44 NORTH
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BCN w 44North HRA

WEXFORD MISSAUKEE ISD

Deductible, Copays and Dollar Maximums

Note: The **Deductible** will apply to certain services as defined below.

Deductible	$5,000 per individual/$10,000 per family per benefit year HRA to $500 individual/$1,500 family
Fixed Dollar Copays	$5 for allergy injections HRA to $0
	$40 for office visits HRA to $20
	$50 for urgent care visits HRA to $20
	$250 for emergency room visits
	No fixed dollar copay for ambulance services. See below for applicable coinsurance.
	$40 for referral physician visits HRA to $20
Coinsurance	50% for select services as noted below No HRA Reimbursement for most 50% Copays
	30% for select services as noted below HRA reimburses to to $1,500/individual/$3,000 family
Annual Coinsurance Maximum (ACM)	None
Out of Pocket Maximum - applies to deductibles, copays and coinsurance amounts for all covered services	$6,350 per individual/$12,700 per family

Preventive Services

Health Maintenance Exam	100%
Annual Gynecological Exam	100%
Pap Smear Screening	100%
Well-Baby and Child Care	100%
Immunizations	100%
Prostate Specific Antigen (PSA) Screening	100%
Routine Colonoscopy	100%
Mammography Screening	100%
Voluntary Female Sterilization	100%
Breast Pumps (DME guidelines apply.)	100%
Maternity Pre-Natal care	100%

Physician Office Services

PCP Office Visits	$40 Copay HRA to $20
Online Visits	$40 Copay
Consulting Specialist Care	$40 Copay after deductible HRA to $20

Emergency Medical Care

Hospital Emergency Room - Copay waived if admitted	$250 Copay after deductible HRA to $250
Urgent Care Center	$50 Copay HRA to $20
Ambulance Services	70% after deductible

Benefits Selected -
CI30%,D5000,DSR30%,ER250,HA,CO40,6350PM,6350PM,OMRR,2065%C,MOPD2O,BENYR,UR50

Diagnostic Services

Laboratory and Pathology Tests	100%
Diagnostic Tests and X-rays	70% after deductible
High Technology Radiology Imaging (MRI, MRA, CAT, PET)	70% after deductible
Radiation Therapy	70% after deductible

Maternity Services Provided by a Physician

Post-Natal and Non-routine Pre-Natal Care (See Preventive Services section for routine Pre-Natal Care)	$40 Copay HRA to $20
Delivery and Nursery Care	100% For professional services. (See Hospital Care for facility charges) after deductible

Hospital Care

General Nursing Care, Hospital Services and Supplies	70% after deductible
Outpatient Surgery - included all related surgical services and anesthesia - see member certificate for specific surgical copays.	70% after deductible

Alternatives to Hospital Care

Skilled Nursing Care	70% after deductible
	Up to 45 days per member per benefit year
Hospice Care	100% (When authorized) after deductible
Home Health Care	$40 Copay after deductible HRA to $20 after deductible Please call 44North to notify of service

Surgical Services

Surgery - includes all related surgical services and anesthesia - see member certificate for specific surgical copays.	70% after deductible
Voluntary Male Sterilization – See Preventive Services section for voluntary female sterilization	50% after deductible
Elective Abortion (One procedure per two year period of membership)	Not Covered
Human Organ Transplants	70% after deductible HRA to 100% Please call 44North to notify of service
Reduction Mammoplasty	50% after deductible
Male Mastectomy	50% after deductible
Temporomandibular Joint Syndrome	50% after deductible
Orthognathic Surgery	50% after deductible
Weight Reduction Procedures (Limited to one procedure per lifetime)	50% after deductible

Benefits Selected -
CI30%,D5000,DSR30%,ER250,HA,CO40,6350PM,6350PM,OMRR,2065%C,MOPD2O,BENYR,UR50

Mental Health Care and Substance Use Disorder Treatment Must Call 1-800-482-5982 for authorization

Inpatient Mental Health Care	70% after deductible
Inpatient Substance Use Disorder	70% after deductible
Outpatient Mental Health Care includes online visits Note: For diagnostic and therapeutic services, the medical benefit applies.	$40 Copay after deductible HRA to $0 if processed as Office Visit
Outpatient Substance Use Disorder	$40 Copay after deductible HRA to $0 if processed as Office Visit

Autism Spectrum Disorders, Diagnoses and Treatment

Applied behavioral analyses (ABA) treatment	$40 Copay after deductible HRA to $20 after deductible
Outpatient physical therapy, speech therapy and occupational therapy for autism spectrum disorder through age 18. Unlimited visits for PT/OT/ST with autism spectrum disorder diagnosis.	$40 Copay after deductible HRA to $20 after deductible
Other covered services, including mental health services, for Autism Spectrum Disorder	See your outpatient mental health, medical office visit and preventive benefit.

Other Services

Allergy Testing and Therapy	50% after deductible HRA to 100%
Allergy Injections	$5 copay HRA to $0
Chiropractic Spinal Manipulation - when referred	$40 Copay after deductible HRA to $20
	(up to 30 visits per benefit year)
Outpatient Physical, Speech and Occupational Therapy	$40 Copay after deductible HRA to $20 after deductible
	60 visits per benefit year for any combination of therapies
Infertility Counseling and Treatment (Excludes In-vitro fertilization)	50% after deductible
Durable Medical Equipment (DME)	50% HRA to 100% **Must call Nothwood for participaitng provider at 1-800-667-8496**
Prosthetic and Orthotic Appliances (P&O)	50% HRA to 100%
Diabetic Supplies	70% HRA to 100% **Must call J&B Medical Supply for participating provider at 1-888-896-6233**
Prescription Drugs	Tier 1 - $20 copay, Tier 2 - $60 copay, Tier 3 - 50% (min $80/max $100); 30 day supply with contraceptives
	Sexual Dysfunction drugs - 50% coinsurance
	Women's Contraceptives - Tier 1 - 100%, Tier 2 - Tier 2 Copayment/Coinsurance above applies, Tier 3 - Tier 3 Copayment/Coinsurance above applies
Mail Order Prescription Drugs	Two times the applicable copay up to a 90 day supply
Prescription Drug Deductible	None
Hearing Aid	One hearing aid and exam every 36 months covered 100%

This is intended as an easy-to-read summary. **It is not a contract.** Additional limitations and exclusions may apply to covered services. For a complete description of benefits, please see the applicable Carrier certificates and riders. Payment amounts are based on the Carrier approved amount, less any applicable deductible, coinsurance and copay amounts required by the plan. If there is a discrepancy between the Benefits-at-a-Glance and any applicable plan documents, the plan document will control. This coverage is provided pursuant to a contract entered into in the State of Michigan and shall be construed under the jurisdiction and according to the laws of the State of Michigan. **Services must be provided or arranged by member's primary care physician or health plan.**