

# Plymouth-Canton Community Schools Health Plan Outline Teachers

<i>Benefit</i>		<i>Community Blue PPO</i>	
		<u>Network</u>	<u>Non-Network</u>
	<b>Deductible</b>	None	\$100 per individual; \$200 per family
	<b>Coinsurance/Copay</b>	\$15 Office Visit Copay, \$15 Urgent Care copay, \$30 Emergency Room Copay.	20% Coinsurance
	<b>Out-of-Pocket Maximum</b>	100% paid by the plan unless otherwise noted	* \$1,000 Individual; * \$2,000 Family <i>*(Does not include Mental Health/Substance Abuse or Private Duty Nursing)</i>
	<b>Benefit Dollar Maximums/ Lifetime Maximum</b>	\$5 million lifetime maximum; separate \$1 million maximum for Human Organ and Tissue Transplants.	
<b>PREVENTIVE CARE SERVICES (NO ANNUAL DOLLAR MAXIMUM)</b>	<b>Health Maintenance Exam - includes chest x-ray, EKG and select lab procedures</b>	Covered at 100%, one per calendar year	Not Covered
	<b>Annual Gynecological Exam</b>	Covered at 100%, one per calendar year	Not Covered
	<b>Pap smear screening - laboratory services only</b>	Covered at 100%, one per calendar year	Not Covered
	<b>Well-baby and child care</b>	Covered at 100%; 6 visits, birth through 12 months, 6 visits, 13 months through 23 months, 2 visits, 24 months through 35 months, 2 visits, 36 months through 47 months, 1 visit per birth year, 48 months through age 15	Not Covered
	<b>Childhood immunizations as recommended by the Advisory Committee on Immunization Practices and the American Academy of Pediatrics</b>	Covered at 100%, up through age 16	Not Covered
	<b>Fecal Occult Blood Screening</b>	Covered at 100%, one per calendar year	Not Covered
	<b>Flexible Sigmoidoscopy Exam</b>	Covered at 100%, one per calendar year	Not Covered
	<b>Prostate Specific Antigen (PSA)</b>	Covered at 100%, one per calendar year	Not Covered
	<b>Mammography Screening (one per calendar year, no age restrictions)</b>	Covered at 100%	Covered, deductible and coinsurance apply
<b>OUTPATIENT &amp; PHYSICIAN SERVICES</b>	<b>Office Visits &amp; Consultations</b>	\$15 copay; 100% covered	Covered, deductible and coinsurance apply
	<b>Outpatient Visits</b>	100% covered	Covered, deductible and coinsurance apply
	<b>Laboratory and Pathology Tests</b>	100% covered	Covered, deductible and coinsurance apply
	<b>Diagnostic Tests and X-rays</b>	100% covered	Covered, deductible and coinsurance apply
	<b>Radiation Therapy</b>	100% covered	Covered, deductible and coinsurance apply
	<b>Pre-Natal &amp; Post Natal Visits and Delivery and Nursery Care (includes Mid-Wife Services)</b>	100% covered	Covered, deductible and coinsurance apply

<i>Benefit</i>		<i>Community Blue PPO</i>	
		<u>Network</u>	<u>Non-Network</u>
<b>EMERGENCY MEDICAL CARE</b>	<b>Hospital Emergency Room - Approved Diagnosis</b>	\$30 copay (\$30 copay waived if you are treated for an accidental injury or admitted to the hospital)	\$30 copay (\$30 copay waived if you are treated for an accidental injury or admitted to the hospital)
	<b>Urgent Care Center</b>	\$15 copay; 100% covered	Covered, deductible and coinsurance apply
	<b>Ambulance Services - medically necessary</b>	100% covered	100% covered
<b>INPATIENT HOSPITAL CARE/SURGERY</b>	<b>Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies (unlimited days)</b>	100% covered	Covered, deductible and coinsurance apply
	<b>Inpatient Consultations</b>	100% covered	Covered, deductible and coinsurance apply
	<b>Chemotherapy</b>	100% covered	Covered, deductible and coinsurance apply
	<b>Surgery - includes related surgical services</b>	100% covered	Covered, deductible and coinsurance apply
	<b>Voluntary Sterilization</b>	100% covered	Covered, deductible and coinsurance apply
	<b>Hospital Pre-Certification/ Case Mgt.</b>	Yes	Yes
<b>OTHER SERVICES</b>	<b>Skilled Nursing Facility (up to 730 days)</b>	100% covered	100% covered
	<b>Hospice Care</b>	100% covered, up to lifetime maximum, amount adjusted annually	100% covered, up to lifetime maximum, amount adjusted annually
	<b>Home Health Care (unlimited visits)</b>	100% covered	100% covered
	<b>Outpatient Diabetes Management Program (ODMP)</b>	100% covered	Covered, deductible and coinsurance apply
	<b>Allergy Testing and Therapy</b>	100% covered	Covered, deductible and coinsurance apply
	<b>Chiropractic Spinal Manipulation (20 Visits in the first 90 days for acute conditions, 2 Visits per month thereafter for chronic conditions, maximum of 38 visits per year)</b>	\$15 copay; 100% covered	Covered, deductible and coinsurance apply
	<b>Outpatient Physical, Speech and Occupational Therapy (up to a combined maximum of 120 visits per calendar year)</b>	<b>Facility &amp; Clinic:</b> 100% covered; <b>Physician's Office</b> (excludes speech and occupational therapy): 100% covered	<b>Facility &amp; Clinic:</b> 100% covered; <b>Physician's Office</b> (excludes speech and occupational therapy): deductible and coinsurance apply
	<b>Durable Medical Equipment and Supplies</b>	100% covered	100% covered
	<b>Prosthetic &amp; Orthotic Appliances</b>	100% covered	100% covered
	<b>Private Duty Nursing</b>	80% covered	80% covered
<b>ORGAN TRANSPLANTS</b>	<b>Specified Organ Transplants - in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)</b>	100% covered	Covered - in designated facilities <b>only</b>
	<b>Bone Marrow - when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)</b>	100% covered	Covered, deductible and coinsurance apply
	<b>Kidney, Cornea and Skin</b>	100% covered	Covered, deductible and coinsurance apply

<i>Benefit</i>		<i>Community Blue PPO</i>	
		<u>Network</u>	<u>Non-Network</u>
<b>MENTAL HEALTH/SUBSTANCE ABUSE TREATMENT</b>	<b>Mental/Health - Inpatient Stays (60 day maximum per year, 120 days per lifetime combined with In-patient Substance Abuse)</b>	<i>90% covered</i>	<i>90% covered after deductible</i>
	<b>Mental/Health Outpatient Treatment</b>	<i>\$10 copay, 100% covered</i>	<i>\$10 copay, 100% covered</i>
	<b>Substance Abuse - Inpatient Stays (60 day maximum per year, 120 days per lifetime combined with In-patient Mental/Nervous)</b>	<i>90% covered</i>	<i>90% covered after deductible</i>
	<b>Substance Abuse Outpatient Treatment (50 visits per year, 120 visits per lifetime)</b>	<i>90% covered</i>	<i>90% covered</i>
<b>PRESCRIPTION DRUGS</b>	<b>Prescription Drugs (Including Mail Order)</b>	<i>\$10 generic/ \$20 brand copay. Mail Order: 3 month supply of maintenance drugs. Paid at 75% minus copay. Mail Order: Not Covered</i>	

REMINDER: The Comparison Booklet is intended to be a summary of the benefits not a contract. An official description is contained in applicable benefit booklets.