Plymouth Canton Community Schools

Plan Offering - TEACHERS

	SEPTEMBER 1, 2024 - AUGUST 31, 2025											
BCBS COMMUNITY BLUE PPO	Plan Choice #1		Plan Choice #2		Plan Choice #3		Plan Choice #4		Plan Choice #5		Plan Choice #6	
Plan Design	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible (Single/Family)	$100 / $200	$250 / $500	$500 / $1,000	$1,000/$2,000	$500 / $1,000	$1,000/$2,000	$1,250/$2,500	$2,500/$5,000	$1,450/$2,900	$2,900/$5,800	$2,000/$4,000	$4,000/$8,000
Office Visit / Urgent Care	$20 copay	70% after deductible	$20 copay	70% after deductible	$20 copay	60% after deductible	$30 copay	80% after deductible	$15 Office Visit/$40 Urgent Care	70% after deductible	$30 Office Visit/$60 Urgent Care	60% after deductible
Emergency Room	$100 copay (waived if injury or if admitted)	$100 copay (waived if injury or if admitted)	$100 copay (waived if injury or if admitted)	$100 copay (waived if injury or if admitted)	$150 copay (waived if injury or if admitted)	$150 copay (waived if injury or if admitted)	$150 copay (waived if injury or if admitted)	$150 copay (waived if injury or if admitted)	$150 copay (waived if injury or if admitted)	$150 copay (waived if injury or if admitted)	$250 copay (waived if injury or if admitted)	$250 copay (waived if injury or if admitted)
Preventive Care	100% (not subject to deductible)	Not Covered	100% (not subject to deductible)	Not Covered	100% (not subject to deductible)	Not Covered	100% (not subject to deductible)	Not Covered	100% (not subject to deductible)	Not Covered	100% (not subject to deductible)	Not Covered
Coinsurance	90% after deductible	70% after deductible	90% after deductible	70% after deductible	80% after deductible	60% after deductible	100% after deductible	80% after deductible	90% after deductible	70% after deductible	80% after deductible	60% after deductible
Coinsurance Maximum (Single/Family) Not Including	$500/$1,000	$1,500/$3,000	$1,000/$2,000	$2,000/$4,000	$1,500/$3,000	$3,000/$6,000	N/A	$3,000/$6,000	$1,000/$2,000	$2,000/$4,000	$1,500/$3,000	$3,000/$6,000
Prescription Drugs	$10 Generic $40 Brand $40 Non Preferred Brand (Mail Order x 1)	75% of approved amount; plus copays	$10 Generic $40 Brand $40 Non Preferred Brand (Mail Order x 2)	75% of approved amount; plus copays	$10 Generic $40 Brand $40 Non Preferred Brand (Mail Order x 2)	75% of approved amount; plus copays	$10 Generic $40 Brand $40 Non Preferred Brand (Mail Order x 2)	75% of approved amount; plus copays	$10 Generic $40 Brand $40 Non Preferred Brand (Mail Order x 2)	75% of approved amount; plus copays	$15 Generic $50 Brand 50% ($70 min/$100 max) Non Preferred Brand (Mail Order x 2)	75% of approved amount; plus copays
Out-of-Pocket Maximum In-Network includes applicable deductibles, coinsurance and copays. Out-of-Network excludes copays	$6,350 per member/$12,700 for 2 or more members per calendar year	$12,700 per member/$25,400 for 2 or more members per calendar year	$6,350 per member/$12,700 for 2 or more members per calendar year	$12,700 per member/$25,400 for 2 or more members per calendar year	$6,350 per member/$12,700 for 2 or more members per calendar year	$12,700 per member/$25,400 for 2 or more members per calendar year	$6,350 per member/$12,700 for 2 or more members per calendar year	$12,700 per member/$25,400 for 2 or more members per calendar year	$6,350 per member/$12,700 for 2 or more members per calendar year	$12,700 per member/$25,400 for 2 or more members per calendar year	$6,350 per member/$12,700 for 2 or more members per calendar year	$12,700 per member/$25,400 for 2 or more members per calendar year
	YEARLY PAYROLL DEDUCTION		YEARLY PAYROLL DEDUCTION		YEARLY PAYROLL DEDUCTION		YEARLY PAYROLL DEDUCTION		YEARLY PAYROLL DEDUCTION		YEARLY PAYROLL DEDUCTION	
Single	$5,945.13		$4,525.29		$3,663.93		$2,660.01		$1,752.69		$1,066.53	
2-Person	$11,248.08		$8,423.52		$6,699.12		$5,557.56		$3,664.08		$2,230.68	
Family	$16,604.13		$12,633.45		$10,262.37		$7,254.81		$4,781.85		$2,907.21	
	PER PAY DEDUCTION BEGINNING 9-10-24 (OVER 20 PAYS)		PER PAY DEDUCTION BEGINNING 9-10-24 (OVER 20 PAYS)		PER PAY DEDUCTION BEGINNING 9-10-24 (OVER 20 PAYS)		PER PAY DEDUCTION BEGINNING 9-10-24 (OVER 20 PAYS)		PER PAY DEDUCTION BEGINNING 9-10-24 (OVER 20 PAYS)		PER PAY DEDUCTION BEGINNING 9-10-24 (OVER 20 PAYS)	
Single	$297.26		$226.27		$183.20		$133.01		$87.64		$53.33	
2-Person	$562.41		$421.18		$334.96		$277.88		$183.21		$111.54	
Family	$830.21		$631.68		$513.12		$362.75		$239.10		$145.37	