Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Plymouth-Canton Community Schools
Group Number: 71711 Package Code(s): 034
Section Code(s): 1000, 1100
PLAN 6
Effective Date: 09/01/2019
Benefits-at-a-glance

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

BCBSM provides administrative claims services only. Your employer or plan sponsor is financially responsible for claims.

Note: A list of services that require approval **before** they are provided is available online at (https://www.bcbsm.com/importantinfo). Select **Approving covered Services**.

Member's responsibility (deductibles, copays, coinsurance and dollar maximums)

Benefits	In-Network	Out-of-Network
Deductibles - per calendar year	$2,000 per member $4,000 per family	$4,000 per member $8,000 per family
Copays • Fixed Dollar Copays	$30 copay for : • Office visits • Chiropractic spinal manipulations $60 copay for : • Urgent care services $250 copay for : • Facility medical emergency	$250 copay for : • Facility medical emergency
Coinsurance • Percent Coinsurance	20% up to a maximum of: $1,500 per member $3,000 per family	40% **Note:** Services without a network are covered at the in-network level.
Annual out-of-pocket maximums	$6,350 per member $12,700 per family Includes Deductible, Coinsurance and Copays	$7,000 per member $14,000 per family Includes Deductible and Coinsurance
Lifetime dollar maximum	Unlimited	

Preventive Care Services

Benefits	In-Network	Out-of-Network
Health Maintenance Exam - beginning age 4; one per calendar year	Covered - 100%	Not Covered
Routine Physical Related Test X-Rays, EKG and lab procedures performed as part of the health maintenance exam	Covered - 100%	Not Covered

Benefits	In-Network	Out-of-Network
Annual Gynecological Exam - two per calendar year, in addition to health maintenance exam	Covered - 100%	Not Covered
Pap Smear Screening - one per calendar year	Covered - 100%	Not Covered
Mammography Screening - one per calendar year includes 3D Mammography	Covered - 100%	Covered - 60% after deductible
Contraceptive Methods and Counseling	Covered - 100%	Covered - 60% after deductible
Prostate Specific Antigen (PSA) screening - one per calendar year	Covered - 100%	Not Covered
Endoscopic Exams - one per calendar year	Covered - 100%	Covered - 60% after deductible
Well Child Care • 8 visits, birth through 12 months • 6 visits, 13 months through 35 months • 2 visits, 36 months through 47 months Visits beyond 47 months are limited to one per member per calendar year under the health maintenance exam benefit	Covered - 100%	Not Covered
Immunizations - pediatric and adult	Covered - 100%	Not Covered

Physician Office Services

Benefits	In-Network	Out-of-Network
Office Visits	Covered - 100% after $30 copay	Covered - 60% after deductible
Online Visits Note: Services are payable when rendered by American Well providers through Blue Cross Online Visits℠ or BCBS providers	Covered - 100% after $30 copay	Not Covered
Office Consultations	Covered - 100% after $30 copay	Covered - 60% after deductible
Pre-Surgical Consultations	Covered - 100%	Covered - 60% after deductible

Emergency Medical Care

Benefits	In-Network	Out-of-Network
Hospital Emergency Room Qualified medical emergency	Covered - 100% after $250 copay; copay waived if admitted or for an accidental injury	Covered - 100% after $250 copay; copay waived if admitted or for an accidental injury
Non-Emergency use of the Emergency Room	Not Covered	Not Covered
Urgent Care Services	Covered - 100% after $60 copay	Covered - 60% after deductible
Ambulance Services - Medically Necessary Transport	Covered - 80% after deductible	Covered - 80% after deductible

Diagnostic Services

Benefits	In-Network	Out-of-Network
MRI, MRA, PET and CAT Scans and Nuclear Medicine	Covered - 80% after deductible	Covered - 60% after deductible
Diagnostic Tests, X-rays, Laboratory & Pathology	Covered - 80% after deductible	Covered - 60% after deductible
Radiation Therapy and Chemotherapy	Covered - 80% after deductible	Covered - 60% after deductible

Maternity Services Provided by a Physician

Benefits	In-Network	Out-of-Network
Prenatal and Postnatal Care Visits	Covered - 100%	Covered - 60% after deductible
Delivery and Nursery Care	Covered - 80% after deductible	Covered - 60% after deductible

Hospital Care

Benefits	In-Network	Out-of-Network
Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered - 80% after deductible	Covered - 60% after deductible
Inpatient Medical Care	Covered - 80% after deductible	Covered - 60% after deductible

Alternatives to Hospital Care

Benefits	In-Network	Out-of-Network
Hospice Care	Covered - 100%	Covered - 100%
Home Health Care	Covered - 80% after deductible	Covered - 80% after deductible
Skilled Nursing Limited to a maximum of 120 days per calendar year	Covered - 80% after deductible	Covered - 80% after deductible

Surgical Services

Benefits	In-Network	Out-of-Network
Surgery (includes related surgical services)	Covered - 80% after deductible	Covered - 60% after deductible
Bariatric Surgery	Covered - 80% after deductible	Not Covered
Sterilization - males only excludes reversal sterilization	Covered - 80% after deductible	Covered - 60% after deductible
Sterilization - females only excludes reversal sterilization	Covered - 100%	Covered - 60% after deductible

Human Organ Transplants

Benefits	In-Network	Out-of-Network
Specified Organ Transplants In designated facilities only, when coordinated through BCBSM Human Organ Transplant Program (800-242-3504)	Covered - 100%	Not covered except in designated facilities
Kidney, Cornea, Bone Marrow and Skin	Covered - 80% after deductible	Covered - 60% after deductible

Behavioral/Mental Health Care and Substance Abuse Treatment Services

Benefits	In-Network	Out-of-Network
Inpatient Behavioral/Mental Health Care and Substance Abuse Treatment	Covered - 80% after deductible	Covered - 60% after deductible
Outpatient Behavioral/Mental Health Care and Substance Abuse Treatment • Online Behavioral/Mental Health Visits	Covered - 100% after $30 copay Covered - 100% after $30 copay	Covered - 60% after deductible Covered - 60% after deductible

Other Covered Services

Benefits	In-Network	Out-of-Network
Cardiac Rehabilitation	Covered - 80% after deductible	Covered - 60% after deductible
Chiropractic Spinal Manipulation Limited to a maximum of 24 visits per calendar year	Covered - 100% after $30 copay	Covered - 60% after deductible
Durable Medical Equipment	Covered - 80% after deductible	Covered - 80% after deductible
Prosthetic and Orthotic Devices	Covered - 80% after deductible	Covered - 80% after deductible
Private Duty Nursing Care	Covered - 50% after deductible	Covered - 50% after deductible
Allergy Testing and Therapy	Covered - 100%	Covered - 60% after deductible

Therapy Services

Benefits	In-Network	Out-of-Network
Physical, Occupational and Speech Therapy Limited to a combined maximum of 60 visits per calendar year	Covered - 80% after deductible	Covered - 60% after deductible

Plymouth-Canton Community Schools
Group Number: 71711 Package Code(s): 034
Section Code(s): 1000, 1100
Hearing Care Coverage
Effective Date: 09/01/2019
Benefits-at-a-glance

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Covered services

To be payable, hearing care benefits must be received from a participating provider and in the order listed.

Benefits	Coverage
Frequency Limitation	Once every 36 months for dependents age 6 years and under
Audiometric Exam	Covered - 100%
Hearing Aid Evaluation	Not Covered
Hearing Aid	Not Covered
Hearing Aid Conformity Test	Not Covered

Plymouth-Canton Community Schools
Group Number: 71711 Package Code(s): 034
Section Code(s): 1000, 1100
Prescription Drugs
Effective Date: 09/01/2019
Benefits-at-a-glance

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Your prescription drug copays, including mail order copays, may be subject to the same annual out-of-pocket maximum required under your medical coverage.

Member's responsibility (copays and coinsurance amounts)

Benefits	Coverage
Retail - 30 day supply	$15 copay - Generic drugs $50 copay - Preferred brand drugs 50% coinsurance - Non-Preferred brand drugs $70 minimum, $100 Maximum Prescriptions and refills obtained from a non-network pharmacy are reimbursed at 75% of the approved amount, less the member's copay.
Mail Order - 90 day supply	$30 copay - Generic drugs $100 copay - Preferred brand drugs 50% coinsurance - Non-Preferred brand drugs $140 minimum, $200 Maximum
Specialty Drugs – 30 day supply Retail and Mail Order	$15 copay - Generic drugs $50 copay - Preferred brand drugs 50% coinsurance - Non-Preferred brand drugs $70 minimum, $100 Maximum Members are restricted to a 30 day supply at both retail and mail order and certain specialty drugs are limited to only a 15 day supply for each fill.
Adult and childhood select preventive immunizations as recommended by the USPSTF, ACIP, HRSA or other sources as recognized by BCBSM that are in compliance with the provisions of the PPACA	Covered - 100%
Oral and Injectable Contraceptives Retail and Mail Order	Covered - 100% for Generic and Select Brand name drugs; other Brand name drugs are subject to the applicable copay/coinsurance
Additional Services	
Smoking Cessation Drugs	Covered
Weight Loss Drugs	Covered
Impotency Drugs	Covered
Infertility Drugs	Covered

Benefits	Coverage
Diabetic Supplies	Not Covered

Features of your prescription drug plan

Preferred Therapy Program	A step-therapy approach that encourages physicians to prescribe generic, generic alternative or over-the-counter medications before prescribing a more expensive brand-name drug. It applies only to prescriptions being filled for the first time of a targeted medication. Before filling your initial prescription for select, high-cost, brand-name drugs, the pharmacy will contact your physician to suggest a generic alternative. A list of select brand-name drugs targeted for the preferred therapy program is available at bcbsm.com/pharmacy, along with the preferred medications. If our records indicate you have already tried the preferred medication(s), we will authorize the prescription. If we have no record of you trying the preferred medication(s), you may be liable for the entire cost of the brand-name drug unless you first try the preferred medication(s) or your physician obtains prior authorization from BCBSM. These provisions affect all targeted brand- name drugs, whether they are dispensed by a retail pharmacy or through a mail order provider.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call the Plymouth-Canton Community Schools Employee Benefits Office at 734-416-4834. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at http://www.dol.gov/ebsa/healthreform or call the number on the back of your BCBSM ID card to request a copy. Group Number 7177-024, 025

Important Questions	Answers		Why This Matters:
What is the overall deductible?	$2,000 Individual/ $4,000 Family	$4,000 Individual/ $8,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes		This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No		You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	$6,350 Individual/ $12,700 Family	$7,000 Individual/ $14,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges and health care this plan doesn't cover.		Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. For a list of in-network providers, see www.bcbsm.com or call the number on the back of your ID card.		This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.		This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 co-pay	40% after deductible	---none---
	Specialist visit	$30 co-pay	40% after deductible	Chiropractic care limited to 24 visits/cal yr.
	Preventive care/screening/ immunization	No charge	Coverage for mammograms & colonoscopies only – 30% after deductible	As required by the U.S. Preventive Task Force (USPSTF)
If you have a test	Diagnostic test (x-ray, blood work)	20% after deductible	40% after deductible	---none---
	Imaging (CT/PET scans, MRIs)	20% after deductible	40% after deductible	---none---
If you need drugs to treat your illness or condition More information about prescription drug coverage, call the number on the back of your BCBSM ID card.	Generic drugs	$15 co-pay for retail 30-day supply; $30 co-pay for mail order 90-day supply	$15 co-pay plus an additional 25% of BCBSM approved amount for the drug	Mail order drugs are not covered out-of-network. Generic contraceptive medications are covered at 100%
	Preferred brand drugs	$50 co-pay for retail 30-day supply; $100 co-pay for mail order 90-day supply	$50 co-pay plus an additional 25% of BCBSM approved amount for the drug	Mail order drugs are not covered out-of-network.
	Non-preferred brand drugs	50% coinsurance $70 minimum $100 maximum for retail 30-day supply; 50% coinsurance $140 minimum $200 maximum for mail order 90-day supply	Coinsurance plus an additional 25% of BCBSM approved amount for the drug	Mail order drugs are not covered out-of-network.
	Specialty drugs	50% coinsurance $70 minimum $100 maximum for retail 30-day supply; 50% coinsurance $140 minimum $200 maximum for mail order 90-day supply	50% coinsurance $70 minimum $100 maximum for retail 30-day supply; 50% coinsurance $140 minimum $200 maximum for mail order 90-day supply plus an additional 25% of BCBSM approved amount for the drug	Mail order drugs are not covered out-of-network.

* For more information about limitations and exceptions, see the plan or policy document, please contact Dawn Schaller at 734-416-4834.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% after deductible	40% after deductible	---none---
	Physician/surgeon fees	20% after deductible	40% after deductible	---none---
If you need immediate medical attention	Emergency room care	$250 co-pay	$250 co-pay	Co-pay waived if admitted or for accidental injury.
	Emergency medical transportation	20% after deductible	20% after in-network deductible	Must be medically necessary.
	Urgent care	$60 co-pay	40% after deductible	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	20% after deductible	40% after deductible	Semi-private room
	Physician/surgeon fees	20% after deductible	40% after deductible	---none---
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 co-pay	40% after deductible	In approved facilities only for outpatient substance abuse.
	Inpatient services	20% after deductible	40% after deductible	---none---
If you are pregnant	Office visits	No charge	40% after deductible	---none---
	Childbirth/delivery professional services	20% after deductible	40% after deductible	---none---
	Childbirth/delivery facility services	20% after deductible	40% after deductible	---none---
If you need help recovering or have other special health needs	Home health care	20% after deductible	20% after in-network deductible	Must be medically necessary and provided by a participating home health care agency.
	Rehabilitation services	20% after deductible	40% after deductible	Physical, Occupational, Speech therapy is limited to a combined maximum of 60 visits per member, per calendar year.
	Habilitation services	Not covered	Not covered	---none---
	Skilled nursing care	20% after deductible	20% after in-network deductible	Limited to a maximum of 120 days per member. Must be in a participating skilled nursing facility.
	Durable medical equipment	20% after deductible	20% after in-network deductible	---none---

* For more information about limitations and exceptions, see the plan or policy document, please contact Dawn Schaller at 734-416-4834.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Hospice services	No charge	No charge	Up to 28 pre-hospice counseling visits before electing hospice services; when elected, 4, 90-day periods – provided through participating hospice program only; limited to a dollar limit that is reviewed and adjusted periodically (after reaching dollar maximum, member transitions to individual case management).
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	---none---
	Children's glasses	Not covered	Not covered	---none---
	Children's dental check-up	Not covered	Not covered	---none---

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Routine eye care (Adult)
- Hearing aids
- Long-term care
- Dental care (Adult)
- Weight loss programs
- Cosmetic surgery
- Routine foot care
- Infertility treatment

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery (Blue Distinction Centers)
- Private duty nursing
- Chiropractic care
- Coverage provided outside the United States. See http://provider.bcbs.com

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: [Michigan, HHS, DOL, and/or other applicable agency contact information]. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact the number on the back of your BCBSM ID card.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

* For more information about limitations and exceptions, see the plan or policy document, please contact Dawn Schaller at 734-416-4834.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-752-1455

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-752-1455.

Chinese (中文): 如果需要中文的帮助，**请拨打这个号码** 1-800-752-1455.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-752-1455.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$2,000
Specialist *[cost sharing]*	$30
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance - $1,500 coinsurance max	$1,500
What isn't covered	
Limits or exclusions	$0
The total Peg would pay is	$3,500

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$2,0000
Specialist *[cost sharing]*	$30
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$540
Coinsurance	$1,080
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	$3,620

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$2,000
Specialist *[cost sharing]*	$30
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	$1,900

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,900
Copayments	$165
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2,065

The plan would be responsible for the other costs of these EXAMPLE covered services.