COLUMBUS CITY SCHOOLS

Latchkey Teachers

2018 Employee Contributions for Benefits

Medical

21 Pay Plan	Select	Choice
Employee only	125.77	133.93
Employee plus one (Child or Spouse)	250.77	267.03
Family (Child or Spouse)	369.99	393.99

Medical

26 Pay Plan	Select	Choice
Employee only	101.58	108.17
Employee plus one (Child or Spouse)	202.55	215.68
Family (Child or Spouse)	298.84	318.22

Extended Dependent Coverage is no longer offered effective 1/1/2016.

Dental

	21 Pay Plan	26 Pay Plan
Employee only	11.33	9.15
Family	11.33	9.15

Vision

21 Pay Plan	1.31
26 Pay Plan	1.06

→ **Over**

Columbus City Schools Medical/Pharmacy Benefit Summaries — Revised 9/1/2017

Teachers & Administrators

	Select	Choice	
Benefit		**Network**	**Non- Network**
Choice of Physician	Member selects a physician from the network	Member selects a physician from the network	Member can also receive care from non-network providers at a lower benefit level
Annual Medical Deductible - Deductible applies except for services with a copay unless otherwise noted			
Medical Deductible Individual/Family	$250/$500	$250/$500	$500/$1,000
Annual Out-of-Pocket Maximum (OOP)	**Network medical copayments will accumulate to the Out of Pocket Maximum along with any applicable medical deductibles and coinsurance. (See Pharmacy Out of Pocket Maximum below)**		
Medical OOP Individual/Family	$600/$1,200	$600/$1,200	$1,200/$2,400
Preventive Care Services (Routine preventive care services. Immunizations)	$0 Copay	$0 Copay	Not Covered
Physician /Specialist Office Visits	$20 Copay	$20 Copay	20% Coinsurance after deductible
Urgent Care Visits	$25 Copay	$35 Copay	Not Covered
Hospital Emergency Room	$100 Copay	$100 Copay	$100 Copay
	(waived if admitted)	(waived if admitted)	(waived if admitted)
Inpatient Facility Services	0% Coinsurance after deductible No Physical Medicine & Rehabilitation (PM&R) limit	0% Coinsurance after deductible 60 day combined PM&R limit	20% Coinsurance after deductible 60 day combined PM&R limit
Outpatient Facility Services	0% Coinsurance after deductible	0% Coinsurance after deductible	20% Coinsurance after deductible
Chiropractic Services (30 visits per year)	$20 Copay	$20 Copay	20% Coinsurance after deductible
Physical and Occupational Therapy (60 visits per year combined)	$20 Copay	$20 Copay	20% Coinsurance after deductible
Speech Therapy (20 visits per year)	$20 Copay	$20 Copay	20% coinsurance after deductible
DME – Medical Supplies, Equipment and Appliances	20% Coinsurance after deductible	20% Coinsurance after deductible	
Diabetic/Asthmatic Supplies	$0 Copay	$0 Copay	Not covered
Human Organ /Tissue Transplant	Plan pays 100%	Plan pays 100%	Not covered
Mental Health/ Substance Abuse Inpatient Services	0% Coinsurance after deductible	0% Coinsurance after deductible	20% Coinsurance after deductible
Mental Health/ Substance Abuse Outpatient Services	$20 Copay	$20 Copay	20% Coinsurance after deductible
Hospice Services	Plan Pays 100%	Plan Pays 100%	
Home Health Care	0% Coinsurance after deductible	0% Coinsurance after deductible	20% Coinsurance after deductible (30 visit limit)
Pharmacy Out of Pocket Maximum Individual/Family	$1,500/$3,000	$1,500/$3,000	$2,500/$5,000
Prescription Drugs Retail Pharmacy (30 day supply)	$4 Generic / $25 Brand Preferred / $40 Brand Non-Preferred	$4 Generic / $25 Brand Preferred / $40 Brand Non-Preferred	50% Coinsurance
Prescription Drugs Mail Order Pharmacy (90 day supply)	$10 Generic / $50 Brand Preferred / $80 Brand Non-Preferred	$10 Generic / $50 Brand Preferred / $80 Brand Non-Preferred	Not Covered
Dependent Child Age	Up to age 26		

Notes: Above summaries are for reference only. Please consult summary plan document, amendments, and riders for exact plan benefits

See Reverse Side for Employee Contributions →