

Benefit Summary
for Bellingham School District



Effective Date 10/1/2009	Health Plan Group Health	Ref RQ-16290
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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
Plan deductible (PCY) - per calendar year	No Annual Deductible
Plan coinsurance	No Plan Coinsurance
Pre-existing condition (PEC) waiting period	No PEC
Out-of-pocket limit	Individual out-of-pocket limit: \$2000 Family out-of-pocket limit: \$4000
Lifetime Maximum	\$2 million
Outpatient Services (Office visits - OV)	\$20 copay
Hospital services	Inpatient services: Covered in full Outpatient surgery: \$20 copay
Prescription drugs	Formulary generic and/or brand \$15 copay
Prescription mail order	2 x prescription cost share per 90 day supply
Acupuncture	Self-referred up to 8 visits per medical diagnosis PCY; additional visits when approved by plan \$20 copay
Ambulance Services	80/20% coinsurance
Chemical Dependency	\$14,500 per 24 months Outpatient: \$20 copay Inpatient: Covered in full
Devices, equipment and supplies (DME prosthetics)	20% coinsurance
Diagnostic lab and X-ray Services (outpatient)	Covered in full
Emergency Services (copay waived if admitted)	\$75 copay at a designated facility \$125 copay at a non designated facility
Growth hormone	Covered at pharmacy cost share; no wait
Hearing exams (Routine)	\$20 copay
Hearing hardware	Not covered
Home health	Covered in full. No visit limit.
Infertility services	Not covered
Manipulative therapy	Self-referred up to 10 visits PCY \$20 copay
Maternity services	Outpatient: \$20 copay Inpatient: Covered in full
Mental Health	Outpatient: 20 visits PCY \$20 copay Inpatient: 12 days PCY Covered in full
Naturopathy	Self-referred up to 3 visits per medical diagnosis PCY; additional visits when approved by plan \$20 copay
Obesity-related surgery (bariatric) When medically necessary and authorized lifetime max	Not covered

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

