\$400	\$1,000
- Family Limit*	\$600	\$1,200	\$3,000
Annual Out-of-Pocket Maximum (includes Deductible, Medical and Rx Copays)			
- Per Covered Person	\$1,500	\$3,000	\$3,000
- Family Limit*	\$3,750	\$7,500	\$7,500

FACILITY BENEFITS – Payment Levels:

This section applies to covered expenses for services rendered by Hospitals and other types of facilities which are not included in the **Preferred Provider Organization (PPO) network**.

BENEFIT PERCENTAGE FOR:	IMAGINE HEALTH FACILITY BENEFIT	ENNIS REGIONAL FACILITY BENEFIT	NON IMAGINE/ ENNIS REGIONAL FACILITY BENEFIT	MAXIMUM BENEFITS, LIMITS & PROVISIONS
Inpatient Hospital Services	90% after Deductible	80% after Deductible	70% after Deductible	UR Notification required.
Maternity Inpatient Hospital Services	90% after Deductible	80% after Deductible	70% after Deductible	Contact UR Company for coordination of care.
Routine Newborn Care Inpatient Hospital Services	90%; Deductible waived	80%; Deductible waived	70% after Deductible	Payable under covered mother' claim.
Skilled Nursing Facility/Rehabilitation Facility	90% after Deductible	80% after Deductible	70% after Deductible	UR Notification required. Limited to 60 days combined per Plan Year.
Hospital Services for Mental/ Nervous Disorders, Chemical Dependency, Drug and Substance Abuse Inpatient/Residential Treatment Facilities	90% after Deductible	80% after Deductible	70% after Deductible	UR Notification required.
Hospital Emergency Room - Medical Emergency/Accidental Injury - Illness not a Medical Emergency	100% after \$150 Copay; Deductible waived 80% after \$250 Copay; Deductible applies		70% after Deductible	Contact UR Company for coordination of care.
Outpatient Surgical Facility	90% after Deductible	80% after Deductible	70% after Deductible	UR Notification required.
Outpatient Therapy/Other Services Physical/Occupational Therapy/Speech Therapy Cardiac Rehabilitation	90% after Deductible 90% after Deductible	80% after Deductible 80% after Deductible	70% after Deductible 70% after Deductible	Limited to 20 visits per therapy per Plan Year.
Outpatient Diagnostic Services Select Diagnostic Procedures (CT Scans, MRIs, PET Scans, etc.)	90% after Deductible	80% after Deductible	70% after Deductible	
All Other Diagnostic Lab/X-ray (Facility only)	100%; Deductible waived	80% after Deductible	70% after Deductible	
Preventive and Wellness Lab and X-ray	100%; Deductible waived		70% after Deductible	



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PHYSICIAN BENEFITS – Payment Levels and Limits:

This section applies to Physicians and all other Providers of service not included as Facility Providers. Benefits shown are available **based upon the Provider's participation in the PPO network.**

BENEFIT PERCENTAGE FOR:	IMAGINE HEALTH BENEFIT	ENNIS REGIONAL AND HEALTHSMART PPO BENEFIT 2), 3)	NON-HEALTHSMART PPO BENEFIT 2), 3)	MAXIMUM BENEFITS, LIMITS & PROVISIONS
Physician Hospital Visits/Surgeon/Anesthesia	90% after Deductible	80% after Deductible	70% after Deductible	
Physician Hospital Visit for Mental & Nervous Disorders/ Chemical Dependency, Drug and Substance Abuse	90% after Deductible	80% after Deductible	70% after Deductible	
Maternity (Including Prenatal delivery and Postnatal care)	90% after Deductible	80% after Deductible	70% after Deductible	Contact UR Company for coordination of care.
Routine Newborn Care (Pediatric care to date of mother's discharge.)	90% after Deductible	80% after Deductible	70% after Deductible	
Office Visit (includes Exam, treatment, office surgery)	100% after \$10 Copay PCP/\$30 Copay Specialist	100% after \$25 Copay PCP/\$50 Copay Specialist	70% after Deductible	
Allergy Testing/Serum	100% after \$10 Copay PCP/\$30 Copay Specialist	100% after \$25 Copay PCP/\$50 Copay Specialist	70% after Deductible	
Allergy Injections (without office visit billed)	90%; Deductible waived	80%; Deductible waived	70%; Deductible waived	
Mental/Nervous Disorders and Substance Abuse Office Visits	100% after \$10 Copay PCP/\$30 Copay Specialist	100% after \$25 Copay PCP/\$50 Copay Specialist	70% after Deductible	
Urgent Care Facility Physician Medical Care - Medical Emergency/Accidental Injury - Illness not a Medical Emergency	100% after \$25 Copay Deductible waived 100% after \$25 Copay Deductible applies	100% after \$45 Copay Deductible waived 100% after \$45 Copay Deductible applies	100% after \$75 Copay Deductible waived 100% after \$75 Copay Deductible applies	
Teladoc Telephone Consultation	N/A	\$0 Consult Fee		Call 1-800-835-2362
Chiropractic Services	100% after \$30 Copay Deductible waived	100% after \$50 Copay Deductible waived	70% after Deductible	
Select Diagnostic Medical Procedures CT Scans, MRIs, PET Scans, etc. (Physician's Office or Freestanding Facility)	90% after Deductible	80% after Deductible	70% after Deductible	
Diagnostic Lab/X-ray (Freestanding Facility, Independent Lab)	100%; Deductible waived	100%; Deductible waived	70% after Deductible	

2) This plan is a PPO Physician Only plan. Benefits shown in this summary apply to PPO provider services.

3) Plan limits apply collectively/combined for PPO and Non-PPO services.



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BENEFIT PERCENTAGE FOR:	IMAGINE HEALTH BENEFIT	ENNIS REGIONAL AND HEALTHSMART PPO BENEFIT 2), 3)	NON-HEALTHSMART PPO BENEFIT 2), 3)	MAXIMUM BENEFITS, LIMITS & PROVISIONS
Outpatient Therapy/Other Services Physical/Occupational Therapy, Speech Therapy	100% after \$30 Copay Deductible waived	100% after \$50 Copay Deductible waived	70%; Deductible waived	Limited to 20 visits per therapy per Plan Year.
Cardiac Rehabilitation	90% after Deductible	80% after Deductible	70% after Deductible	
Home Health Services	90% after Deductible	80% after Deductible	70% after Deductible	UR Notification required. Limited to 60 visits per Plan Year.
Inpatient Hospice (Home Hospice)	90% after Deductible	80% after Deductible	70% after Deductible	UR Notification required.
Durable Medical Equipment	90% after Deductible	80% after Deductible	70% after Deductible	UR Notification required.
Prosthetic Devices and Orthotics	90% after Deductible	80% after Deductible	70% after Deductible	
Ambulance Services	90% after Deductible			Contact UR Company for Coordination of Care.
All Other Provider Covered Physician Services	90% after Deductible	80% after Deductible	70% after Deductible	

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Preventive and Wellness Care Benefits

This benefit is payable for Covered Procedures incurred as part of a Preventive and Wellness Care Program and is not payable for treatment of a diagnosed illness or injury. Services must be identified and billed as routine or part of a routine physical exam/or as specified below.

BENEFIT PERCENTAGE FOR:	IMAGINE HEALTH BENEFIT ENNIS REGIONAL AND HEALTHSMART PPO BENEFIT 2), 3)	NON-PPO BENEFIT 2), 3)	LIMITS & PROVISIONS
All Covered Wellness Benefits	100%; Deductible waived	100%; Deductible waived	See age and frequency limits and other special provisions below

Examples of Covered Wellness Procedures to include but are not limited to:

- 1) Routine Physical Exam
- 2) Annual Well Woman Exam
- 3) *Annual Pap smear and other routine lab
- 4) *Annual Routine Mammogram
- 5) *Bone Density test
- 6) Annual PSA test (routine)
- 7) Well Baby Care Exam/Well Child Care Exam
- 8) Vision Screenings (to age 19)
- 9) Hearing Screenings for newborns
- 10) Routine Immunizations
- 11) Flu vaccine/pneumonia vaccine
- 12) *Routine lab, x-ray, diagnostic testing and other medical screenings
- 13) Smoking/Tobacco Use Cessation (limited to 2 attempts + 4 counseling sessions per attempt)
- 14) *All FDA-approved Women's Contraceptive methods/Sterilization procedures
- 15) *Routine Colonoscopy (includes polyp removal) – age 50 and older or family history of colon cancer

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* If these services are rendered by providers billing as a Facility, please refer to the appropriate category under Level I for the benefit.

NOTE: This Summary of Benefits only represents an overview of your medical benefits and are subject to change.