

	Traditional / MEBS (FHP1)	PPO / MEBS (FHP2)	Original BCN HMO Plan	Mid-Range BCN HMO Plan
Deductible, Co-pays, and Dollar Maximums		<i>In-Network</i>	<i>Out-of-Network</i>	
Deductible	\$250 per member, \$500 per family	\$100 per member, \$200 per family	\$250 per member, \$500 per family	None
Copays				
• Fixed	None	\$10 office visits, urgent care and \$50 for emergency room visits	\$50 for emergency room visits	\$10 office visits and \$50 for emergency room visits
• Percent	10% for general services	10% for general services	30% for general services; services without a network are covered at the in-network level	20% for general services
Copay Dollar Maximums				
• Fixed	None	None	None	None
• Percent	\$1,000	\$500 per member, \$1,000 per family	\$1,500 per member, \$3,000 per family	\$5,000 per member, \$10,000 per family (excludes services with a 50% coinsurance)
Dollar Maximums	Unlimited lifetime per member for all covered services and as noted below for individual services	Unlimited lifetime per member for all covered services and as noted below for individual services		None
Prescription Drugs - Retail	\$5 generic/\$30 brand (No DAW Penalty)	\$5 generic/\$20 single-source brand/\$30 multi-source brand (DAW Penalty)	75% after copay	\$5 generic/\$10 preferred brand/\$20 non-preferred brand (No DAW Penalty)
Prescription Drugs - Mail Order	\$10 generic/\$60 brand (No DAW Penalty)	\$5 generic/\$20 single-source brand/\$45 multi-source brand (DAW Penalty)	Not Covered	\$10 generic/\$20 brand (No DAW Penalty)
				\$10 generic/20% (min \$20 / max \$70) preferred brand/40% (min \$40 / max \$90) non-preferred brand (No DAW Penalty)

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FARMINGTON PUBLIC SCHOOLS

BENEFIT SUMMARY

	Traditional / MEBS (FHP1)	PPO / MEBS (FHP2)	Original BCN HMO Plan	Mid-Range BCN HMO Plan
Preventive Services	<i>In-Network</i>		<i>Out-of-Network</i>	
Dollar Maximum	None	None	Not Covered	None
Health Maintenance Exam	Covered - 100%	Covered - 100%, one per calendar year	Not Covered	Covered - 100%
Annual Gynecological Exam	Covered - 100%	Covered - 100%, one per calendar year	Not Covered	Covered - 100%
Pap Smear Screening - lab services only	Covered - 100%	Covered - 100%, one per calendar year	Not Covered	Covered - 100%
Well-Baby and Child Care	Covered - 100%	Covered - 100%	Not Covered	Covered - 100%,
Childhood immunizations as recommended by the Advisory Committee on Immunizations Practices and the American Academy of Pediatrics	Covered - 100%	Covered - 100%	Not Covered	Covered - 100%
Fecal Occult Blood Screening	Covered - 100%	Covered - 100%, one per calendar year	Not Covered	Covered - 100%
Flexible Sigmoidoscopy Exam	Covered - 100%	Covered - 100%, one per calendar year	Not Covered	Covered - 100%
Prostate Specific Antigen (PSA) Screening	Covered - 100%	Covered - 100%, one per calendar year	Not Covered	Covered - 100%,
Mammography				
Mammography Screenings	Covered - 100%	Covered - 100%	Covered - 70% after deductible	Covered - 100%
	One per calendar year	One per calendar year	One per calendar year	One per calendar year

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	Traditional / MEBS (FHP1)	PPO / MEBS (FHP2)		Original BCN HMO Plan	Mid-Range BCN HMO Plan
Physician Office Services		<i>In-Network</i>	<i>Out-of-Network</i>		
Office Visits	Covered - 90% after deductible	Covered - \$10 copay	Covered - 70% after deductible, must be medically necessary	Covered - \$10 copay	Covered - \$20 copay
Outpatient and Home Visits	Covered - 90% after deductible	Covered - 90% after deductible	Covered - 70% after deductible, must be medically necessary	Covered - \$10 copay	Covered - \$20 copay
Office Consultations	Covered - 90% after deductible	Covered - \$10 copay	Covered - 70% after deductible, must be medically necessary	Covered - \$10 copay	Covered - \$20 copay
Emergency Medical Care					
Hospital Emergency Room - approved diagnosis	Covered - 100% (accident/injury) or 90% after deductible (illness)	Covered - \$50 copay, waived if admitted or for accidental injury	Covered - \$50 copay, waived if admitted or for accidental injury	Covered - \$50 copay, waived if admitted	Covered - \$75 copay after deductible, waived if admitted
Urgent Care Center	Covered - 100% (accident/injury) or 90% after deductible (illness)	Covered - \$10 copay	Covered - 70% after deductible, must be medically necessary	Covered - 100%	Covered - \$25 copay
Ambulance Services - medically necessary	Covered - 90% after deductible	Covered - 90% after deductible	Covered - 90% after deductible	Covered - 100%, ground and air service	Covered - 80% after deductible, ground and air service
Diagnostic Services					
Laboratory and Pathology Tests	Covered - 100%	Covered - 90% after deductible	Covered - 70% after deductible	Covered - 100%, office visit copay may apply	Covered - 100%, office visit copay may apply
Diagnostic Tests and X-rays	Covered - 100%	Covered - 90% after deductible	Covered - 70% after deductible	Covered - 100%, office visit copay may apply	Covered - 80% after deductible
Radiation Therapy	Covered - 100%	Covered - 90% after deductible	Covered - 70% after deductible	Covered - 100%, office visit copay may apply	Covered - 80% after deductible
Maternity Services Provided by a Physician					
Pre-Natal and Post-Natal Care	Covered - 100%	Covered - 100%	Covered - 70% after deductible	Covered - \$10 copay	Covered - \$20 copay
Delivery and Nursery Care	Covered - 100%	Covered - 90% after deductible	Covered - 70% after deductible	Covered - 100%	Covered - 100% after deductible for professional services; see Hospital Care for facility charges

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FARMINGTON PUBLIC SCHOOLS

BENEFIT SUMMARY

	Traditional / MEBS (FHP1)	PPO / MEBS (FHP2)		Original BCN HMO Plan	Mid-Range BCN HMO Plan
		<i>In-Network</i>	<i>Out-of-Network</i>		
Hospital Care					
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered - 100%	Covered - 90% after deductible	Covered - 70% after deductible	Covered - 100%	Covered - 80% after deductible
Inpatient Consultations	Covered - 100%	Covered - 90% after deductible	Covered - 70% after deductible	Covered - 100%	Covered - 80% after deductible
Chemotherapy	Covered - 100%	Covered - 90% after deductible	Covered - 70% after deductible	Covered - 100%	Covered - 80% after deductible
Alternatives to Hospital Care					
Skilled Nursing Care	90% after deductible	Covered - 90% after deductible	Covered - 90% after deductible	Covered - 100%	Covered - 80% after deductible
		Up to 120 days per calendar year		Up to 730 days lifetime	Up to 45 days per calendar year
Hospice Care	Covered - 100%	Covered - 100%	Covered - 100%	Covered - 100%	Covered - 100% after deductible
Home Health Care	Covered - 100%	Covered - 90% after deductible	Covered - 90% after deductible	Covered - \$10 copay	Covered - \$20 copay after deductible
Surgical Services					
Surgery, including all related surgical services, anesthesia, and surgical assistance	Covered - 100%	Covered - 90% after deductible	Covered - 70% after deductible	Covered - 100%	Covered - 80% after deductible
Voluntary Sterilization	Covered - 100%	Covered - 90% after deductible	Covered - 70% after deductible	Covered - 100%	Covered - 50% after deductible
Human Organ Transplants					
Liver, Heart, Lung, Pancreas, and Heart-lung; must be pre-approved at designated facilities	Covered - 100%	Covered - 100%	Covered - 100% in designated facilities only	Covered - 100%	Covered - 80% after deductible
	Up to \$1 million maximum per transplant type	Up to \$1 million maximum per transplant type			
Bone Marrow	Covered - 100%	Covered - 90% after deductible	Covered - 70% after deductible	Covered - 100%	Covered - 80% after deductible
Kidney, Cornea, and Skin	Covered - 100%	Covered - 90% after deductible	Covered - 70% after deductible	Covered - 100%	Covered - 80% after deductible

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	Traditional / MEBS (FHP1)	PPO / MEBS (FHP2)		Original BCN HMO Plan	Mid-Range BCN HMO Plan
Mental Health Care and Substance Abuse Treatment		<i>In-Network</i>	<i>Out-of-Network</i>		
Inpatient Mental Health Care	Covered - 100%	Covered - 100%	Covered - 70% after deductible	Covered - 100%	Covered - 80% after deductible
	Unlimited Days	Unlimited Days		Up to 45 days, renewable 60 days after discharge	
Inpatient Substance Abuse Treatment	Covered - 100%	Covered - 100%	Covered - 70% after deductible	Covered - 100%	Covered - 80% after deductible
	Unlimited Days	Unlimited Days		Up to 45 days, renewable 60 days after discharge	
Outpatient Mental Health Care • Facility and Clinic • Physician's Office	Covered - 100%	Covered - 90% after deductible	Covered - 70% after deductible	Covered - 100%	Covered - \$20 copay after deductible
	Covered - 100%	Covered - 90%	Covered - 70% after deductible	Covered - 100%	
	Up to 50 visits per calendar year	Unlimited Visits		Up to 20 visits per calendar year	
Outpatient Substance Abuse Treatment	Covered - 100%	Covered - 90% after deductible	Covered - 70% after deductible	Covered - 100%	Covered - \$20 copay after deductible
				Up to 35 visits per calendar year	

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	Traditional / MEBS (FHP1)	PPO / MEBS (FHP2)		Original BCN HMO Plan	Mid-Range BCN HMO Plan
Other Services		<i>In-Network</i>	<i>Out-of-Network</i>		
Allergy Testing and Therapy	Covered - 100% for testing, 90% after deductible for treatment and supplies	Covered - 100%	Covered - 70% after deductible	Covered - 100%	Covered - 50% after deductible
Chiropractic Spinal Manipulation	Covered - 90% after deductible	Covered - 90%	Covered - 70% after deductible	Covered - \$10 copay	Covered - \$20 copay after deductible
	FEA, FASA, FAHS, Non-Unit Personnel, Administrators: Up to 38 visits per calendar year / CMC, ESP, FTA: Unlimited	FEA, FASA, FAHS, Non-Unit Personnel, Administrators: Up to 24 visits per calendar year / CMC, ESP, FTA: Up to 52 visits per calendar year		Must be referred	Must be referred
Outpatient Physical, Speech, and Occupational Therapy • Facility and Clinic • Physician's Office - excludes speech and occupational therapy	Covered - 90% after deductible	Covered - 90% after deductible	Covered - 90% after deductible	Covered - \$10 copay	Covered - \$20 copay after deductible
	Covered - 90% after deductible	Covered - 90% after deductible	Covered - 70% after deductible	Covered - \$10 copay	Covered - \$20 copay after deductible
		Up to 60 visits per calendar year		Limited to 60 consecutive days per medical episode	Limited to 60 consecutive days per medical episode
Durable Medical Equipment	Covered - 90% after deductible	Covered - 90% after deductible	Covered - 90% after deductible	Covered - 100%	Covered - 50%
Prosthetic and Orthotic Appliances	Covered - 90% after deductible	Covered - 90% after deductible	Covered - 90% after deductible	Covered - 100%	Covered - 50%
Hearing Care	Included	Included	Not Included	Not Included	Not Included

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