imagine360

CITY OF ENNIS

COST PLUS PLAN

Effective October 1, 2023
Group #H870922

PLEASE CONTACT IMAGINE360 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 - Family Limit*	 $200 $600	 $400 $1,200	 $1,000 $3,000
Annual Out-of-Pocket Maximum (includes Deductible, Medical and Rx Copays) - Per Covered Person - Family Limit*	 $1,500 $3,750	 $3,000 $7,500	 $3,000 $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	

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	100% after $25 Copay Deductible waived	100% after $45 Copay Deductible waived	100% after $75 Copay Deductible waived	
- Illness not a Medical Emergency	100% after $25 Copay Deductible applies	100% after $45 Copay Deductible applies	100% after $75 Copay Deductible applies	
United Concierge Medicine	N/A	$0 Consult Fee		***Call 844-4-VIPDOC***
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.

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.