

**D.R.S. SERVICES, INC.**

**EMPLOYEE BROCHURE**

**FOR**

**HEALTH CARE BENEFITS**

**OF**

**MILAN AREA SCHOOLS**

**CLASS II – Transportation (004)**

# **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 \$10.00 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 - Transportation

### 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"><li>• 6 visits per year through age 1</li><li>• 2 visits per year age 2 through 3</li><li>• 1 visit per year age 4 through 15</li></ul>	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
<b>ROUTINE MAMMOGRAPHY</b>		
Mammography	Covered-100% No Deductible or Co pay. One per calendar year	Covered-60% after deductible
<b>COLONOSCOPY</b>		
Routine or Medically Necessary	Covered 100% No Deductible or Co pay. Subsequent subject to deductible and co insurance	Covered-60% after deductible
<b>PHYSICIAN OFFICE SERVICES</b>		
Office Visits	Covered-\$ 40.00 Co-Pay (Reimbursed back to \$30.00)	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 \$30.00)	Covered-60% after deductible must be medically necessary
<b>EMERGENCY MEDICAL CARE</b>		
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 \$30.00)	Covered-60% after deductible
Urgent Care Center	Covered-\$40.00 co-pay, waived if a medical emergency or accidental injury (Reimbursed back to \$30.00)	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  
 Diagnostic Tests and X-Rays  
 Radiation Therapy

Covered-100 %  
 Covered-100 %  
 Covered-100 %

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

**MATERNITY SERVICES PROVIDED BY A PHYSICIAN**

Pre-Natal and Post-Natal Care  
 Delivery and Nursery Care

Covered-100 %  
 Covered-100 % after deductible

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

**HOSPITAL CARE**

Semi-Private Room, Inpatient  
 Physical care, General Nursing  
 Care, Hospital Services and  
 Supplies  
 In-Patient Consultations  
 Chemotherapy

Covered-100 %  
 Unlimited Days  
 Covered-100 %  
 Covered-100 %

Covered-60 % after deductible  
 Unlimited Days  
 Covered-60 % after deductible  
 Covered-60 % after deductible

**ALTERNATIVES TO HOSPITAL CARE**

Skilled Nursing Care

Covered-80 % after deductible  
 Up to 120 days per calendar year  
 Covered-100 %

Covered-80 % after deductible  
 Up to 120 days per calendar year  
 Covered- 100 %

Hospice Care

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  
 Voluntary Sterilization

Covered-100 %  
 Covered-100 %

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

**HUMAN ORGAN TRANSPLANTS**

Liver, Heart, Lung, Pancreas,  
 and Heart-Lung  
 Bone Marrow  
 Kidney, Cornea and Skin

Covered-100 % No deductible  
 Covered-80 % after deductible  
 Covered-80 % after deductible

Covered-60 %  
 Covered-60 % 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
- Physician's Office

Covered-50 % after deductible  
 Covered-50 % after deductible

Covered-50 % after deductible  
 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

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-80% after deductible  
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  
Private Duty Nursing

Covered-80% after deductible  
Covered-80% after deductible  
Covered-50% after deductible

Covered-60% after deductible  
Covered-60% after deductible  
Covered-50% after deductible

**DEDUCTIBLE, COPAYS AND DOLLAR MAXIMUM**

**Employee Deductibles**

**IN-NETWORK**  
\$50 per member, \$ 100 family,  
For Certain services listed

**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 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: \_\_\_\_\_

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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