

Benefit Summary  
for Bellingham School District



**Effective Date** 10/1/2009      **Health Plan** Group Health      **Ref** RQ-16290

This is a brief summary of benefits. THIS IS NOT A CONTRACT OR CERTIFICATE OF COVERAGE. All benefit descriptions, including alternative care, are for medically necessary services. The Member will be charged the lesser of the cost share for the covered service or the actual charge for that service. For full coverage provisions, including limitations, please contact our Sales or Customer Service Departments or refer to the plan contract.

Benefits	Inside Network
<b>Plan deductible</b> (PCY) - per calendar year	Individual deductible: \$500 Family deductible: \$1500
<b>Plan coinsurance</b>	Plan pays 80%, you pay 20%
<b>Deductible and/or coinsurance waiver riders</b>	1st 4 visits not subject to ded/coins, lab/xray paid in full up to first \$500
<b>Pre-existing condition (PEC) waiting period</b>	No PEC
<b>Out-of-pocket limit</b>	Individual out-of-pocket limit: \$2000 Family out-of-pocket limit: \$6000
<b>Lifetime Maximum</b>	\$2 million
<b>Outpatient Services</b> (Office visits - OV)	\$20 copay, deductible and coinsurance apply
<b>Hospital services</b>	<b>Inpatient services:</b> Deductible and coinsurance apply <b>Outpatient surgery:</b> \$20 copay, deductible and coinsurance apply
<b>Prescription drugs</b>	Formulary generic/formulary brand \$15/\$30 copay
<b>Prescription mail order</b>	2 x prescription cost share per 90 day supply
<b>Acupuncture</b>	Self-referred up to 8 visits per medical diagnosis PCY; additional visits when approved by plan \$20 copay, deductible and coinsurance apply
<b>Ambulance Services</b>	80/20% coinsurance
<b>Chemical Dependency</b>	\$14,500 per 24 months <b>Outpatient:</b> \$20 copay, deductible and coinsurance apply <b>Inpatient:</b> Deductible and coinsurance apply
<b>Devices, equipment and supplies</b> (DME prosthetics)	20% coinsurance
<b>Diagnostic lab and X-ray Services</b> (outpatient)	Deductible and coinsurance apply (Paid in full up to the first \$500)
<b>Emergency Services</b> (copay waived if admitted)	\$75 copay at a designated facility \$125 copay at a non designated facility Deductible and coinsurance apply
<b>Growth hormone</b>	Covered at pharmacy cost share; no wait
<b>Hearing exams (Routine)</b>	\$20 copay, deductible and coinsurance apply
<b>Hearing hardware</b>	Not covered
<b>Home health</b>	Covered in full. No visit limit.
<b>Infertility services</b>	Not covered
<b>Manipulative therapy</b>	Self-referred up to 10 visits PCY \$20 copay, deductible and coinsurance apply
<b>Maternity services</b>	<b>Outpatient:</b> \$20 copay, deductible and coinsurance apply <b>Inpatient:</b> Deductible and coinsurance apply
<b>Mental Health</b>	<b>Outpatient:</b> 20 visits PCY \$20 copay, deductible and coinsurance apply <b>Inpatient:</b> 12 days PCY Deductible and coinsurance apply
<b>Naturopathy</b>	Self-referred up to 3 visits per medical diagnosis PCY; additional visits when approved by plan \$20 copay, deductible and coinsurance apply

<b>Obesity-related surgery (bariatric)</b> When medically necessary and authorized lifetime max	Not covered
<b>Organ transplants</b> Donor search & harvest rolls to lifetime max	\$250,000 lifetime max; includes donor search & harvest of \$50,000; 6 month wait <b>Outpatient:</b> \$20 copay, deductible and coinsurance apply <b>Inpatient:</b> Deductible and coinsurance apply
<b>Preventive care</b> Well-care physicals, immunizations, Pap smear exams, mammograms	Covered in full
<b>Rehabilitation services</b> (Occupational, speech, physical-including massage) Rehab visits are a total of combined therapy visits PCY	<b>Outpatient:</b> 60 visits PCY \$20 copay, deductible and coinsurance apply <b>Inpatient:</b> 60 days PCY Deductible and coinsurance apply
<b>Skilled nursing facility (PCY)</b>	Up to 60 days, deductible and coinsurance apply
<b>Sterilization</b> (vasectomy, tubal ligation)	\$20 copay, deductible and coinsurance apply
<b>Temporomandibular Joint (TMJ) Services</b>	\$1,000 PCY; \$5,000 lifetime max <b>Outpatient:</b> \$20 copay, deductible and coinsurance apply <b>Inpatient:</b> Deductible and coinsurance apply
<b>Tobacco Cessation</b> See pharmacy benefit for associated drug coverage	Free & Clear Program - covered in full
<b>Vision care</b> Routine vision exam (1 visit every 12 months) No limit for medically necessary eye visits	\$20 copay, deductible and coinsurance waived
<b>Optical Hardware</b> Lenses, including contact lenses, and frames	Not covered

