



**WEST OTTAWA PUBLIC SCHOOLS**  
**Administrative & Support Staff**  
**Group Health Insurance Programs - Benefits-at-a-Glance**  
**Effective February 1, 2009**

**Option I - Basic Select with RX Plan 2**

**Options II and III - PPO Select with RX Plan 2**

**Preventive Services – limited to \$500 per member per calendar year**

Annual Health Maintenance Exam – beginning age 16, includes related X-rays, EKG, lab procedures, and routine screening tests performed as part of the physical exam	Covered – 100%; deductible waived
Annual Well Woman Exam – one per calendar year	Covered – 100%; deductible waived
Pap Smear Screening – one per calendar year - <i>Does not contribute to annual dollar maximum</i>	Covered – 100%; deductible waived
Well-Baby and Child Care – through age 15 6 visits birth through age 1, 2 visits per year age 2 through 3, 1 visit per year age 4 through 15	Covered – 100%; deductible waived
Immunizations – child and adult - <i>Does not contribute to annual dollar maximum</i>	Covered – 100%; deductible waived
Prostate Specific Antigen (PSA) exam - one per calendar year - <i>Does not contribute to annual dollar maximum</i>	Covered – 100%; deductible waived
Fecal Occult Blood Test – one per calendar year - <i>Does not contribute to annual dollar maximum</i>	Covered – 100%; deductible waived
Endoscopic Exam – one per calendar year - <i>Does not contribute to annual dollar maximum</i>	Covered – 100%; deductible waived
Hearing Exam – one per calendar year	Covered – 100%; deductible waived

**Mammograms**

Mammography Screening – one per calendar year - <i>Does not contribute to annual dollar maximum</i>	Covered – 100%; deductible waived
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**Physician Office Services**

Office Visits <ul style="list-style-type: none"> <li>· PCP and Specialist</li> </ul> Services include: <ul style="list-style-type: none"> <li>· Initial OB visit to determine pregnancy</li> <li>· Outpatient and home visits</li> <li>· Office consultations</li> <li>· Urgent care visits</li> </ul>	Covered – 90% after deductible All services performed during the office visit (e.g., lab, x-rays, etc.) are covered 100%; deductible waived
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**Emergency Medical Care**

Hospital Emergency Room Qualified Medical Emergency & First Aid Services	Covered – 100%; deductible waived
Non-emergency use of the Emergency Room	Covered – 90% after deductible
Ambulance Services – any medically necessary transport	Covered – 90% after deductible

**Diagnostic Services**

Laboratory and Pathology Tests	Covered – 100%; deductible waived
Independent Laboratory Test	Covered - 100%; deductible waived
Diagnostic Tests and X-rays	Covered – 100%; deductible waived
Radiation Therapy	Covered – 90% after deductible

**Maternity Services Provided by a Physician**

Pre-Natal and Post-Natal Care	Covered – 100%; deductible waived
Delivery and Nursery Care	Covered – 100%; deductible waived

**Hospital Care**

Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered – 100%; deductible waived
Inpatient Consultations	Covered – 100%; deductible waived
Chemotherapy	Covered – 90% after deductible

**Alternatives to Hospital Care**

Skilled Nursing Care – Unlimited visits	Covered – 90% after deductible
Hospice Care	Covered – 100%; deductible waived
Home Health Care – Unlimited visits	Covered – 100% ; deductible waived

**Surgical Services**

Surgery – includes related surgical services	Covered – 100% ; deductible waived
Dental surgery and related anesthesia for the removal of wisdom teeth	Covered – 100% ; deductible waived
Voluntary Abortion	Not Covered
Voluntary Sterilization – excludes reverse sterilizations	Covered – 90% after deductible

**In-Network**

**Out-of-Network**

**Preventive Services – limited to \$500 per member per calendar year maximum**

Health Maintenance Exam – beginning age 16, one per calendar year; includes related X-rays, EKG, and lab procedures performed as part of the physical exam	Covered – 100%	Not Covered
Annual Gynecological Exam - one per calendar year - <i>Does not contribute to annual dollar maximum</i>	Covered – 100%	Not Covered
Pap Smear Screening – one per calendar year; laboratory services only - <i>Does not contribute to annual maximum</i>	Covered – 100%	Not Covered
Well-Baby and Child Care - through age 15 6 visits birth through age 1, 2 visits per year age 2 through 3, 1 visit per year age 4 through 15	Covered – 100%	Not Covered
Immunizations - pediatric and adult - <i>Does not contribute to annual dollar maximum</i>	Covered – 100%	Not Covered
Prostate Specific Antigen (PSA) Screening - one per calendar year - <i>Does not contribute to annual maximum</i>	Covered – 100%	Not Covered
Fecal Occult Blood Test – one per calendar year - <i>Does not contribute to annual dollar maximum</i>	Covered – 100%	Not Covered
Endoscopic Exams – one per calendar year - <i>Does not contribute to annual dollar maximum</i>	Covered – 100%	Not Covered
Hearing Exam – one per calendar year	Covered – 100%	Not Covered

**Mammography**

Mammography Screening – one per calendar year	Covered – 100%	Not Covered
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**Physician Office Services**

Office Visits Includes: <ul style="list-style-type: none"> <li>· Primary Care Physicians and Specialists</li> <li>· Presurgical consultations</li> <li>· Initial visit to determine pregnancy</li> </ul> Urgent Care Visits	Covered – 100% after \$5 copay  One copay applies to the office visit exam and all services performed during the office visit (e.g., lab, x-rays, etc.)  Covered – 100% after \$5 copay	Covered – 80% after deductible   Covered – 80% after deductible
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**Emergency Medical Care**

Hospital Emergency Room Qualified Medical Emergency & First Aid Services	Covered – 100%	Covered – 100%
Non-Emergency use of the Emergency Room	Covered – 100% after \$25 copay	Covered – 100% after \$25 copay
Ambulance Services – medically necessary transport	Covered – 100%	Covered – 100%

**Diagnostic Services**

MRI, MRA, PET and CAT Scans and Nuclear Medicine	Covered – 100%	Covered – 80% after deductible
Other Diagnostic Tests, X-rays, Laboratory & Pathology	Covered – 100%	Covered – 80% after deductible
Radiation Therapy	Covered – 100%	Covered – 80% after deductible

**Maternity Services Provided by a Physician**

Pre-Natal and Post-Natal Care	Covered – 100%	Covered – 80% after deductible
Delivery and Nursery Care	Covered – 100%	Covered – 80% after deductible

**Hospital Care**

Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies	Covered – 100%	Covered – 80% after deductible Unlimited days
Inpatient Medical Care	Covered – 100%	Covered – 80% after deductible
Chemotherapy	Covered – 100%	Covered – 80% after deductible

**Alternatives to Hospital Care**

Skilled Nursing Facility	Covered – 100%	Covered – 100% Limited to 120 days per calendar year
Hospice Care	Covered – 100%	Covered – 100%
Home Health Care	Covered – 100%	Covered – 100%

**Outpatient Surgical Services**

Surgery – includes related surgical services	Covered – 100%	Covered – 80% after deductible
Dental surgery and related anesthesia for the removal of wisdom teeth	Covered – 100% ; deductible waived	Covered – 100% ; deductible waived
Voluntary Abortion	Not Covered	Not Covered
Voluntary Sterilization – excludes reversal sterilization	Covered – 100%	Covered – 80% after deductible

**Human Organ Transplants**

Specified Organ Transplants – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	Covered – 100%; deductible waived Unlimited dollar maximum per transplant type
Kidney, Cornea and Skin	Covered – 100%; deductible waived

**Mental Health Care and Substance Abuse Treatment**

Inpatient Mental Health and Substance Abuse Care - limited to a lifetime maximum of 45 days - <i>Does not contribute to out-of-pocket maximum</i>	Covered – 100%; deductible waived
Outpatient Mental Health Care – limited to 50 visits per calendar year - <i>Does not contribute to out-of-pocket maximum</i>	Covered - 90% after deductible
Outpatient Substance Abuse Care - limited to the annually adjusted state dollar maximum - <i>Does not contribute to out-of-pocket maximum</i>	Covered - 90% after deductible

**Other Services**

Cardiac Rehabilitation	Covered – 90% after deductible
Acupuncture – performed by an MD, DO and other select provider specialties	Covered – 90% after deductible
TMJ Services	Covered – 90% after deductible
Allergy Testing	Covered – 100%; deductible waived
Allergy Therapy	Covered – 90% after deductible
Chiropractic Care	Covered – 90% after deductible Unlimited spinal manipulation visits
Outpatient Physical, Speech and Occupational Therapy	Covered – 90% after deductible Unlimited visits. Services are covered when performed in the outpatient department of the hospital, approved freestanding facility or independent therapist's office.
Durable Medical Equipment/Medical Supplies (including diabetic supplies)	Covered – 90% after deductible
Massage Therapy rendered by MD, DO or Chiropractor	Covered – 90% after deductible. Unlimited visits
Prosthetic and Orthotic Appliances	Covered – 90% after deductible
Private Duty Nursing	Covered – 90% after deductible
Hearing Aids	Covered – 100% of the approved amount. Hearing aids must be purchased from an approved hearing aid provider.

**Deductible, Copays/Coinsurance and Dollar Maximums**

<b>Deductible – per calendar year</b>	\$ 50 per member \$150 per family
<b>Copays/Coinsurance</b>	
• Fixed Dollar Copays	Not Applicable
• Percent Coinsurance	10%
<b>Out-of-Pocket Maximum – per calendar year</b>	\$1,000 per contract
• Fixed Dollar Copays • Percent Coinsurance – <i>Does not include deductible</i>	
<b>Lifetime Maximum</b>	Unlimited

**Prescription Drugs**

<b>Retail – 34 day supply</b>	\$ 0 copay – OTC drugs (Only – Zyrtec, Zyrtec D, Prilosec, Claritin, Children's Claritin, Claritin RediTabs and Claritin-D) \$10 copay – Generic drugs \$20 copay – Brand name drugs
<b>Mail Order - 90-day supply</b>	\$ 0 copay – OTC drugs (Only – Zyrtec, Zyrtec D, Prilosec, Claritin, Children's Claritin, Claritin RediTabs and Claritin-D) \$20 copay – Generic drugs \$40 copay – Brand name drugs
<b>Additional Services:</b>	
Oral & Injectable Contraceptives	Covered
Smoking Cessation Drugs	Covered
Weight Loss Drugs	Covered
Impotency Drugs	Covered – limited to 12 doses per month
Infertility Drugs	Covered

**In-Network** **Out-of-Network**

**Human Organ Transplants**

Specified Organ Transplants – in designated facilities only, when coordinated through the BCBSM Human Organ Transplant Program (1-800-242-3504)	Covered - 100%	Not Covered
	Unlimited dollar maximum per transplant type	
Kidney, Cornea, Bone Marrow and Skin	Covered – 100%	Covered – 80% after deductible

**Mental Health Care and Substance Abuse Treatment**

Inpatient Mental Health Care - <i>Does not contribute to out-of-pocket maximum</i>	Covered – 100%	Covered – 80% after deductible
	Limited to a lifetime maximum of 45 days (Combined with inpatient substance abuse care)	
Inpatient Substance Abuse Care - <i>Does not contribute to out-of-pocket maximum</i>	Covered – 100%	Covered – 100% after deductible
	Limited to a lifetime maximum of 45 days (Combined with inpatient mental health care)	
Outpatient Mental Health Care - <i>Does not contribute to out-of-pocket maximum</i>	Covered – 90% after deductible	Covered – 80% after deductible
	Limited to 50 visits per calendar year	
Outpatient Substance Abuse Care - <i>Does not contribute to out-of-pocket maximum</i>	Covered – 90% after deductible	Covered – 90% after deductible
	Limited to annually adjusted state dollar maximum	

**Other Services**

Cardiac Rehabilitation	Covered – 100%	Covered – 80% after deductible
Acupuncture – performed by an MD, DO and other select provider specialties	Covered – 100%	Covered – 80% after deductible
Allergy Testing and Therapy	Covered – 100%	Covered – 80% after deductible
Chiropractic Spinal Manipulation	Covered – 100%	Covered – 80% after deductible
	Limited to 24 visits per calendar year	
Outpatient Physical, Speech and Occupational Therapy	Covered – 100%	Covered – 80% after deductible
	Limited to 60 combined visits per calendar year. Services are covered when performed in the outpatient department of the hospital, or approved freestanding facility. Physical therapy is also covered in an independent therapist's office.	
Durable Medical Equipment/Medical Supplies	Covered – 100%	Covered – 100%
Massage Therapy rendered by MD, DO, or Chiropractor	Covered – 100%	Covered – 80% after deductible
	Limited to 24 visits per calendar year	
Prosthetic and Orthotic Appliances	Covered – 100%	Covered – 100%
Private Duty Nursing - <i>Does not contribute to out-of-pocket maximum</i>	Covered – 90%	Covered – 90%; deductible waived
Hearing Aids	Covered – 100% of approved amount. Hearing aids must be purchased from an approved hearing aid provider.	

**Deductible, Copays/Coinsurance and Dollar Maximums**

<b>Deductible - per calendar year</b>	Not Applicable	\$250 per member \$500 per family
<b>Copays/Coinsurance</b>		
• Fixed Dollar Copays	\$5 copay for: • Office visits • Urgent Care visits	\$25 copay for: • Non-emergency visits in emergency room
• Percent Coinsurance	Not Applicable	<b>20%</b> <b>Note:</b> Services without a network are covered at the in-network level.
<b>Out-of-Pocket Maximum – per calendar year</b>	Not Applicable	\$2,000 per member \$4,000 per family
• Percent Coinsurance - <i>Excludes Deductible</i>		
<b>Lifetime Maximum</b>	Unlimited	

**Prescription Drugs**

<b>Retail – 34 day supply</b>	<b>Options II and III</b> \$ 0 copay – OTC drugs (Only – Zyrtec, Zyrtec D, Prilosec, Claritin, Children's Claritin, Claritin RediTabs and Claritin-D) <b>Options II and III</b> \$10 copay – Generic drugs <b>Option II</b> - \$20 copay – Brand name drugs <b>Option III</b> - \$40 copay - Brand name drugs Prescriptions and refills obtained from a non-network pharmacy are reimbursed at 75% of the approved amount, less the member's copay.
<b>Mail Order - 90-day supply</b>	<b>Options II and III</b> \$ 0 copay – OTC drugs (Only – Zyrtec, Zyrtec D, Prilosec, Claritin, Children's Claritin, Claritin RediTabs and Claritin-D) <b>Options II and III</b> \$20 copay – Generic drugs <b>Option II</b> - \$40 copay – Brand name drugs <b>Option III</b> - \$80 copay - Brand name drugs
<b>Additional Services</b>	
Oral & Injectable Contraceptives	Covered
Smoking Cessation Drugs	Covered
Weight Loss Drugs	Covered
Impotency Drugs	Covered – limited to 12 doses per month
Infertility Drugs	Covered

This is intended as an easy-to-read guide. It is not a contract. An official description of benefits is contained in applicable Blue Cross Blue Shield of Michigan coverage documents.