PLYMOUTH SCHOOL DISTRICT

STATEWIDE/FIRST HEALTH

Outline of Benefits – WPS Group PPO Plan

Effective July 1, 2017

PROVISION/BENEFIT	PREFERRED PROVIDERS	ALL OTHER PROVIDERS
Annual Deductible Amount	$600 per member, not to exceed $1,200 per family	$1,200 per member, not to exceed $2,400 per family
Coinsurance	90% of charges	70% of charges
Annual Deductible & Coinsurance Out-of-Pocket Limit –	$1,600 per member, not to exceed $3,200 per family	$4,200 per member, not to exceed $8,400 per family
Maximum Annual Out-of-Pocket Limit- this includes medical & prescription drug copays	$7,150 per member, not to exceed $14,300 per family	Not Applicable
Physician office visits by a **primary care physician** - office visit charge only	$20 copayment, Deductible, then 90% of charges	Deductible, then 70% of charges
Physician office visits by a **specialty care physician** - office visit charge only	$35 copayment, Deductible, then 90% of charges	Deductible, then 70% of charges
Telehealth visits through Teladoc	$10 copayment, then 100% of charges	Not Covered
Diagnostic x-rays and lab services provided in a physician's office	100% of charges	Deductible, then 70% of charges
Dependent Coverage	Dependent children to age 26	
Hospital Services		
Inpatient services	Deductible, then 90% of charges	Deductible, then 70% of charges
Outpatient miscellaneous hospital expenses	Deductible, then 90% of charges	Deductible, then 70% of charges
Emergency Services		
Ambulance services - Non-emergency transport requires prior approval or benefits not payable	Deductible, then 90% of charges	Preferred Deductible, then 90% of charges
Emergency room visit - emergency room charge only	$200 copayment, then 100% of charges	$200 copayment, then 100% of charges
Emergency room services provided during an emergency room visit	90% of charges	90% of charges
Preventive Services-includes screenings as required by the United States Preventive Services Task Force (USPSTF)		
Immunizations	100% of charges	100% of charges
Routine exams, lab tests, mammograms & pap smears	100% of charges	Deductible, then 70% of charges
Routine screenings as required by the USPSTF-see policy for list of covered screenings	100% of charges	Deductible, then 70% of charges
Routine colonoscopy – one per member every five years	100% of charges	Deductible, then 70% of charges
Blood lead tests	100% of charges	Deductible, then 70% of charges
Covered Health Care Services		
Autism Services – subject to policy limits	Deductible, then 90% of charges	Deductible, then 70% of charges
Chiropractic manipulations	$20 copayment, Deductible, then 90% of charges	Deductible, then 70% of charges
Contraceptives, other than those purchased from a pharmacy (for contraceptives purchased from a pharmacy – see "Prescription Legend Drugs" below	100% of charges	Deductible, then 70% of charges

PROVISION/BENEFIT	PREFERRED PROVIDERS	ALL OTHER PROVIDERS
Diabetic supplies (including disposable) and equipment purchased from a health care provider other than a pharmacy (this does not include insulin (for disposable diabetic supplies purchased from a pharmacy – see "Prescription Legend Drugs" below	Deductible, then 90% of charges	Deductible, then 70% of charges
Durable medical equipment (including oxygen equipment and oxygen)	Deductible, then 90% of charges	Deductible, then 70% of charges
Hearing Aids and Cochlear Implants – see policy for limitations	Deductible, then 90% of charges	Deductible, then 70% of charges
Home care visits - limited to 40 visits per calendar year	90% of charges	90% of charges
Hospice care	90% of charges	90% of charges
Kidney disease - dialysis and transplantation expenses	Deductible, then 90% of charges	Deductible, then 70% of charges
Medical supplies	Deductible, then 90% of charges	Deductible, then 70% of charges
Nutritional counseling	100% of charges	Deductible, then 70% of charges
Outpatient therapy services for treatment of alcoholism, drug abuse and nervous or mental disorders	$20 copayment, Deductible, then 90% of charges	Deductible, then 70% of charges
Skilled nursing facility confinements – limited to 30 days per calendar year	Deductible, then 90% of charges	Preferred Deductible, then 90% of charges
Surgical services (Oral surgical services limited to those listed in the policy) – includes bariatric surgery approved by us	Deductible, then 90% of charges	Deductible, then 70% of charges
Temporomandibular joint (TMJ) treatment	Deductible, then 90% of charges	Deductible, then 70% of charges
Therapy Services - Physical, speech, and occupational therapy; cognitive rehabilitative therapy	Deductible, then 90% of charges	Deductible, then 70% of charges
Respiratory/pulmonary therapy	$20 copayment, Deductible, then 90% of charges	Deductible, then 70% of charges
Transplants		
All non-experimental transplants	Deductible, then 90% of charges	Deductible, then 70% of charges Limited to $35,000 per covered organ transplant
Direct, non-medical costs (lodging and transportation) – limited to $10,000 per covered organ transplant	Deductible, then 90% of charges	Not Covered
Prescription Legend Drugs		
Copayment – Applies to prescription drugs and covered supplies	Retail: $10 - generic drugs $25 - preferred brand-name drugs $50 - brand-name drugs *Maintenance medications must be purchased through home delivery, unless the member has elected to opt out of that program prior to the fourth purchase*	Mail Order: $20 - generic drugs $50 - preferred brand-name drugs $100 - brand-name drugs
Oral contraceptives, contraceptive patch, diaphragms and NuvaRing	Covered – not subject to applicable copayments	
Limitation	Retail: 30-day supply/90-day supply for maintenance drugs Mail Order: 90-day supply	
Preauthorization required for certain drugs	Applicable	
Specialty Drugs	For specialty drugs obtained in a physician's office, outpatient department of a hospital or home health agency, prior approval is recommended	

This is a partial summary of the benefits. For specific benefits, limitations, terms, provisions and conditions, please refer to your certificate of coverage or the group master policy. The term "charges" as used in this chart means the amount that does not exceed our determination of the maximum allowable fee for such health care service.