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Group Name / Group ID: FARMINGTON BOARD OF EDUCATION / 00134678
**Sub Group Name / Sub Group ID: FARMINGTON BOARD OF EDUCATION/
COBRA-SELF FUNDED / 0004**
Class ID: 0036
Plan Description: HDHP with HSA
Effective Date: 2023-01-01

Disclaimer: 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 certificate and riders. Payment amounts are based on the Blue Care Network approved amount, less any applicable deductible, coinsurance and/or copay amounts required by the plan. If there is a discrepancy between this benefit summary and any applicable plan documents, the plan document will control.

DEDUCTIBLE

\$1,500 per individual; \$3,000 per family aggregate deductible per calendar year. For a two-person or family contract, the entire family deductible must be met before BCN pays for covered services. One or more individuals on the contract can contribute towards meeting the family deductible.

COINSURANCE MAXIMUM

This plan has no coinsurance maximum.

OUT-OF-POCKET MAXIMUM

\$6,350 per individual; \$6,350 per family aggregate out-of-pocket maximum per calendar year. For a two-person or family contract, the entire family OOPM must be met before you don't pay any more cost-sharing for the rest of the year for covered services.

ALLERGY OFFICE VISIT

Allergy office visits are covered in full after deductible.

AMBULANCE EMERGENT

Emergency ambulance transport is covered in full after deductible when other transportation would endanger a member's life.

AMBULANCE NON-EMERGENT

Non-emergent ambulance transport is covered in full after deductible. Requires prior authorization by BCN.

DETOX - SUB ABUSE

Inpatient or outpatient detox services are covered in full after deductible. Requires prior authorization by BCN.

DURABLE MEDICAL EQUIPMENT

Durable medical equipment is covered in full after deductible. Breastpump to support breast feeding is covered in full. Authorization required.

EMERGENCY ROOM

Emergency room treatment is covered in full after deductible.

HOME CARE VISITS

Home care visits are covered in full after deductible.

INFERTILITY CARE (CRITERIA REQUIRED)

20% coinsurance after deductible for infertility services. Requires prior authorization by BCN. In-vitro fertilization is not covered.

INPATIENT HOSPITAL

Inpatient hospital admission is covered in full after deductible; unlimited days. See certificate for specific surgical coinsurance.

LAB

Lab and pathology services are covered in full after deductible.

MENTAL HEALTH INPATIENT

Inpatient mental health/partial hospitalization is covered in full after deductible. Requires prior authorization by BCN.

MENTAL HEALTH INPATIENT DAYS

Unlimited visits when medically necessary. Requires prior authorization by BCN Behavioral Health management.

MENTAL HEALTH INPATIENT TIME PERIOD

Coordinated by BCN Behavioral Health management

MENTAL HEALTH OUTPATIENT

Outpatient/intensive outpatient mental health is covered in full after deductible. Online mental health visit with a designated online BCN participating provider is covered in full after deductible. Prior authorization not required for routine psychotherapy visits.

MENTAL HEALTH OUTPATIENT VISITS

Unlimited visits when medically necessary. Prior authorization not required for routine psychotherapy visits.

MENTAL HEALTH OUTPT ADDL VISITS

Unlimited visits when medically necessary. Prior authorization not required for routine psychotherapy visits.

ORTHOGNATHIC SURGERY

20% coinsurance after deductible for orthognathic surgery

ORTHOTICS

Orthotic appliances are covered in full after deductible. Must be preauthorized and obtained from a BCN supplier.

OUTPATIENT SURGERY FACILITY

Outpatient surgery is covered in full after deductible. Preventive services and screenings as mandated by the Affordable Care Act are covered in full. See certificate for specific surgical coinsurance.

OUTPT FAC VISITS/DIAGNOSTIC SRVCS

Outpatient diagnostic or therapeutic services are covered in full after deductible. Preventive services and screenings as mandated by the Affordable Care Act are covered in full, deductible does not apply.

PCP VISITS

Primary care physician office visits are covered in full after deductible. Preventive services and screenings as mandated by the Affordable Care Act are covered in full. See BCBSM.com for a complete list of preventive services. Medical online visits are covered in full after deductible when performed by a BCN designated online provider, PCP or participating referral physician.

PHYSICAL THERAPY/REHAB OUTPT

Physical therapy and rehabilitation is covered in full after deductible.

PHYSICAL THERAPY/REHAB OUTPT LIMITS

60 visits for each therapy per medical episode per calendar year

PRE-EXISTING CONDITION

Not applicable

PRE-EXISTING TIME PERIOD

Not applicable

PROSTHETICS

Prosthetic appliances are covered in full after deductible. Must be preauthorized and obtained from a BCN supplier.

SKILLED NURSING FACILITY

Services in a skilled nursing facility are covered in full after deductible.

SKILLED NURSING FACILITY DAYS

Limited to 730 days of skilled nursing care in a skilled nursing facility. Requires prior authorization by BCN.

SPECIALIST VISITS

Specialist office visit when referred is covered in full after deductible. Spinal manipulations are limited to 30 combined visits per calendar year when provided by a chiropractor or osteopathic physician. Preventive services and screenings as mandated by the Affordable Care Act are covered in full.

STERILIZATIONS

20% coinsurance after deductible for male sterilization. Female sterilization is covered in full.

SUB ABUSE INTERMEDIATE

Inpatient partial hospitalization substance use disorder is covered in full after deductible. Requires prior authorization by BCN Behavioral Health management.

SUB ABUSE INTERMEDIATE TIME PERIOD

Coordinated by BCN Behavioral Health management

SUB ABUSE OUTPATIENT

Outpatient/intensive outpatient substance use disorder is covered in full after deductible. Prior authorization not required for routine psychotherapy visits.

SUB ABUSE OUTPATIENT VISITS

Unlimited visits when medically necessary. Prior authorization not required for routine psychotherapy visits.

TEMPOROMANDIBULAR JOINT

20% coinsurance after deductible for TMJ services. Requires prior authorization by BCN.

ELECTIVE ABORTIONS

20% coinsurance after deductible for first trimester elective abortion. Limited to one procedure per 24 month period.

URGENT CARE CENTER

Urgent care visits are covered in full after deductible.

WEIGHT REDUCTION (CRITERIA REQUIRED)

20% coinsurance after deductible for weight reduction procedures. Requires prior authorization by BCN. Limited to one procedure per lifetime.

X-RAY

X-ray and radiology services are covered in full after deductible. Preventive services and screenings as mandated by the Affordable Care Act are covered in full, deductible does not apply.

ANESTHESIA

Anesthesia is covered in full after deductible.

SURGICAL ASSISTANT

Services performed by a surgical assistant are covered in full after deductible.

SECOND SURGICAL OPINION

Second surgical opinion when referred is covered in full after deductible.

HOSPICE

Inpatient and outpatient hospice are covered in full after deductible. Inpatient care requires prior authorization.

NEWBORN CARE

Newborn care in an inpatient setting is covered in full after deductible.

IMMUNIZATIONS

Pediatric and adult immunizations as recommended by the Advisory Committee on Immunization Practices are covered in full.

MATERNITY

Routine postnatal and Prenatal visits are covered in full.

DIALYSIS

Dialysis treatment in an inpatient or outpatient facility setting is covered in full after deductible.

CHEMOTHERAPY

Chemotherapy in an inpatient or outpatient facility setting is covered in full after deductible.

RADIATION THERAPY

Radiation therapy in an inpatient or outpatient facility setting is covered in full after deductible.

AUTISM

Applied behavioral analysis is covered in full after deductible. Outpatient therapy cost sharing applies for autism related speech, physical and occupational therapy with unlimited visits.

DIABETIC SUPPLIES

Diabetic supplies and equipment are covered in full after deductible. Must be preauthorized and obtained from a BCN supplier.

ALLERGY EVAL/SERUM/TESTING

Allergy related services are covered in full after deductible.

ALLERGY INJECTIONS

Allergy injections are covered in full after deductible.