

D.R.S. SERVICES, INC.

EMPLOYEE BROCHURE

FOR

HEALTH CARE BENEFITS

OF

MILAN AREA SCHOOLS

CLASS II – Secretaries (001)

MILAN AREA SCHOOLS HEALTH CARE BENEFITS

INTRODUCTION TO PLAN

TO COVERED EMPLOYEES AND DEPENDENTS:

This Employee Booklet will help you better understand your benefits covered under Blue Cross and Blue Shield of Michigan (BCBSM) and offered through Milan Schools.

As you go through this booklet, please keep in mind that this is a simple summary of the benefits covered under your plan and is not intended to cover every situation which might occur.

BCBSM will provide a “Benefits Guide” to you which describes in greater detail: eligibility, description of benefits and terms and conditions of benefits.

The BCBSM plan that Milan Schools has purchased includes deductibles and co-payments which may not be your responsibility. This booklet describes the plan deductible and co-payments that you will be responsible for.

Please remember that D.R.S. Services will be paying the deductibles and co-payments as described in this booklet and that have been set forth by your employer, Milan Schools.

We hope you will find this information useful and will help you to have a better understanding of your benefits.

**If you have any questions, please direct them to : D.R.S. Services, Inc.
28104 Orchard Lake Rd., Ste. 140 Farmington Hills, MI 48334
(248) 539-8000 or 1-800-253-2688. Fax #(248) 539-8002.**

Claims Processor: Deneen Ferguson

**MILAN AREA SCHOOLS
COMMUNITY BLUE PPO PLAN #15**

**TOTAL PLAN DEDUCTIBLE AMOUNT:
\$2,500.00 Single/ \$5,000.00 for 2 Person or Family- IN
\$5,000.00 Single/ \$10,000.00 for 2 Person or Family-OUT**

**EMPLOYEE DEDUCTIBLES
IN-NETWORK**

\$ 50 Single/ \$ 100 2 Person or Family Deductible

**The Plan deductible paid at 100% by Milan Schools
except for certain benefits that the Employee will owe
The above deductible and 20% co-payment to a maximum
out-of-pocket co-pay of \$1000.00 Single/ \$2000.00 2 Person
or Family per Calendar year.**

OUT OF NETWORK

**\$ 250.00 Single/ \$500.00 2 Person or Family Deductible
Then employee pays 40% co-payment to a maximum out-
of-pocket co-pay of \$2000.00 Single/ \$4000.00
2 Person or Family per Calendar year.**

**OFFICE VISIT CO-PAYS WILL BE \$ 40.00 per Visit .
(DRS will reimburse you \$20.00 for each office visit,
please send paid receipt to DRS Services.)**

**Emergency Room co pay will be \$100.00, DRS will
Reimburse back to \$50.00.**

**Preventive Services –covered at 100% (No deductible)
if using an IN-Network provider.**

CLASS II – Secretaries

COMMUNITY BLUE PPO BENEFITS-AT-A-GLANCE Option 15

PREVENTIVE SERVICES	IN-NETWORK	OUT-OF-NETWORK
Health Maintenance Exam	Covered-100%, one per calendar year	Not Covered
Annual Gynecological Exam	Covered-100%, one per calendar year	Not Covered
Pap Smear Screening, Laboratory services only.	Covered-100%, one per calendar year	Not Covered
Well-Baby and Child Care	Covered-100% <ul style="list-style-type: none">• 6 visits per year through age 1• 2 visits per year age 2 through 3• 1 visit per year age 4 through 15	Not Covered
Immunizations	Covered-100%, up through age 16	Not Covered
Fecal Occult Blood Screening	Covered-100%, one per calendar year	Not Covered
Flexible Sigmoidoscopy Exam	Covered-100%, one per calendar year	Not Covered
Prostate Specific Antigen (PSA) Screening	Covered-100%, one per calendar year	Not Covered
Chemical Profile	Covered-100%, one per calendar year	Not Covered
Complete Blood Count	Covered-100%, one per calendar year	Not Covered
EKG	Covered-100%, one per calendar year	Not Covered
Urinalysis	Covered-100%, one per calendar year	Not Covered
Chest X-Ray	Covered-100%, one per calendar year	Not Covered
ROUTINE MAMMOGRAPHY		
Mammography	Covered-100% No Deductible or Co pay. One per calendar year	Covered-60% after deductible
COLONOSCOPY		
Routine or Medically Necessary	Covered 100% No Deductible or Co pay. Subsequent subject to deductible and co insurance	Covered-60% after deductible
PHYSICIAN OFFICE SERVICES		
Office Visits	Covered-\$ 40.00 Co-Pay (Reimbursed back to \$20.00)	Covered-60% after deductible, must be medically necessary
Out-Patient and Home Visits	Covered-80% after deductible	Covered-60% after deductible, must be medically necessary
Office Consultations	Covered-\$ 40.00 Co-Pay (Reimbursed back to \$20.00)	Covered-60% after deductible must be medically necessary
EMERGENCY MEDICAL CARE		
Hospital Emergency Room- approved diagnosis	Covered-\$100 co-pay, waived if admitted or for an accidental injury (Reimbursed back to \$50.00)	Covered-\$100 co-pay, waived if admitted or for an accidental injury
Physician's Office-approved Diagnosis	Covered-\$40.00 co-pay (Reimbursed back to \$20.00)	Covered-60% after deductible
Urgent Care Center	Covered-\$40.00 co-pay, waived if a medical emergency or accidental injury (Reimbursed back to \$20.00)	Covered-60% after deductible, waived if a medical emergency or accidental injury.
Ambulance Services-	Covered-80% after deductible	Covered-60% after deductible

	IN-NETWORK	OUT-OF-NETWORK
DIAGNOSTIC SERVICES		
Laboratory and Pathology Tests	Covered-100%	Covered-60% after deductible
Diagnostic Tests and X-Rays	Covered-100%	Covered-60% after deductible
Radiation Therapy	Covered-100%	Covered-60% after deductible
MATERNITY SERVICES PROVIDED BY A PHYSICIAN		
Pre-Natal and Post-Natal Care	Covered-100%	Covered-60% after deductible
Delivery and Nursery Care	Covered-100% after deductible	Covered-60% after deductible
HOSPITAL CARE		
Semi-Private Room, Inpatient	Covered-100%	Covered-60% after deductible
Physical care, General Nursing Care, Hospital Services and Supplies	Unlimited Days	Unlimited Days
In-Patient Consultations	Covered-100%	Covered-60% after deductible
Chemotherapy	Covered-100%	Covered-60% after deductible
ALTERNATIVES TO HOSPITAL CARE		
Skilled Nursing Care	Covered-80% after deductible Up to 120 days per calendar year	Covered-80% after deductible Up to 120 days per calendar year
Hospice Care	Covered-100%	Covered- 100%
Home Health Care	Covered-80% after deductible Unlimited visits	Covered-80% after deductible Unlimited visits
SURGICAL SERVICES		
Surgery, including all related surgical services, anesthesia and surgical assistance	Covered-100%	Covered-60% after deductible
Voluntary Sterilization	Covered-100%	Covered-60% after deductible
HUMAN ORGAN TRANSPLANTS		
Liver, Heart, Lung, Pancreas, and Heart-Lung	Covered-100% No deductible	Covered-60%
Bone Marrow	Covered-80% after deductible	Covered-60% after deductible
Kidney, Cornea and Skin	Covered-80% after deductible	Covered-60% after deductible
MENTAL HEALTH CARE AND SUBSTANCE ABUSE		
In-Patient Mental Health Care and Substance Abuse Care	Covered-100%	Covered-50% after deductible
Out-Patient Mental Health Care		
• Facility and Clinic	Covered-50% after deductible	Covered-50% after deductible
• Physician's Office	Covered-\$40.00 Office Visit co-pay (Reimbursed back to \$20.00)	Covered-50% after deductible
Out-Patient Substance Abuse Care	Covered-50% after deductible	Covered-50% after deductible

IN-NETWORK**OUT-OF-NETWORK****OTHER SERVICES**

Allergy Testing and Therapy
 Chiropractic Spinal Manipulation

 Out-Patient Physical, Speech and
 Occupational Therapy
 Durable Medical Equipment
 Prosthetic and Orthotic Appliances
 Private Duty Nursing

Covered-100%
 Covered-100%
 up to 24 visits per calendar year
 Covered-80% after deductible
 up to 60 visits per calendar year
 Covered-80% after deductible
 Covered-80% after deductible
 Covered-50% after deductible

Covered-60% after deductible
 Covered-60% after deductible
 up to 24 visits per calendar year
 Covered-60% after deductible
 up to 60 visits per calendar year
 Covered-60% after deductible
 Covered-60% after deductible
 Covered-50% after deductible

DEDUCTIBLE, COPAYS AND DOLLAR MAXIMUM**IN-NETWORK****OUT-OF-NETWORK****Employee Deductibles**

\$50 per member, \$100 family,
 For Certain services listed

\$250 per member, \$500 family,
 out-of-network deductible amounts
 also apply toward the in-network
 deductible

Plan Deductibles
 (Paid by Milan Area Schools)

\$2500 per member, \$5000 family

\$5000 per member, \$10000 family

Copays

- Fixed

\$40 for office visits and \$100 for
 Emergency room visits

\$100 for emergency room visits

- Percent

Employee pays 20% for certain services,
 And 50% for mental health care,
 Substance abuse care and private
 duty nursing. Milan pays 20% for
 certain other services.

40% for general services and 50%
 for mental health care, substance
 abuse care and private duty nursing.
 Services without a network are
 covered at the in-network level.

Copay Dollar Maximums

- Fixed
- Percent, excludes mental
 health care, substance abuse
 care and private duty nursing copays

None
 \$1000 per member, \$2000 family

None
 \$2000 per member, \$4000 family
 out-of-network copays also apply
 toward the in-network maximum

Dollar Maximums

None

PRESCRIPTION DRUG PROGRAM

Covered **SELF-INSURED**
 80% co-pay after Deductible
 Send receipts to DRS Services

Same

HOW TO FILE A MEDICAL CLAIM (PROCEDURES)

STEP 1) Have Provider of service (Your Doctor, Hospital, or Lab) submit claim(s) directly to Blue Cross - Blue Shield of Michigan

STEP 2) After you receive a billing from the provider of medical services, send it to DRS Services.

STEP 3) If you have already paid this bill, send a receipt to DRS Services, stating you have paid this bill. A reimbursement check will be issued to you directly.

STEP 4) DRS will issue ALL checks to the providers of the medical services, unless otherwise directed.

SEND ALL BILLS AND ANY OTHER CORRESPONDENCE, INCLUDING BLUE CROSS EXPLANATION OF BENEFITS (EOB) FORMS TO: D.R.S. SERVICES, INC.

IF YOU HAVE ANY QUESTIONS REGARDING YOUR BENEFITS OR HOW TO FILE CLAIM, PLEASE CALL OR SEND INFORMATION TO:

D.R.S. SERVICES, INC.

28104 ORCHARD LAKE RD., STE.140

FARMINGTON HILLS, MI 48334

#(248) 539-8000 OR 1-800-253-2688

Fax # (248) 539-8002



Deductible Reimbursement
Systems Services, Inc.
28104 Orchard Lake Rd. • Suite 140
Farmington Hills, MI 48334
Phone: (248) 539-8000
Fax: (248) 539-8002
Toll Free: 1-800-253-2688

PRESCRIPTION DRUG CLAIM FORM

EMPLOYEE NAME: _____

HOME ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PATIENT NAME: _____

EMPLOYER NAME: _____ GROUP NUMBER: _____

ATTACH PAID RECEIPTS HERE:

I acknowledge that I have received the above prescription(s) and have paid for them in full!

Employee Signature

Patient Signature

Date