Marion CUSD #2

Group Health Plan Benefit Summary - PPO Plan

This is a brief summary of benefits. Please refer to your BlueCross booklet for details.	*If you use a BlueCross PPO Contracted Provider:*
Wellness/Preventive - Routine physical exams, tests, screenings and immunizations for children and adults. *If you have symptoms or your visit or test is a follow up from previous treatment is it NOT Preventive. See benefits below.*	**No Deductible or Co-pay. Covered at 100%.** Covers school physicals. Females age 14+ covered for one physical exam *and* one gynecological exam per year.
Doctor's Office Visits For the diagnosis or treatment of illness or injury	*Services received at the doctor's office are covered at 100% after the co-pay. You do Not have to meet any part of your deductible to receive this benefit.*
Primary Care	You pay a **$30 Co-pay**
Specialist	You pay a **$50 Co-pay**
Prescription Drugs At participating Pharmacies or by Mail Order	*Prescription Drugs are covered at 100% after the co-pay. You do NOT have to meet any part of your deductible to receive this benefit.*
Generic Drugs	You pay a **$10 co-pay** (up to a 34 day supply) You pay a **$20 co-pay** (up to a 90 day supply)
Brand Name Drugs	You pay a **$10 co-pay + 20%** (up to a 34 day supply) You pay a **$40 co-pay** (up to a 90 day supply)
Specialty Drugs (may require prior authorization)	You pay a **$10 co-pay + 20%** (up to a 30 day supply) 20% capped @ $500 per month per prescription
Calendar Year Deductible - All Services other than office visits and Prescriptions Drugs are subject to deductible.	**$1,500 Deductible** per Individual No more than $3,000 in Deductibles per Family
Hospital Inpatient	**You pay 20%** after deductible is met
Hospital Outpatient	**You pay 20%** after deductible is met
Outpatient Surgical Center	**You pay 20%** after deductible is met
Emergency Room	**You pay 20%** after deductible is met
Urgent Care Center	**You pay 20%** after deductible is met
Diagnostic Tests (Lab or X-ray)	**You pay 20%** after deductible is met
Imaging (such as CT or PET Scans, MRIs)	**You pay 20%** after deductible is met
Physical, Occupational or Speech Therapy/ Chiropractic/ Rehabilitation (Visit limits may apply. Please see booklet)	**You pay 20%** after deductible is met
Medical Equipment	**You pay 20%** after deductible is met
Calendar Year Out of Pocket Limit - this plan includes limits on the amount you have to pay for covered services. Once an Out of Pocket Limit is reached, you do not pay any more co-pays, deductible or 20% for the balance of the calendar year. Coverage increases to 100% until Jan 1st of the following year.	*All co-pays, deductible and the 20% you pay count toward reaching your out of pocket limit.* **Medical Out of Pocket Limit: $2,500** per Individual, no more than $5,000 per Family **Prescription Drug Out of Pocket Limit: $1,000** per Individual, no more than $2,000 per Family