Plymouth Canton Community Schools

Plan Offering - TEACHERS

	SEPTEMBER 1, 2026 - AUGUST 31, 2027											
BCBS COMMUNITY BLUE PPO	**Plan Choice #1 (FSA Compatible)**		**Plan Choice #2 (FSA Compatible)**		**Plan Choice #3 (FSA Compatible)**		**Plan Choice #4 (FSA Compatible)**		**Plan Choice #5 (FSA Compatible)**		**Plan Choice #6 (FSA Compatible)**	
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 Deductible	$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	$8,853.36		$7,080.72		$6,022.44		$4,792.68		$3,674.40		$2,832.12	
2-Person	$17,000.04		$13,529.88		$11,411.40		$10,008.96		$7,682.76		$5,922.72	
Family	$24,542.52		$19,669.44		$16,756.44		$13,071.00		$10,029.48		$7,721.16	
	PER PAY DEDUCTION BEGINNING 9-10-26 (OVER 20 PAYS)		PER PAY DEDUCTION BEGINNING 9-10-26 (OVER 20 PAYS)		PER PAY DEDUCTION BEGINNING 9-10-26 (OVER 20 PAYS)		PER PAY DEDUCTION BEGINNING 9-10-26 (OVER 20 PAYS)		PER PAY DEDUCTION BEGINNING 9-10-26 (OVER 20 PAYS)		PER PAY DEDUCTION BEGINNING 9-10-26 (OVER 20 PAYS)	
Single	$442.67		$354.04		$301.13		$239.64		$183.72		$141.61	
2-Person	$850.01		$676.50		$570.57		$500.45		$384.14		$296.14	
Family	$1,227.13		$983.48		$837.83		$653.55		$501.48		$386.06	