Benefits At A Glance

BCN10 with Deductibles

Option III

00159598 Washtenaw Intermediate School District - Transportation

This is intended as an easy to read summary and provides only a general overview of your benefits. **It is not a contract.** Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable Blue Care Network certificates and riders. Payment amounts are based on the Blue Care Network approved amount, less any applicable deductible and/or copay amounts required by the plan. This coverage is provided pursuant to a contract entered into in the State of Michigan and shall be construed under the jurisdiction and according to the laws of the State of Michigan. **Services must be provided or arranged by member's primary care physician or health plan.**

Deductible, Copays and Dollar Maximums

Note: The **Deductible** is applicable to all covered services except (1) **preventive services** provided by the member's PCP; (2) **preventive services** obtained as a result of a referral from the PCP; (3) routine maternity care; and (4) services paid by a provider or vendor under the delegation of a claim payment arrangement.

Deductible	$7,500 per member/$15,000 per contract per calendar year
Fixed Dollar Copays	$5 for allergy injections
	$30 for office visits
	$50 for urgent care visits
	$150 for emergency room visits
	No fixed dollar copay for ambulance services. See below for applicable coinsurance.
	$30 for referral physician visits
Percent Copay (Coinsurance)	50% for select services as noted below
	30% for select services as noted below
Copay Dollar Maximums	
Fixed Dollar Copay Maximum	None
Percent Copay Maximums	
	$1,500/member, $3,000/contract/calendar year
Dollar Maximums	None except as noted below for individual services

Preventive Services

Health Maintenance Exam	$30 Copay
Annual Gynecological Exam	$30 Copay
Pap Smear Screening	Office visit copay may apply per member, per visit
Well-Baby and Child Care	$30 Copay
Immunizations - pediatric and adult	Office visit copay may apply per member, per visit
Prostate Specific Antigen (PSA) Screening	Office visit copay may apply per member, per visit

Mammography

Mammography Screening	100%

Physician Office Services

Office Visits	$30 Copay
Consulting Specialist Care - when referred	$30 Copay after deductible

Emergency Medical Care

Hospital Emergency Room (copay waived if admitted, if applicable)	$150 Copay after deductible
Urgent Care Center	$50 Copay
Ambulance Services - medically necessary	70%, with a 30% coinsurance after deductible

CO30,ER150,UR50,IP10,7500D,30%CR,1500CM,2065%C,MOPD2O

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Diagnostic Services

Laboratory and Pathology Tests	Office visit copay may apply per member, per visit
Diagnostic Tests and X-rays	70%, with a 30% coinsurance after deductible
High Technology Radiology Imaging	70%, with a 30% coinsurance after deductible
Radiation Therapy	70%, with a 30% coinsurance after deductible

Maternity Services Provided by a Physician

Pre-Natal and Post-Natal Care	$30 Copay
Delivery and Nursery Care	100% (For professional services. See Hospital Care for facility charges) after deductible

Hospital Care

General Nursing Care, Hospital Services and Supplies (unlimited days)	70%, with a 30% coinsurance after deductible
Outpatient Surgery	70%, with a 30% coinsurance after deductible

Alternatives to Hospital Care

Skilled Nursing Care	70%, with a 30% coinsurance after deductible
	Up to 45 days per member per calendar year
Hospice Care	100% after deductible
Home Health Care	$30 Copay after deductible

Surgical Services

Surgery - included all related surgical services and anesthesia	See Hospital Care for inpatient and outpatient copay
Voluntary Sterilization	50% on all associated cost after deductible
Elective Termination (First Trimester Termination of Pregnancy)	50% on all associated cost after deductible
Human Organ Transplants (subject to medical criteria)	70%, with a 30% coinsurance after deductible

Mental Health Care and Substance Abuse Treatment

Inpatient Mental Health Care	75% with a 25% coinsurance/admission, max $1,000 per individual/$2,000 per contract
	Limited to 30 days per calendar year
Inpatient Substance Abuse Care	50% up to the annual State mandated amount. One program of treatment per 12 month period. A program of treatment may include outpatient or intermediate services or both.
Outpatient Mental Health Care	50% coinsurance, up to 20 visits per calendar year after deductible
Outpatient Substance Abuse	50% up to the annual State mandated amount. One program of treatment per 12 month period. A program of treatment may include outpatient or intermediate services or both. after deductible

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Other Services

Allergy Testing and Therapy	50% for testing and therapy after deductible
Allergy Injections	$5 copay for allergy injections
Chiropractic Spinal Manipulation - when referred	$30 Copay after deductible
Outpatient Physical, Speech and Occupational Therapy (60 consecutive days/episode)	$30 Copay after deductible
Infertility Counseling and Treatment (excludes In-vitro Fertilization)	50% on all associated costs after deductible
Durable Medical Equipment	50%
Prosthetic and Orthotic Appliances	50%
Weight Reduction Procedures	50% after deductible
Prescription Drugs	Generic - $20 copay, Brand - $60 copay, Non-Formulary 50% (min $80/max $100); 34-day supply with contraceptives
	Sexual Dysfunction drugs - 50% coinsurance
Mail Order Prescription Drugs	Two times the applicable copay up to a 90 day supply
Prescription Drug Deductible	None
Hearing Aid	Not Covered

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