

Plymouth-Canton Community Schools Health Plan Outline Teachers

<i>Benefit</i>		<i>Community Blue PPO</i>	
		<u>Network</u>	<u>Non-Network</u>
	Deductible	None	\$100 per individual; \$200 per family
	Coinsurance/Copay	\$15 Office Visit Copay, \$15 Urgent Care copay, \$30 Emergency Room Copay.	20% Coinsurance
	Out-of-Pocket Maximum	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>
	Benefit Dollar Maximums/ Lifetime Maximum	\$5 million lifetime maximum; separate \$1 million maximum for Human Organ and Tissue Transplants.	
PREVENTIVE CARE SERVICES (NO ANNUAL DOLLAR MAXIMUM)	Health Maintenance Exam - includes chest x-ray, EKG and select lab procedures	Covered at 100%, one per calendar year	Not Covered
	Annual Gynecological Exam	Covered at 100%, one per calendar year	Not Covered
	Pap smear screening - laboratory services only	Covered at 100%, one per calendar year	Not Covered
	Well-baby and child care	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
	Childhood immunizations as recommended by the Advisory Committee on Immunization Practices and the American Academy of Pediatrics	Covered at 100%, up through age 16	Not Covered
	Fecal Occult Blood Screening	Covered at 100%, one per calendar year	Not Covered
	Flexible Sigmoidoscopy Exam	Covered at 100%, one per calendar year	Not Covered
	Prostate Specific Antigen (PSA)	Covered at 100%, one per calendar year	Not Covered
	Mammography Screening (one per calendar year, no age restrictions)	Covered at 100%	Covered, deductible and coinsurance apply
UTPATIENT & PHYSICIAN SERVICES	Office Visits & Consultations	\$15 copay; 100% covered	Covered, deductible and coinsurance apply
	Outpatient Visits	100% covered	Covered, deductible and coinsurance apply
	Laboratory and Pathology Tests	100% covered	Covered, deductible and coinsurance apply
	Diagnostic Tests and X-rays	100% covered	Covered, deductible and coinsurance apply
	Radiation Therapy	100% covered	Covered, deductible and coinsurance apply

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O	Pre-Natal & Post Natal Visits and Delivery and Nursery Care (includes Mid-Wife Services)	100% covered	Covered, deductible and coinsurance apply
	EMERGENCY MEDICAL CARE		
	Hospital Emergency Room - Approved Diagnosis	\$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)
	Urgent Care Center	\$15 copay; 100% covered	Covered, deductible and coinsurance apply
	Ambulance Services - medically necessary	100% covered	100% covered
INPATIENT HOSPITAL CARE/SURGERY	Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies (unlimited days)	100% covered	Covered, deductible and coinsurance apply
	Inpatient Consultations	100% covered	Covered, deductible and coinsurance apply
	Chemotherapy	100% covered	Covered, deductible and coinsurance apply
	Surgery - includes related surgical services	100% covered	Covered, deductible and coinsurance apply
	Voluntary Sterilization	100% covered	Covered, deductible and coinsurance apply
	Hospital Pre-Certification/ Case Mgt.	Yes	Yes
OTHER SERVICES	Skilled Nursing Facility (up to 730 days)	100% covered	100% covered
	Hospice Care	100% covered, up to lifetime maximum, amount adjusted annually	100% covered, up to lifetime maximum, amount adjusted annually
	Home Health Care (unlimited visits)	100% covered	100% covered
	Outpatient Diabetes Management Program (ODMP)	100% covered	Covered, deductible and coinsurance apply
	Allergy Testing and Therapy	100% covered	Covered, deductible and coinsurance apply
	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)	\$15 copay; 100% covered	Covered, deductible and coinsurance apply
	Outpatient Physical, Speech and Occupational Therapy (up to a combined maximum of 120 visits per calendar year)	Facility & Clinic: 100% covered; Physician's Office (excludes speech and occupational therapy): 100% covered	Facility & Clinic: 100% covered; Physician's Office (excludes speech and occupational therapy): deductible and coinsurance apply
	Durable Medical Equipment and Supplies	100% covered	100% covered
	Prosthetic & Orthotic Appliances	100% covered	100% covered
	Private Duty Nursing	80% covered	80% covered
ORGAN TRANSPLANTS	Specified Organ Transplants - in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% covered	Covered - in designated facilities only
	Bone Marrow - when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	100% covered	Covered, deductible and coinsurance apply

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		Kidney, Cornea and Skin	100% covered
MENTAL HEALTH/SUBSTANCE ABUSE TREATMENT	Mental/Health - Inpatient Stays (60 day maximum per year, 120 days per lifetime combined with In-patient Substance Abuse)	90% covered	90% covered after deductible
	Mental/Health Outpatient Treatment	\$10 copay, 100% covered	\$10 copay, 100% of BCBS Approved Amount Covered
	Substance Abuse - Inpatient Stays (60 day maximum per year, 120 days per lifetime combined with In-patient Mental/Nervous)	90% covered	90% covered after deductible
	Substance Abuse Outpatient Treatment (50 visits per year, 120 visits per lifetime)	90% covered	90% covered
PRESCRIPTION DRUGS	Prescription Drugs (Including Mail Order)	\$10 generic/ \$20 brand copay. Mail Order: 3 month supply of maintenance drugs.	Paid at 75% minus copay. Mail Order: Not Covered

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.