ST. CHARLES COMMUNITY UNIT SCHOOL DISTRICT 303
2017 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 $75 copay
Chiropractic	$50 copay	70% after ded.	80% after ded.	70% after ded.	100% after $40 copay
	12 visit maximum/calendar year for muscle manipulations/spinal adjustments		12 visit maximum/calendar year for muscle manipulations/spinal adjustments		referral required
Physical Therapy	$50 copay	70% after ded.	80% after ded.	70% after ded.	100% after $20 copay
	65 visits/calendar year/therapy maximum		65 visits/calendar year/therapy maximum		
Occupational Therapy	$50 copay	70% after ded.	80% after ded.	70% after ded.	100% after $20 copay
	70 visits/calendar year/therapy maximum		70 visits/calendar year/therapy maximum		
Speech Therapy	$50 copay	70% after ded.	80% after ded.	70% after ded.	100% after $20 copay
	45 visits/calendar year/therapy maximum		45 visits/calendar year/therapy maximum		
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 $20 copay for primary care/mental health and $40 for specialist
Out of Area	80% after ded.		80% after ded.		N/A
Private Duty Nursing	80% after ded.	70% after ded.	80% after ded.	70% after ded.	100%
	10 visits/calendar year maximum		10 visits/calendar year maximum		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.				

Please Refer to your Summary Plan Description for Further Details
The D303 Benefits Coordinator can be reached at 331-228-4929.

Plan Year 2017

	PPO Plan		Consumer Driven Health Plan (CDHP)		HMOI
	In-Network	Out-of-Network	In-Network	Out-of-Network	
WELLNESS BENEFITS					
Well Baby/Child Care	100%	90%	100%	90%	100% less $20 copay per visit for primary care
Preventive & Wellness Services	100%	90%	100%	90%	100% less $20 copay per visit for primary care $40 for specialist
PRESCRIPTION DRUG BENEFITS ***(Included in all medical plans)***					
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.
Note: D303 participates in Prior Authorization, Step Therapy, Mandatory Specialty Pharmacy, and Member-Pay-the-Difference programs.

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 90th 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%	80%
Coverage B *Minor Restorative*	80%	70%
Coverage C *Major Restorative*	50%	40%
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.