## **Buck Montgomery County Schools Health Care Consortium Preferred Plan Designs**

	BMCS Open Choice 1 (Formerly known as PC 10/20/70%)		BMCS Open Choice 2 (Formerly known as PC 20/30/70%)		BMCS POS (Formerly known as KPOS 15S)	
	In Network	Out of Network	In Network	Out of Network	Referred	Self- Referred
Referrals Required	l l	No No		No	Yes	No
Deductible			_			
Individual	\$0	\$600	\$0	\$1,000	None	\$1,000
Family	\$0	\$1,200	\$0	\$3,000	None	\$3,000
After Deductible, Plan pays	100%	70%	100%	70%	None	50%
Out-of-Pocket Maximum			_			
Individual	\$3,500	\$7,500	\$5,000	\$7,500	\$3,500	\$10,000
Family	\$7,000	\$15,000	\$10,000	\$15,000	\$7,000	\$30,000
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Doctor's Office Visits						
Primary care services	\$10 copay	70%, after deductible	\$20 copay	70%, after deductible	\$15 copay	50%, after deductible
Specialist services	\$20 copay	70%, after deductible	\$40 copay	70%, after deductible	\$25 copay	50%, after deductible
Preventive Care for Adults and Children	100%	70%, no deductible	100%	70%, no deductible	100%	50%, (no deductible)
Routine Eye Exam	N/A	N/A	N/A	N/A	\$25 copay (once every 24 months)	Not covered
Pediatric Immunizations	100%	70%, no deductible	100%	70%, no deductible	100%	50%, (no deductible)
(Office visit copay does not apply)	100%	70%, 110 deductible	100%	70%, 110 deductible	100%	Jow, (no deductible)
Routine Gynecological Exam/Pap	100%	70%, no deductible	100%	70%, no deductible	100%	50%, (no deductible)
(1 per year for women of any age)	100/0	7070, 110 deddetible	100/0	7070, 110 deddetible	100%	John, (no deddenbie)
Mammogram	100%	70%, no deductible	100%	70%, no deductible	100%	50%, (no deductible)
Allergy Injections/Testing	100%	70%, after deductible	100%	70%, after deductible	100%	50%, after deductible
(Office visit copay waived if no office visit	100/0	7078, arter deductible	100/0	7070, arter dedderible	100%	30%, arter deddensie
is charged)						
Nutrition Counseling for Weight Mgmt	100% (6 visits per cal year)	70%, after deductible	100% (6 visits per year)	70%, after deductible	100% (6 visits per cal year)	50%, after deductible
Maternity		,	20070 (0 110100 pc. 700)			
First OB Visit	\$10 copay	70%, after deductible	\$20 copay	70%, after deductible	\$25 copay	50%, after deductible
Hospital	\$75 copay per day	70%, after deductible	\$350 copay per admit	70%, after deductible	\$250 copay per admit	50%, after deductible
litospitai	(max 5 copays per admit)	70%, arter deductible	3330 copay per admit	70%, after deductible	3230 copay per admit	30%, after deductible
Inpatient Hospital Services	(max 5 copays per admit)					
Facility	\$75 copay per day	70%, after deductible	\$350 copay per admit	70%, after deductible	\$250 copay per admit	50%, after deductible
l domey	(max 5 copays per admit)	7 676, 41121 424421.212	pose copa, per danne	7 676, arter deddensie	yzso copa, per danne	Jove, arter deddenore
Physician/ Surgeon	100%	70%, after deductible	100%	70%, after deductible	100%	50%, after deductible
Inpatient Hospital Days	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Outpatient Surgery	\$75 copay	70%, after deductible	\$200 copay	70%, after deductible	\$100 copay	50%, after deductible
Emergency Room	\$100 copay	\$100 copay, no deductible	\$100 copay (waived if	\$100 copay, no deductible	\$100 copay	\$100 copay, no deductible
Emergency Room	(waived if admitted)	(waived if admitted)	admitted)	(waived if admitted)	(waived if admitted)	(waived if admitted)
Ambulance						
Emergency	100%	100%, no deductible	100%	100%, no deductible	100%	100%
Non- Emergency	100%	70%, after deductible	100%	70%, after deductible	100%	50%, after deductible
Urgent Care	\$28 copay	70%, after deductible	\$28 copay	70%, after deductible	\$24 copay	50%, after deductible
Outpatient Laboratory/Pathology	100%	70%, after deductible	100%	70%, after deductible	100%	50%, after deductible
Outpatient Radiology						
Routine Radiology/ Diagnostic	\$20 copay	70%, after deductible	\$40 copay	70%, after deductible	100%	50%, after deductible
MRI/MRA, CT/CTA Scan, PET SCAN	\$20 copay	70%, after deductible	\$40 copay	70%, after deductible	100%	50%, after deductible
Therapy Services						

## **Buck Montgomery County Schools Health Care Consortium Preferred Plan Designs**

	BMCS Ope	BMCS Open Choice 1		BMCS Open Choice 2		BMCS POS	
	(Formerly known as PC 10/20/70%)		(Formerly known as PC 20/30/70%)		(Formerly known as KPOS 15S)		
	In Network	Out of Network	In Network	Out of Network	Referred	Self- Referred	
Physical and Occupational	\$15 copay [visits 1-30]	70%, after deductible	\$20 copay [visits 1-30]	70%, after deductible	100%	50%, after deductible	
	\$25 copay [visits 31-60]		\$40 copay [visits 31-60]		(up to 60 consecutive days	(up to 60 consecutive days	
	(60 visits per cal year for		(60 visits per cal year for		per condition covered,	per condition covered,	
	PT/OT/ST )		PT/OT/ST)		subject to significant	subject to significant	
Speech	\$15 copay [visits 1-30]	70%, after deductible	\$20 copay [visits 1-30]	70%, after deductible	100%	50%, after deductible (up to	
	\$25 copay [visits 31-60]		\$40 copay [visits 31-60]		(up to 60 consecutive days	60 consecutive days per	
	(60 visits per calendar year		(60 visits per calendar year		per condition covered,	condition covered, subject to	
	for PT/OT/ST )		for PT/OT/ST)		subject to significant	significant	
Cardiac Rehabilitation	100%	70%, after deductible	100%	70%, after deductible	100%	50%, after deductible	
(36 visits per cal year)							
Pulmonary Rehabilitation	100%	70%, after deductible	100%	70%, after deductible	100%	50%, after deductible	
(12 visits per cal year)							
Respiratory Therapy	100%	70%, after deductible	100%	70%, after deductible	100%	50%, after deductible	
Restorative Services, Including	\$20 copay	70%, after deductible (30	\$40 copay	70%, after deductible	100%	50%, after deductible	
Chiropractic Care	(30 visits per cal year)	visits per cal year)	(30 visits per cal year)	(30 visits per cal year)	(100 visits per cal year)	(100 visits per cal year)	
Chemo/Radiation/Dialysis	100%	70%, after deductible	100%	70%, after deductible	100%	50%, after deductible	
Outpatient Private Duty Nursing	100%	70%, after deductible	100%	70%, after deductible	100%	50%, after deductible	
(45 8-hour shifts per cal year)							
Skilled Nursing Facility	100%	70%, after deductible (up to	100%	70%, after deductible (up to	100%	50%, after deductible (up to	
	(up to 120 days)	120 days)	(up to 120 days)	120 days)	(up to 180 days)	240 days)	
Hospice and Home Health Care	100%	70%, after deductible	100%	70%, after deductible	100%	50%, after deductible	
Durable Medical Equipment and	\$20 copay	70%, after deductible	\$40 copay	70%, after deductible	100%	50%, after deductible	
Prosthetics							
Outpatient Diabetic Education	100%	Not covered	100%	Not covered	100%	50%, after deductible	
Mental Health Care							
Outpatient	\$20 copayment	70%, after deductible	\$40 copayment	70%, after deductible	\$25 copay	50%, after deductible	
Inpatient	\$75 copay per day	70%, after deductible	\$350 copay per admit	70%, after deductible	\$250 copay per admit	50%, after deductible	
	(max 5 copays per admit)						
Serious Mental Health Illness							
Outpatient	\$20 copayment	70%, after deductible	\$40 copayment	70%, after deductible	\$25 copay	50%, after deductible	
Inpatient	\$75 copay per day	70%, after deductible	\$350 copay per admit	70%, after deductible	\$250 copay per admit	50%, after deductible	
Substance Abuse Treatment	(max 5 copays per admit)						
Outpatient/Partial facility visits	\$20 copayment	70%, after deductible	\$40 copayment	70%, after deductible	\$25 copay	50%, after deductible	
Inpatient Rehabilitation	\$75 copayment	70%, after deductible	\$350 copay per admit	70%, after deductible	\$25 copay \$250 copay per admit	50%, after deductible	
חוףמנופות הפוומטוותמנוטוו		70%, after deductible	3550 copay per admit	70%, after deductible	3230 copay per admit	50%, after deductible	
Inpatient Detoxification	(max 5 copays per admit) \$75 copay per day	70%, after deductible	\$350 copay per admit	70%, after deductible	\$250 copay per admit	50%, after deductible	
mpatient betoxineation		7070, arter deductible	2000 copay per aumit	7070, arter deductible	7230 copay per aumit	50%, arter deductible	
	(max 5 copays per admit)				l		

This document is for comparison purposes only. For further detail on benefit exclusions and precertification requirements, please refer to the Benefits at A Glance Summaries for each plan design.