

D.R.S. SERVICES, INC.

EMPLOYEE BROCHURE

FOR

HEALTH CARE BENEFITS

OF

MILAN AREA SCHOOLS

CLASS III – Custodians and Maintenance Employees
(002)

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

\$ 0 Single/ \$ 0 2 Person or Family Deductible

The Plan deductible paid at 100% by Milan Schools except for certain benefits that the Employee will owe 10% 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 III – Custodians and Maintenance Employees

COMMUNITY BLUE PPO BENEFITS-AT-A-GLANCE

Option 15

PREVENTIVE SERVICES

Health Maintenance Exam
Annual Gynecological Exam
Pap Smear Screening, Laboratory services only.
Well-Baby and Child Care

IN-NETWORK

Covered-100%, one per calendar year
Covered-100%, one per calendar year
Covered-100%, one per calendar year

OUT-OF-NETWORK

Not Covered
Not Covered
Not Covered

Immunizations

Fecal Occult Blood Screening
Flexible Sigmoidoscopy Exam
Prostate Specific Antigen (PSA) Screening
Chemical Profile
Complete Blood Count
EKG
Urinalysis
Chest X-Ray

Covered-100%
• 6 visits per year through age 1
• 2 visits per year age 2 through 3
• 1 visit per year age 4 through 15
Covered-100%, up through age 16
Covered-100%, one per calendar year
Covered-100%, one per calendar year
Covered-100%, one per calendar year

Not Covered
Not Covered
Not Covered
Not Covered

ROUTINE MAMMOGRAPHY

Mammography

Covered-100% No Deductible, No Co Pay. One Routine per Year.

Covered-60% after deductible

COLONOSCOPY

Routine or Medically Necessary

Covered-100% No Deductible, No 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-90%

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-90%

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%	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-100% 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-100% 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-90%	Covered-60% after deductible
Kidney, Cornea and Skin	Covered-90%	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-90%	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-90%	Covered-50% after deductible

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

Allergy Testing and Therapy
Chiropractic Spinal Manipulation

Covered-100%
Covered-100%
up to 24 visits per calendar year

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

Out-Patient Physical, Speech and
Occupational Therapy

Covered-100%
up to 60 visits per calendar year

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

Durable Medical Equipment
Prosthetic and Orthotic Appliances

Covered-90%
Covered-100%

Covered-60% after deductible
Covered-60% after deductible

Private Duty Nursing

Covered-90%

Covered-50% after deductible

DEDUCTIBLE, COPAYS AND DOLLAR MAXIMUM

Employee Deductibles

IN-NETWORK
\$0 per member, \$0 family,
waived if service is performed in
a PPO physician's office

OUT-OF-NETWORK
\$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 10% for general services,
Milan pays 10% as well for both,
and 10% mental health care,
substance abuse care and private
duty nursing.

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

Lifetime Maximum

None

PRESCRIPTION DRUG PROGRAM

Covered through BCBSM
\$10.00 co-pay for Generic,
\$60.00 co-pay for Brand -
Brand is reimbursed back to
\$10.00 through 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:

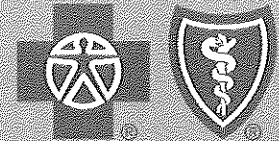
D.R.S. SERVICES, INC.

28104 ORCHARD LAKE RD., STE.140

FARMINGTON HILLS, MI 48334

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

Fax # (248) 539-8002



Blue Preferred[®] Rx Prescription Drug Coverage with \$10 Generic / \$60 Brand Name Fixed Dollar Copay Benefits-at-a-Glance for Milan Area Schools 007009580/0000, 0002

This is intended as an easy-to-read summary and provides only a general overview of your benefits. It is not a contract. Additional limitations and exclusions may apply. Payment amounts are based on BCBSM's approved amount, less any applicable deductible and/or copay. For a complete description of benefits, please see the applicable BCBSM certificates and riders if your group is underwritten or your summary plan description if your group is self-funded. If there is a discrepancy between this Benefits-at-a-Glance and any applicable plan document, the plan document will control.

Specialty Drugs – The mail order pharmacy for specialty drugs is Walgreens Specialty Pharmacy, LLC, an independent company. Specialty prescription drugs (such as Enbrel[®] and Humira[®]) are used to treat complex conditions such as rheumatoid arthritis. These drugs require special handling, administration or monitoring. Walgreens Specialty Pharmacy will handle mail order prescriptions only for specialty drugs while many retail pharmacies will continue to dispense specialty drugs (check with your local pharmacy for availability). Other mail order prescription medications can continue to be sent to Medco. (Medco is an independent company providing pharmacy benefit services for Blues members.) A list of specialty drugs is available on our Web site at bcbsm.com. Log in under "I am a Member." If you have any questions, please call Walgreens Specialty Pharmacy customer service at 1-866-515-1355.

BCBSM reserves the right to limit the initial quantity of select specialty drugs. Your copay will be reduced by one-half for this initial fill (15 days).

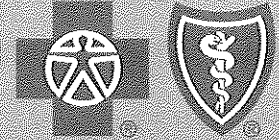
	Network pharmacy	Non-network pharmacy
Member's responsibility (copays)		
Generic drugs	\$10 copay	\$10 copay <i>plus</i> an additional 25% of BCBSM approved amount for the drug
Prescribed over-the-counter drugs – when covered by BCBSM Note: Over-the-counter (OTC) drugs are drugs that do not require a prescription under federal law.	\$10 copay	\$10 copay <i>plus</i> an additional 25% of BCBSM approved amount for the drug
Brand name drugs	\$60 copay	\$60 copay <i>plus</i> an additional 25% of BCBSM approved amount for the drug
Mail order (home delivery) prescription drugs	<ul style="list-style-type: none"> • \$10 copay for generic drugs • \$60 copay for brand name drugs 	No coverage

Note: If your prescription is filled by any type of network pharmacy, and you request the brand-name drug when a generic equivalent is available on the BCBSM MAC list and the prescriber has not indicated "Dispensed as Written" (DAW) on the prescription, you must pay the difference in cost between the brand-name drug dispensed and the maximum allowable cost for the generic *plus* the applicable copay.

Covered services		
FDA-approved drugs	100% of approved amount less plan copay	75% of approved amount less plan copay
Prescribed over-the-counter drugs – when covered by BCBSM	100% of approved amount less plan copay	75% of approved amount less plan copay
State-controlled drugs	100% of approved amount less plan copay	75% of approved amount less plan copay
Disposable needles and syringes – when dispensed with insulin or other covered injectable legend drugs Note: Needles and syringes have no copay.	100% of approved amount less plan copay for the insulin or other covered injectable legend drug	75% of approved amount less plan copay for the insulin or other covered injectable legend drug
Mail order (home delivery) prescription drugs – up to a 90-day supply of medication by mail from Medco (BCBSM network mail order provider)	100% of approved amount less plan copay	No coverage

Note: A network pharmacy is a Preferred Rx pharmacy in Michigan or a Medco pharmacy outside Michigan. Medco is an independent company providing pharmacy benefit services for Blues members. A non-network pharmacy is a pharmacy NOT in the Preferred Rx or Medco networks.

bcbsm.com



Blue Cross Blue Shield of Michigan is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

Features of your prescription drug plan

Drug Interchange and generic copay waiver	<p>Certain drugs may not be covered for a second prescription if a suitable alternate drug is identified by BCBSM, unless the prescribing physician demonstrates that the drug is medically necessary. A list of drugs that may require authorization is available at bcbsm.com.</p> <p>If your physician rewrites your prescription for the recommended generic or OTC alternate drug, you will only have to pay a generic copay. If your physician rewrites your prescription for the recommended brand-name alternate drug, you will have to pay a brand-name copay. In select cases BCBSM may waive the initial copay after your prescription has been rewritten. BCBSM will notify you if you are eligible for a waiver.</p>
Quantity limits	<p>Select drugs may have limitations related to quantity and doses allowed per prescription unless the prescribing physician obtains preauthorization from BCBSM. A list of these drugs is available at bcbsm.com.</p>

Additional riders

Rider PD-PT, preferred therapy	<p>A step-therapy approach that encourages physicians to prescribe generic, generic alternative or over-the-counter medications before prescribing a more expensive brand-name drug. It applies only to prescriptions being filed for the first time of a targeted medication.</p> <p>Before filling your initial prescription for select, high-cost, brand-name drugs, the pharmacy will contact your physician to suggest a generic alternative. A list of select brand-name drugs targeted for the preferred therapy program is available at bcbsm.com, along with the preferred medications.</p> <p>If our records indicate you have already tried the preferred medication(s), we will authorize the prescription. If we have no record of you trying the preferred medication(s), you may be liable for the entire cost of the brand-name drug unless you first try the preferred medication(s) or your physician obtains prior authorization from BCBSM. These provisions affect all targeted brand-name drugs, whether they are dispensed by a retail pharmacy or through a mail order provider.</p> <p>Note: Rider PD-PT is not compatible with Rider RXP.</p>
Rider RX-90, prescription drug 90-day supply	<p>Expands retail coverage of prescription drugs to include a 84 to 90-day supply of medication, subject to one copay (prescriptions with days supply between 31 and 83 days are not covered via retail). Requires all retail 90-day supplies of medication be obtained from a "90-Day Retail Network" provider.</p>
Rider CI, contraceptive injections Rider PCD, prescription contraceptive devices Rider PD-CM, prescription contraceptive medications	<p>Adds coverage for contraceptive injections, physician-prescribed contraceptive devices such as diaphragms and intrauterine devices, and FDA-approved oral, or self-injectable contraceptive medications as identified by BCBSM (non-self-administered drugs and devices are not covered).</p> <p>Note: These riders are only available as part of a prescription drug package.</p> <p>Riders CI and PCD are part of your medical-surgical coverage, subject to the same deductible and copay, if any, you pay for medical-surgical services. (Rider PCD waives the copay for services provided by a network provider.)</p> <p>Rider PD-CM is part of your prescription drug coverage, subject to the same copay you pay for prescription drugs.</p>

SUMMARY OF BENEFITS FOR DENTAL CARE

NO DEDUCTIBLE D.R.S. Services, Inc. pays reasonable charges for covered expenses with NO deductible.

CO-INSURANCE

CLASS I: Diagnostic services, preventive services, and palliative treatment are covered at 50% of reasonable charges.
(Preventive)

CLASS II: Restorative, endodontic, periodontic services, oral surgery, repairs, adjustments and relining of dentures and bridges and adjunctive general services are covered at 50% of reasonable charges.
(Basic)

CLASS III: Construction and replacement of dentures and bridges, prosthodontics (which include crowns) are covered at 50% of reasonable charges.
(Major)

CLASS IV: Orthodontic Services covered at 50% of reasonable charges up to age 19. Maximum \$ 500.00 per lifetime.

ANNUAL MAXIMUM Each member is entitled to maximum benefits of \$1000.00 every contract year.

Benefits are limited for certain items such as: oral exams, prophylaxis, full month x-rays, and fluoride treatment.

Benefits are excluded for such items as cosmetic treatment, oral hygiene training, dietary counseling, appliances to increase vertical dimension or restore occlusion.

REMEMBER: Dental is not part of Blue Cross Blue Shield plan. It is self-insured by Milan Area Schools.

All Dental bills should be submitted to: DRS Services, Inc.
28104 Orchard Lake Rd., Ste.140
Farmington Hills, MI 48334
#(248) 539-8000 or 1-800-253-2688

**D.R.S. SERVICES, INC.
SELF-FUNDED VISION
SCHEDULE OF BENEFITS**

For the following services:

Vision Examination

Optometrist	You pay \$6.50*
Ophthalmologist	You pay \$6.50*
(Refractions should be included in Exam)	

Lenses (pair)

Single Vision	You pay \$18.00*
Bifocal Lenses	
Trifocal Lenses	
Progressive Lenses	
Lenticular Lenses	

Frames

You pay amount over
retail value of \$65.00

Contact Lenses (pair, including exam fee)

Medically necessary	Covered up to ABL*
Cosmetic	Covered up to \$90.00
Disposable (1x Yearly)	Covered up to \$180.00

Lenses with Extras

(Photochromics, Sun or Gradient Tints, and tinted or Color Coated - Fees are adjusted accordingly)

Single Vision	Covered up to ABL*
Bifocal Lenses	Covered up to ABL*
Trifocal Lenses	Covered up to ABL*
Lenticular Lenses	Covered up to ABL*

(Transition Lenses)

Single Vision	Covered up to ABL*
Bifocal Lenses	Covered up to ABL*
Trifocal Lenses	Covered up to ABL*
Progressive Lenses	Covered up to ABL*

(Polaroid)

Single Vision	Covered up to ABL*
Bifocal Lenses	Covered up to ABL*
Trifocal Lenses	Covered up to ABL*
Lenticular Lenses	Covered up to ABL*
Oversize	Covered up to ABL*
Rimless	Covered up to ABL*

AntiReflective

Scratch Coat	Covered up to ABL*
UV Filter	Covered up to ABL*
High Index	Covered up to ABL*
Polycarbonate	Covered up to ABL*

Benefit Service Frequency

Vision Examination:	Once every 12 Months
Lenses:	Once every 12 Months
Frames:	Once every 12 Months

**REMEMBER: Vision is not part of Blue Cross- Blue Shield plan. It is self-insured by Milan Schools
ALL Vision bills should be submitted to: D.R.S. Services, Inc.**

*** - Benefits will be paid up to ABL (Approved Benefit Level) 90th percentile**



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

