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Group Name / Group ID: DRYDEN COMMUNITY SCHOOLS / 00416710
Sub Group Name / Sub Group ID: DRYDEN COMMUNITY SCHOOLS / 0001
Class ID: 0002
Plan Description: HDHP High Deductible Health Plan
Effective Date: 2022-07-01

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

$2,000 per individual; $4,000 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

$3,500 per individual; $7,000 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

Covered in full after deductible for allergy office visits

AMBULANCE EMERGENT

Covered in full after deductible for emergency ambulance transport when other transportation would endanger a member's life.

AMBULANCE NON-EMERGENT

Covered in full after deductible for non-emergent ambulance transport. Requires prior authorization by BCN.

DETOX - SUB ABUSE

Covered in full after deductible for inpatient and outpatient or residential detox services. Requires prior authorization by BCN.

DURABLE MEDICAL EQUIPMENT

50% coinsurance after deductible for durable medical equipment. Mustbe preauthorized and obtained from a BCN supplier. Breast pump to support breast feeding is covered in full.

EMERGENCY ROOM

Covered in full after deductible for emergency room treatment

HOME CARE VISITS

Covered in full after deductible per day for home care visits

INFERTILITY CARE (CRITERIA REQUIRED)

50% coinsurance after deductible for infertility services. Requires prior authorization by BCN. In-vitro fertilization is not covered.

INPATIENT HOSPITAL

Covered in full after deductible per inpatient hospital admission; unlimited days. See certificate for specific surgical coinsurance.

LAB

Covered in full after deductible for lab and pathology services

MENTAL HEALTH INPATIENT

Covered in full after deductible for inpatient mental health/partial hospitalization per hospital admission. 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

Covered in full after deductible for outpatient/intensive outpatient mental health. Online mental health visit with a designated online BCN participating provider is covered in full after deductible. Priorauthorization 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

50% coinsurance after deductible for orthognathic surgery

ORTHOTICS

50% coinsurance after deductible for orthotics. Must be preauthorized and obtained from a BCN supplier.

OUTPATIENT SURGERY FACILITY

Covered in full after deductible for outpatient surgery. 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

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

PCP VISITS

Covered in full after deductible per primary care physician office visit. 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. Covered in full after deductible for medical onlinevisits when performed by a BCN designated online vendor, PCP or participating referral physician.

PHYSICAL THERAPY/REHAB OUTPT

Covered in full after deductible per outpatient rehabilitative and habilitative visit

PHYSICAL THERAPY/REHAB OUTPT LIMITS

Outpatient rehabilitation services are limited to 30 combined visits per calendar year for physical and occupational therapy and a separate30 visit limit per calendar year for speech therapy. Rehab therapy must result in meaningful

improvement within 90 days of starting treatment. Outpatient habilitative services are limited to 30 combined visits per calendar year for physical and occupational therapy and a separate 30 visit limit per calendar year for speech therapy.

PRE-EXISTING CONDITION

Not applicable

PRE-EXISTING TIME PERIOD

Not applicable

PROSTHETICS

50% coinsurance after deductible for prosthetics. Must be preauthorized and obtained from a BCN supplier.

SKILLED NURSING FACILITY

Covered in full after deductible for services in a skilled nursing facility

SKILLED NURSING FACILITY DAYS

Limited to 45 days of skilled nursing care per calendar year in a skilled nursing facility. Requires prior authorization by BCN.

SPECIALIST VISITS

Covered in full after deductible per specialist office visit when referred. Spinal manipulations 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

50% coinsurance after deductible for male sterilization. Female sterilization is covered in full.

SUB ABUSE INTERMEDIATE

Covered in full after deductible for residential/intermediate/partialhospitalization substance use disorder. Requires prior authorizationby BCN Behavioral Health management.

SUB ABUSE INTERMEDIATE TIME PERIOD

Coordinated by BCN Behavioral Health management

SUB ABUSE OUTPATIENT

Covered in full after deductible per visit for outpatient/intensive outpatient substance use disorder. 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

50% coinsurance after deductible for TMJ services. Requires prior authorization by BCN.

ELECTIVE ABORTIONS

Elective abortion is not covered.

URGENT CARE CENTER

Covered in full after deductible per urgent care visit

WEIGHT REDUCTION (CRITERIA REQUIRED)

50% coinsurance after deductible for weight reduction procedures. Requires prior authorization by BCN. Limited to one procedure per lifetime.

X-RAY

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

ANESTHESIA

Covered in full after deductible for anesthesia

SURGICAL ASSISTANT

Covered in full after deductible for services performed by a surgicalassistant

SECOND SURGICAL OPINION

Covered in full after deductible for second surgical opinion when referred

HOSPICE

Covered in full after deductible for inpatient and outpatient hospice. Inpatient care requires prior authorization.

NEWBORN CARE

Covered in full after deductible for newborn care in an inpatient setting

IMMUNIZATIONS

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

MATERNITY

Prenatal and postnatal visits are covered in full.

DIALYSIS

Covered in full after deductible for dialysis treatment in an inpatient or outpatient facility setting

CHEMOTHERAPY

Covered in full after deductible for chemotherapy in an inpatient or outpatient facility setting.

RADIATION THERAPY

Covered in full after deductible for radiation therapy in an inpatient or outpatient facility setting

AUTISM

Covered in full after deductible per visit for applied behavioral analysis. Outpatient therapy cost sharing applies for autism related speech, physical and occupational therapy with unlimited visits.

DIABETIC SUPPLIES

Covered in full after deductible for diabetic supplies and equipment. Must be preauthorized and obtained from a BCN supplier.

ALLERGY EVAL/SERUM/TESTING

Covered in full after deductible for allergy related services with the exception of allergy injections

ALLERGY INJECTIONS

Covered in full after deductible for allergy injections