Plymouth Canton Community Schools

Plan Offering - TEACHERS

	SEPTEMBER 1, 2025 - AUGUST 31, 2026											
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	$7,993.27		$6,358.75		$5,367.16		$4,211.45		$3,166.94		$2,377.04	
2-Person	$15,352.21		$12,100.59		$10,115.46		$8,801.30		$6,621.53		$4,971.40	
Family	$22,248.98		$17,677.94		$14,948.35		$11,486.05		$8,639.19		$6,481.10	
	PER PAY DEDUCTION BEGINNING 9-10-25 (OVER 20 PAYS)		PER PAY DEDUCTION BEGINNING 9-10-25 (OVER 20 PAYS)		PER PAY DEDUCTION BEGINNING 9-10-25 (OVER 20 PAYS)		PER PAY DEDUCTION BEGINNING 9-10-25 (OVER 20 PAYS)		PER PAY DEDUCTION BEGINNING 9-10-25 (OVER 20 PAYS)		PER PAY DEDUCTION BEGINNING 9-10-25 (OVER 20 PAYS)	
Single	$399.67		$317.94		$268.36		$210.58		$158.35		$118.86	
2-Person	$767.62		$605.03		$505.78		$440.07		$331.08		$248.57	
Family	$1,112.45		$883.90		$747.42		$574.31		$431.96		$324.06	