APPENDIX A

PLYMOUTH-CANTON Community • Schools

CAFETERIA

(Working 30 hrs. or more weekly)

Benefit Summary Sheet

Eligibility Period: 90 calendar days or 60 working days for health, whichever is sooner/60 working days all other benefits

HEALTH INSURANCE

Company:	**Blue Cross Community Blue PPO Plan**
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/Suffix:	67982

Benefits:

(SEE ATTACHED SHEET FOR PLAN CHOICE 1, 2, 3, 4 OR 5)

No health coverage, $600 lump sum payment

Employee Cost:	Amount above hard cap set by PA 152
Effective:	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
Eligibility:	30 or more hours weekly

LIFE INSURANCE

Company:	CIGNA
Group:	FLX963665 Class 6
Effective:	End of eligibility period

Benefit: $10,000 Term Life

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 completion of eligibility period

Benefit: COB Suffixing

1. 80% without other coverage
2. 50% with other coverage
   $1,000 annual max, $800 life time ortho max

Benefit year: January – December

LONG TERM DISABILITY

Company:	CIGNA
Group:	LK62601 Class 8
Effective:	1st of the month after date of hire
Benefit:	90 calendar day qualifying period 66 2/3% of monthly salary, $ 2,000 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 $48
LENSES	Standard Glass or Plastic Covered 100%	Single Vision Up to $63 Bi-Focal Up to $72 Tri-Focal Up to $90 Lenticular Up to $110
LENS OPTIONS	Progressives (Standard) 100% Progressives (Premium) 100%	N/A N/A
FRAME	Covered up to $44 (20% off remaining balance over $44 allowance)	Up to $44
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 1-800-448-8326 www.lifeadvisor.com

FLEXIBLE SPENDING ACCOUNT

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

***NOTE:** All insurance claim forms are available in the School office and in the Employee Benefit office.

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Plymouth Canton Community Schools

Plan Offering - CAFETERIA

BCBS COMMUNITY BLUE PPO	Plan Choice #1		Plan Choice #2		Plan Choice #3		Plan Choice #4		Plan Choice #5	
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***
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
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
Emergency Room	$30 copay (waived if injury or if admitted)	$30 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)
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
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
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
Prescription Drugs	$10 Generic /$40 Brand Copay (Mail Order x 2)	75% of approved amount; plus copays	$10 Generic /$40 Brand Copay (Mail Order x 2)	75% of approved amount; plus copays	$10 Generic /$40 Brand Copay (Mail Order x 2)	75% of approved amount; plus copays	$10 Generic /$40 Brand Copay (Mail Order x 2)	75% of approved amount; plus copays	$10 Generic /$40 Brand Copay (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