APPENDIX H

Benefit Summary Sheet

Eligibility Period: None

HEALTH INSURANCE

Company: **Blue Cross Blue Shield**
Telephone: 1-800-637-2227 (claims & I.D. cards)
Internet address: www.bcbsm.com
Outside of Michigan: 1-800-810-BLUE (to locate an out of state provider)
Group: 71711

B*enefits*:

(SEE ATTACHED SHEET FOR PLAN CHOICE 1, 2, 3, 4, 5, 6, HSA 1 or HSA 2)

Employee Cost: Amount above hard cap set by PA 152
Effective: Date of hire/end of eligibility period
Open Enrollment: May to be effective September 1
(Only time to enroll or add dependents if not done at the time of the event)
Benefit Year: January – December

Cash In Lieu: $1,000 up to 290 members, $2,000 291-320 members, $3,000 321 + members

DENTAL INSURANCE

Company: BCBS Blue Dental PPO (www.mibluedentist.com)
Telephone: 1-888-826-8152
Group: #71757
Open Enrollment: May to be effective September 1
(Only time to enroll or add dependents, if not done at the time of the event.)
Effective: 1st of the month after date of hire

Benefits: 100/80/80 or 100/90/80/80 if dental PPO is used.
$2,000 annual max (Effective 10/1/21)
$2,000 lifetime ortho max (Effective 10/1/21)
Benefit year: September – August

LIFE INSURANCE

Company: CIGNA
FLX963665
Effective: End of eligibility period

Benefit: $40,000 Term Life (Effective 9-1-21)

LONG TERM DISABILITY

Company:	CIGNA
Group:	LK62601 - Class 1
Effective:	1st of the month after date of hire
Benefit:	90 calendar day qualifying period 66 2/3% of monthly salary, $4500 mo. Max

VISION INSURANCE

Company:	NVA (National Vision Administrators)
Telephone:	1-800-672-7723
Group:	8662
Open Enrollment:	May to be effective September 1 (One time to enroll or add dependents, if not done at the time of the event.)
Effective:	1st of the month after date of hire

BENEFITS	IN-NETWORK	OUT-OF-NETWORK
EXAM	Covered 100%	Up to $75
LENSES	Standard Glass or Plastic Covered 100%	Single Vision Up to $100 Bi-Focal Up to $100 Tri-Focal Up to $125 Lenticular Up to $125
LENS OPTIONS	Progressives (Standard) 100% Progressives (Premium) 100%	N/A N/A
FRAME	Covered up to $75 (20% discount off remaining balance over $75 allowance)	Up to $75
CONTACT LENSES	Up to $150 Retail Allowance (15% discount (Conventional) or 10% discount (Disposable) off remaining balance over $150)	Up to $150

Benefit year: January - December

EMPLOYEE ASSISTANCE PROGRAM

Company:	ULLIANCE
Telephone:	1-800-448-8326
	www.lifeadvisor.com

FINANCIAL ASSISTANCE PROGRAM

Company:	Your Money Line
Telephone:	1-833-890-4077
	yourmoneyline.com/pccsk12

FLEXIBLE SPENDING ACCOUNT

Company:	HealthEquity
Telephone:	1-866-346-5800

1/1/25

Plymouth Canton Community Schools

Plan Offering - TEACHERS

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

JANUARY 1, 2025 - AUGUST 31, 2025				
BCBS COMMUNITY BLUE PPO	Plan Choice #7 (HSA)		Plan Choice #8 (HSA)	
Plan Design	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible (Single/Family)	$2,000/$4,000	$4,000/$8,000	$2,500/$5,000	$5,000/$10,000
Office Visit / Urgent Care	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Emergency Room	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Preventive Care	100% (not subject to deductible)	Not Covered	100% (not subject to deductible)	Not Covered
Coinsurance	80% after deductible	80% after deductible	80% after deductible	80% after deductible
Coinsurance Maximum (Single/Family) Not Including Deductible	N/A	N/A	N/A	N/A
Prescription Drugs (copays for HSA plans apply after deductible is met)	$15 Generic $50 Brand 50% ($70 min/$100 max) 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	$3,000 per member/$6,000 for 2 or more members per calendar year	$6,000 per member/$12,000 for 2 or more members per calendar year	$4,000 per member/$8,000 for 2 or more members per calendar year	$8,000 per member/$16,000 for 2 or more members per calendar year