

**EMPLOYER DATA SCHEDULE
PPO WRAP MEDICAL CARE BENEFITS PLAN**

Constantine Public Schools

Effective Date:	January 1, 2009 Revised February 1, 2009
Group Number:	2105
Employer Identification Number:	38-6003614
Employer:	Constantine Public Schools 664 Canaris Street Constantine, MI 49042-1310 (269) 435-8900
Eligible Class(es):	Non-Teaching Staff (CESPA)
Service Requirement:	Effective on date of hire.
Termination Effective Date:	Effective the day after the date of termination.
"Actively At Work" Requirement:	Yes, as provided in Section 3.02
Weekly Hour Requirement:	30 hours per week
Employee Contributions:	This Plan does require employee contributions.
Annual Open Enrollment Period:	The month of December, effective January 1st.
Benefit Period:	January 1 through December 31
Coordination of Benefits:	Standard
Assignment of Benefits:	Benefits may be assigned.
Underlying Plan:	Blue Cross Blue Shield Community Blue Option 15
Prescription Drug Manager:	Caremark (CMK)
Plan Year:	The records of the Plan are kept separately for each Plan Year. The Plan Year begins on January 1 and ends on December 31.
Agent for Legal Process:	Ted A. Chase 122 East Front Street Buchanan, Michigan 49107 269-695-1567

Constantine Public Schools

Medical Summary Plan Description (SPD) for
Non Teaching Staff

Effective January 1, 2009

Revised February 1, 2009

**POINT OF CARE (POC)
OPTION 1
SCHEDULE OF BENEFITS
for
Constantine Public Schools**

BENEFITS	IN NETWORK	OUT OF NETWORK
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Preventative Services

Health Maintenance Exam (includes chest X-ray, EKG and select lab procedures)	Covered at 100%, one per calendar year	Not Covered
Gynecological Exam	Covered at 100%, one per calendar year	Not Covered
Pap Smear (laboratory and pathology services)	Covered at 100%, one per calendar year	Not Covered
Well Baby and Child Care	Covered at 100%* * 6 visits, birth through 12 months * 6 visits, 13 months through 23 months * 2 visits, 24 months through 35 months * 2 visits, 36 months through 47 months * 1 visit per birth year, 48 months through age 15	Not Covered
Childhood Immunizations (as recommended by the Advisory Committee on Immunizations Practices and the American Academy of Pediatrics)	Covered at 100%	Not Covered
Fecal Occult Blood Screening	Covered at 100%, one per calendar year	Not Covered
Flexible Sigmoidoscopy Exam	Covered at 100%, one per calendar year	Not Covered
Prostate Specific Antigen (PSA) Screening	Covered at 100%, one per calendar year	Not Covered

Mammography Screening

Mammography Screening (one per calendar year, no age restrictions)	Covered at 100%	Covered at 80% after deductible
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BENEFITS	IN NETWORK	OUT OF NETWORK
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Physician Office Services (Must be Medically Necessary)

Office Visits	Covered at 100%	Covered at 80% after deductible
Outpatient and Home Visits	Covered at 100%	Covered at 80% after deductible
Office Consultations	Covered at 100%	Covered at 80% after deductible
Urgent Care Center	Covered at 100%	Covered at 80% after deductible

Emergency Medical Care

Hospital Emergency Room	Covered at 100%	Covered at 100% after a \$50 copay. Waived if admitted or for an accidental injury.
Ambulance Services (medically necessary)	Covered at 100%	Covered at 100%

Diagnostic Services

Laboratory and Pathology Services	Covered at 100%	Covered at 80% after deductible
Diagnostic Tests and X-rays	Covered at 100%	Covered at 80% after deductible
Therapeutic Radiology	Covered at 100%	Covered at 80% after deductible

Maternity Services Provided by a Physician (Includes care provided by a certified nurse/midwife)

Prenatal and Postnatal Care	Covered at 100%	Covered at 80% after deductible
Delivery and Nursery Care	Covered at 100%	Covered at 80% after deductible

Hospital Care

Semi-Private Room, Inpatient Physician Care, General Nursing Care, Hospital Services and Supplies (Unlimited Days) NOTE: Nonemergency services must be rendered in a participating hospital	Covered at 100%	Covered at 80% after deductible
Inpatient Consultations	Covered at 100%	Covered at 80% after deductible
Chemotherapy	Covered at 100%	Covered at 80% after deductible

BENEFITS	IN NETWORK	OUT OF NETWORK
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Alternatives to Hospital Care

Skilled Nursing Care (up to 120 days per calendar year)	Covered at 100%	Covered at 100%
Hospice Care (limited to the lifetime dollar maximum which is adjusted periodically by the state)	Covered at 100%	Covered at 100%
Home Health Care (medically necessary)	Covered at 100%	Covered at 100%
Home Infusion Therapy (medically necessary)	Covered at 100%	Covered at 100%

Surgical Services

Surgery (includes related surgical services)	Covered at 100%	Covered at 80% after deductible
Presurgical Consultations (with a doctor of medicine, osteopathy, podiatry or an oral surgeon)	Covered at 100%	Covered at 80% after deductible
Voluntary Sterilization	Covered at 100%	Covered at 80% after deductible
Colonoscopy	Covered at 100%	Covered at 80% after deductible

Human Organ Transplant

Specified Human Organ Transplants (in designated facilities only , when coordinated through the BCBSM Human Organ Transplant Program 800-242-3504)	Covered at 100%	Covered at 100%, in designated facilities only
	Limited to \$1 million lifetime maximum per member per transplant type for transplant procedure(s) and related professional, hospital and pharmacy services	
Bone Marrow (when coordinated through the BCBSM Human Organ Transplant Program (800-242-3504); specific criteria applies)	Covered at 100%	Covered at 80% after deductible
Kidney, Cornea and Skin	Covered at 100%	Covered at 80% after deductible

Mental Health Care and Substance Abuse

Inpatient Mental Health Care (unlimited days)	Covered at 90%	Covered at 80% after deductible
Inpatient Substance Abuse Care (unlimited days, up to state maximum)	Covered at 50%	Covered at 50% after deductible
Outpatient Mental Health Care (up to 50 visits per calendar year)	Covered at 90%	Covered at 80% after deductible
Outpatient Substance Abuse Care (in approved designated facilities only up to the state dollar amount which is adjusted annually)	Covered at 50%	Covered at 50%

BENEFITS	IN NETWORK	OUT OF NETWORK
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Other Services

Allergy Testing and Therapy	Covered at 100%	Covered at 80% after deductible
Chiropractic Spinal Manipulation (up to 24 visits per calendar year)	Covered at 100%	Covered at 80% after deductible
Outpatient Physical, Speech, and Occupational Therapy (A combined 60-visit maximum per calendar year)	Covered at 100%	Covered at 80% after deductible
Outpatient Diabetes Management Program (ODMP)	Covered at 100%	Covered at 80% after deductible
Durable Medical Equipment	Covered at 100%	Covered at 100%
Prosthetic and Orthotic Appliances	Covered at 100%	Covered at 100%
Private Duty Nursing	Covered at 50%	Covered at 50%

Prescription Drugs (Retail)

Copays:	(Per Prescription)
Generic	\$10.00
Brand	\$60.00
Mail Order	\$20.00 or \$120.00
Insulin, Needles, Syringes	\$20.00 or \$120.00
Contraceptives	\$20.00 or \$120.00
Smoking Cessation	\$20.00 or \$120.00
Bio-Techs/Injectibles	\$20.00 or \$120.00
Lifestyle Medications	\$20.00 or \$120.00
Anti-Retroviral (Mail Order Only)	\$20.00 or \$120.00

When a generic is available, but the pharmacy dispenses the brand name drug for any reason other than a Dr. DAW or equivalent instructions, the covered member is to pay the difference between the calculated AWP cost of the brand name drug and the calculated AWP cost of the generic drug in addition to the Generic copayment.

BENEFITS	IN NETWORK	OUT OF NETWORK
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Deductibles and Copayments

Deductible (per Benefit Year)	None	\$250 per member, \$500 per family
Copayments		
* For Fixed (per service)	None	\$50 for emergency room visits
* For Percent (% of Allowable Charge)	10% for mental health care, 50% inpatient/outpatient substance abuse treatment and private duty nursing.	20% for general services, mental health care, 50% for inpatient/outpatient substance abuse treatment, and private duty nursing.
Out of Pocket Maximum		
* Fixed	None	None
* Percent, excludes mental health care, substance abuse and private duty nursing copayments	Not Applicable	\$2,000 per member, \$4,000 per family

Dollar Maximums: Five Million Dollar (\$5,000,000) lifetime per member for all covered services and as noted above for individual services.

Group Term Life Insurance (Terms and conditions provided under separate documents)	\$5,000.00
Accidental Death and Dismemberment (AD&D)	\$5,000.00
Seatbelt	\$5,000.00

NOTE: Eligibility of medical expenses is determined by BCBSM unless otherwise provided in this document.

Riders Included:

DC - Allows members to continue group coverage for dependent children between the ages of 19-25 when eligibility requirements are met.

XVA - Excludes voluntary abortions.