Medical Benefit Summaries

(Chart illustrates your cost)	HMO BCN	CDHP with Access to an HSA BCBSM		PPO Plan 1 BCBSM		PPO 2 BCBSM	
	In-Network ONLY	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network
Deductibles Coinsurance and Maximums							
Deductible	$2,000 Single $4,000 Family	$1,500 Single $3,000 Family	$3,000 Single $6,000 Family	$2,500 Single $5,000 Family	$5,000 Single $10,000 Family	$1,500 Single $3,000 Family	$3,000 Single $6,000 Family
Coinsurance	20%	20%	40%	20%	40%	20%	40%
Coinsurance Maximum (includes coinsurance only)	$1,250 Single $2,500 Family	NA	NA	$2,500 Single $5,000 Family	$5,000 Single $10,000 Family	$1,750 Single $3,500 Family	$3,500 Single $7,000 Family
Annual Out-of-Pocket Maximum (includes deductible, coinsurance, and copays, including office visits and prescription drugs)	$6,350 Single $12,700 Family	$2,700 Single $5,400 Family	$5,400 Single $10,800 Family	$6,350 Single $12,700 Family	$12,700 Single $25,400 Family	$6,350 Single $12,700 Family	$12,700 Single $25,400 Family
Lifetime Maximum	Unlimited	Unlimited		Unlimited		Unlimited	
Preventive Services							
Health Maintenance Exam	$0	$0	Not covered	$0	Not covered	$0	Not covered
Annual Gynecological Exam	$0	$0	Not covered	$0	Not covered	$0	Not covered
Well-Baby & Child Care	$0	$0	Not covered	$0	Not covered	$0	Not covered
Immunizations—pediatric and adult	$0	$0	Not covered	$0	Not covered	$0	Not covered
Prostate Specific Antigen (PSA) Screening	$0	$0	Not covered	$0	Not covered	$0	Not covered
Mammogram (one per year)	$0	$0	40% *	$0	40% *	$0	40% *
Physician Office Services							
Office Visits	$30 copay	20% *	40% *	$30 copay	40% *	$30 copay	40% *
Specialist Visits	$30 copay	20% *	40% *	$30 copay	40% *	$30 copay	40% *
Online Visits	$10 copay	20% *	40% *	$10 copay	Not Covered	$10 copay	Not Covered
Emergency Medical Care							
Emergency Room (waived if admitted)	$150 copay	20% *	40% *	$150 copay	$150 copay	$150 copay	$150 copay
Urgent Care	$30 copay	20% *	40% *	$30 copay	40% *	$30 copay	40% *
Ambulance	20% *	20% *	40% *	20% *	20% *	20% *	20% *
Hospital Care (Nonemergency services must be rendered in a participating hospital)							
Hospital Visits	20% *	20% *	40% *	20% *	40% *	20% *	40% *
Hospital—Inpatient	20% *	20% *	40% *	20% *	40% *	20% *	40% *
Surgery	20% *	20% *	40% *	20% *	40% *	20% *	40% *
Mental Disorders & Substance Abuse Expenses (Must be provided by a participating hospital, inpatient facility or outpatient facility)							
Inpatient	20% *	20% *	Not Covered	20% *	Not Covered	20% *	Not Covered
Outpatient	$30 copay	20% *	40% *	$30 copay	40% *	$30 copay	40% *

**Indicates the deductible applies.*

Medical Benefit Summaries

(Chart illustrates your cost)	HMO BCN	CDHP with Access to an HSA BCBSM		PPO Plan 1 BCBSM		PPO 2 BCBSM	
	In-Network ONLY	In-Network	Out-Network	In-Network	Out-Network	In-Network	Out-Network
All Other Services							
Allergy Testing / Injections	Testing and Serum 50% Injections $5 copay	20% *	40% *	$0	40% *	$0	40% *
Anesthesia	20% *	20% *	40% *	20% *	40% *	20% *	40% *
Chiropractic Care	**(30 visits per year)**	**(24 visits per year)**		**(24 visits per year)**		**(24 visits per year)**	
- Office visit	$30 copay	20% *	40% *	$30 copay	40% *	$30 copay	40% *
- Spinal Manipulation	$30 copay	20% *	40% *	$0	40% *	$0	40% *
- X-rays	20% *	20% *	40% *	20% *	40% *	20% *	40% *
Contraceptive Devices, Implants, and Injections	$0	$0	40% *	$0	40% *	$0	40% *
Dialysis	20% *	20% *	40% *	20% *	40% *	20% *	40% *
Fertility Testing	50%*	20% *	40% *	20% *	40% *	20% *	40% *
Home Health Care	$30 copay	20% *	40% *	20% *	40% *	20% *	40% *
Hospice	$0	20% *		$0-			
		Limited to four 90-day periods (Respite care limited to 5 days during a 30 day period) Provided through a participating hospice program only					
Labs and X-ray Test	Labs—$0 X-ray—20%*	20% *	40% *	20% *	40% *	20% *	40% *
Medical Equipment	50%	20% *	40% *	20% *	40% *	20% *	40% *
Medical Supplies	50%	20% *	40% *	20% *	40% *	20% *	40% *
Physical, Speech and Occupational Therapy *Services at nonparticipating outpatient physical therapy facilities are not covered*	$30 copay	20% *	40% *	20% *	40% *	20% *	40% *
- Maximum Visits	60 per calendar year	60 per calendar year		60 per calendar year		60 per calendar year	
Orthotics	50%	20% *	40% *	20% *	40% *	20% *	40% *
Maternity							
- Pre and Post Natal Care	$30 copay	20% *	40% *	$0	40% *	$0	40% *
- Delivery	20%*	20% *	40% *	20% *	40% *	20% *	40% *
Prosthetic Devices	50%	20% *	40% *	20% *	40% *	20% *	40% *
Skilled Nursing Facility	20% *	20% *	40% *	20% *	40% *	20% *	40% *
- Maximum Visits	45 per calendar year	120 per calendar year		120 per calendar year		120 per calendar year	
Prescription Drugs							
Retail (Up to a 34-day supply) Generic Formulary Non-Formulary Brand	$10 $40 $80	20% *		$10 $40 $80		$10 $40 $80	
Retail 90 (Up to a 90-day supply) Generic Formulary Non-Formulary Brand	$20 $80 $160	20% *		$20 $80 $160		$20 $80 $160	
Mail-Order (Up to a 90-day supply) Generic Formulary Non-Formulary Brand	$20 $80 $160	20% *		$20 $80 $160		$20 $80 $160	

**Indicates the deductible applies.*

EMPLOYEE CONTRIBUTIONS

You will be charged any amount due based on the total annual cost of your selections divided by your number of payrolls in the year—a per pay deduction. Because pay schedules vary, we have presented the monthly cost of coverage below. You can estimate your per pay cost by multiplying the amount below by 12 months and then dividing by the number of pays in your annual schedule (in most cases either 20 or 24).

Monthly Cost	EE Only	EE + One	Family	
BCN HMO	$0	$0	$0	
CDHP HSA BCBSM	$0	$0	$0	
PPO 1 BCBSM	$21.24	$50.98	$63.73	
PPO 2 BCBSM	$62.88	$150.90	$188.63	
Monthly Cost with the Assessment		**EE + One (+ First Assessment)**	**Family (+ First Assessment)**	**Family (+ Two Person Assessment)**
BCN HMO		$70.19	$70.19	$100.27
CDHP HSA BCBSM		$70.49	$70.49	$100.70
PPO 1 BCBSM		$124.46	$137.21	$168.70
PPO 2 BCBSM		$230.21	$267.94	$301.93

Note: Job Share employees and employees at less than 1.0 FTE have a different schedule of contributions.

Opt-Out Bonus

If you are covered under another group medical or dental plan, and decide not to enroll in the WISD medical or core dental plan, you will be eligible for a refund as a taxable cash payment to you.

If you choose to opt-out of medical or dental, you will receive an annual opt-out bonus:

Medical Opt-Out $2,500
Dental Opt-Out $ 150
50% Dental Plan $ 75

Paid to you in equal amounts throughout the year based on your pay schedule.

To be eligible for this benefit, you must supply proof of coverage under another group medical plan. Proof of coverage must be sent to Fringe Benefits by the end of the Open Enrollment period.

If you lose your other coverage, you may be eligible to enroll in the WISD medical plan as of the date the other coverage is lost as long as you contact Fringe Benefits in writing within 30 calendar days of losing the coverage.