Mesquite ISD: EPOB Plan

Coverage for: Individual + Family | Plan Type: EPO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit myblueelementil.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-855-760-3135 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$1,200** individual / **$3,600** family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Services that charge a copayment, prescription drugs, and in-network preventive care and diagnostic tests are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	Yes. **$200** prescription drug deductible. Does not apply to generic drugs. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	**$6,900** individual / **$13,800** family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See myblueelementil.com or call 1-855-760-3135 for a list of preferred providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Nonpreferred Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay / office and virtual visit deductible does not apply	Not Covered	Includes Internist, General Physician, Family Practitioner, Pediatrician, Behavioral Health Physicians, or Gynecologist. Teladoc: $12 copay deductible does not apply.
	Specialist visit	$70 copay / office and virtual visit deductible does not apply	Not Covered	None.
	Preventive care/screening/ Immunization	No charge deductible does not apply	Not Covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. 1 per plan year for hearing and eye exam.
If you have a test	Diagnostic test (x-ray, blood work)	Lab and Xray in Office: No charge deductible does not apply Independent Lab: No charge deductible does not apply Hospital Outpatient Lab: 20% coinsurance after deductible All other X-rays: 20% coinsurance after deductible	Not Covered	None.
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	Not Covered	Diagnostic imaging of the breast (including diagnostic mammogram, ultrasound imaging, MRI or CT Scan) No charge deductible does not apply Precertification is required for some imaging.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Nonpreferred Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.primetherapeutics.com	Generic drugs	Copay per prescription deductible does not apply $15 (Retail), $45 (Mail Order), and $15 (Extended Supply Network - "ESN")	Not Covered	Covers 31-day supply (Retail), 60-90 day supply (Mail Order). Includes contraceptive drugs and devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives (preferred pharmacy). Precertification and step therapy required. Cost will be higher for choosing Brand over Generic unless prescribed Dispense as Written.
	Preferred brand drugs	25% coinsurance after specific deductible (Retail, Mail Order and ESN)	Not Covered	
	Non-preferred brand drugs	50% coinsurance after specific deductible (Retail, Mail Order and ESN)	Not Covered	
	Specialty drugs	30% coinsurance after specific deductible (specialty pharmacy only)	Not Covered	Specialty drugs must be obtained from preferred specialty pharmacy provider. Retail not covered. 31-day supply limit. Medical specialty drugs including chemo drugs require precertification.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	Not Covered	Precertification is required for some procedures.
	Physician/surgeon fees	20% coinsurance after deductible	Not Covered	Includes office surgery.
If you need immediate medical attention	Emergency room care	20% coinsurance after deductible	Preferred provider benefit applies	Freestanding emergency room visits for an emergency: $500 copay per visit, then 20% coinsurance after deductible.
	Emergency medical transportation	20% coinsurance after deductible	Preferred provider benefit applies	Ground and air transportation covered.
	Urgent care	$50 copay deductible does not apply	Not Covered	None.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Nonpreferred Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	Not Covered	Precertification is required.
	Physician/surgeon fees	20% coinsurance after deductible	Not Covered	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay / office visit and virtual visit deductible does not apply 20% coinsurance after deductible for other outpatient services	Not Covered	None.
	Inpatient services	20% coinsurance after deductible	Not Covered	Precertification is required.
If you are pregnant	Office visits	$30 copay / visit deductible does not apply	Not Covered	Cost sharing does not apply for preventive services. Depending on the type of services, a copay, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% coinsurance after deductible	Not Covered	
	Childbirth/delivery facility services	20% coinsurance after deductible	Not Covered	Precertification is required for stays longer than 48/96 hours.
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	Not Covered	Limited to 60 visits per plan year. Precertification is required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Nonpreferred Provider (You will pay the most)	
If you need help recovering or have other special health needs (continued)	Rehabilitation services	Facility: 20% coinsurance after deductible Professional: $30 copay / visit; deductible does not apply	Not Covered	This includes physical therapy, occupational therapy, and speech therapy.
	Habilitation services	Facility: 20% coinsurance after deductible Professional: $30 copay / visit; deductible does not apply	Not Covered	
	Skilled nursing care	20% coinsurance after deductible	Not Covered	Precertification is required. Limited to 25 days per plan year.
If you need help recovering or have other special health needs (continued)	Durable medical equipment	20% coinsurance after deductible	Not Covered	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse. Precertification is required for DME over $2,500. DME less than $2,500) requires a referral from the physician.
	Hospice services	20% coinsurance after deductible	Not Covered	Precertification is required.
If your child needs dental or eye care	Children's eye exam	$70 copay / visit; deductible does not apply	Not Covered	One routine eye exam per plan year if performed by an ophthalmologist or optometrist.
	Children's glasses	Not Covered	Not Covered	None.
	Children's dental check-up	Not Covered	Not Covered	None.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult & Children)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care (with exception of person with diagnosis of diabetes)
- Weight loss programs (except for required preventive services)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (in lieu of anesthesia and nausea during pregnancy)
- Bariatric surgery (Blue Distinction Center or Blue Distinction Center + only)
- Chiropractic care (35 visits per plan year)
- Hearing aids ($1,000 maximum/36 months for members age 19 and older)
- Infertility treatment (limited to the diagnosis & treatment of underlying medical condition)
- Private-duty nursing
- Routine eye care (Adult, 1 routine eye exam per plan year)

Your Rights to Continue Coverage: Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or visit www.dol.gov/ebsa/healthreform. Additionally, a consumer assistance program can help you file your appeal. Contact the Texas Department of Insurance's Consumer Health Assistance Program at 1-800-252-3439 or visit www.texashealthoptions.com.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-760-3135.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-760-3135.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-855-760-3135.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-760-3135.

*To see examples of how this **plan** might cover costs for a sample medical situation, see the next section.*

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,200
Specialist copayment	$70
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,200
Copayments	$40
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$100
The total Peg would pay is	**$3,310**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,200
Specialist copayment	$70
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$1,000
Copayments	$500
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$200
The total Joe would pay is	**$3,200**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,200
Specialist copayment	$70
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,200
Copayments	$300
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,700**

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

The plan would be responsible for the other costs of these EXAMPLE covered services.