



Rate Sheet
BIG RAPIDS PUBLIC SCHOOLS (TMI0545)



BIG RAPIDS PUBLIC SCHOOLS (TMI0545)		Jul 2009	Jul 2010	Change \$	Change %
<i>Divisions: ALL</i>		Rate	Rate		
MEDICAL / PRSC DRUG	1 Person	\$403.92	\$444.22	\$40.30	9.98%
	2 Person	\$893.26	\$1,021.49	\$128.23	14.36%
	Full Family	\$1,108.34	\$1,270.08	\$161.74	14.59%
WRAP ADMIN FEE	1 Person	\$23.56	\$34.00	\$10.44	44.31%
	2 Person	\$37.44	\$34.00	-\$3.44	-9.19%
	Full Family	\$43.35	\$34.00	-\$9.35	-21.57%
SELF FUNDED DENTAL	1 Person	\$4.25	\$4.25	\$0.00	0.00%
	2 Person	\$4.25	\$4.25	\$0.00	0.00%
	Full Family	\$4.25	\$4.25	\$0.00	0.00%
SELF FUNDED VISION	1 Person	\$1.97	\$2.06	\$0.09	4.57%
	2 Person	\$1.97	\$2.06	\$0.09	4.57%
	Full Family	\$1.97	\$2.06	\$0.09	4.57%

CMM WRAP
SCHEDULE OF BENEFITS
for
BIG RAPIDS PUBLIC SCHOOLS

BENEFITS	BENEFIT LEVELS
<i>Inpatient Hospital Services</i>	
Semi-private room, inpatient physician care, general nursing care, hospital services and supplies (365 days - renewed after 60 consecutive days out of the hospital)	Covered at 100%
Chemotherapy	Covered at 90% after deductible
Dialysis	Covered at 100%
<i>Outpatient Hospital Services</i>	
Surgery	Covered at 100%
Laboratory	Covered at 100%
X-rays	Covered at 100%
<i>Emergency Room Services</i>	
Accidental Injury	Covered at 100%
Medical Emergency - Life Threatening	Covered at 100%
Medical Non-Emergency	Covered at 90% after deductible
<i>Mental Health and Substance Abuse</i>	
Inpatient Mental Health Treatment (up to 60 days)	Covered at 100%
Inpatient Substance Abuse Treatment (up to state maximum)	Covered at 100%
Outpatient Mental Health Treatment (50 visits)	Covered at 90% after deductible
Outpatient Substance Abuse Treatment (up to state maximum)	Covered at 90% after deductible
<i>Dental Treatments</i>	
Multiple extractions (inpatient when hazardous medical conditions exist)	Covered at 100%
Accidental Injury	Covered at 90% after deductible
TMJ (appliance therapy)	Not Covered
<i>Nursing Care</i>	
Private Duty Nursing	Covered at 90% after deductible
Visiting Nurse	Covered at 100%
Home Health Care	Covered at 100%
Hospice	Covered at 100%
Convalescent Care (up to \$45; maximum of 365 days)	Covered at 90%

Surgeries

Cosmetic/Reconstructive	Covered at 100%
General Surgeries	Covered at 100%
Sterilizations	Covered at 100%
Technical Surgical Assistance	Covered at 100%
Anesthesia	Covered at 100%

Human Organ Transplants

Liver, Heart, Lung, Pancreas, and Heart-Lung (up to One Million Dollar maximum per transplant)	Covered at 100%
Kidney, Cornea, Skin and Bone Marrow	Covered at 100%

Cancer Screening/Preventative

Gynecological Exam	Covered at 100%
Pap Smear	Covered at 100%
Mammogram (age restrictions apply)	Covered at 100%
Sigmoidoscopy (age restrictions apply)	Covered at 100%
Fecal Occult Blood (age restrictions apply)	Covered at 100%
Well-Baby Care (newborn to 12 months - 4 visits)	Covered at 100%
Immunizations (newborn to 12 months)	Covered at 100%

Professional Services

Allergy (\$700 annual maximum)	Covered at 90% after deductible
Ambulance	Covered at 90% after deductible
Cardiac Rehabilitation	Not Covered
Chemotherapy	Covered at 90% after deductible
Chiropractic (38 visits annually)	Covered at 90% after deductible
Office Visits	Covered at 90% after deductible
Laboratory	Covered at 100%
Occupational Therapy	Covered at 90% after deductible
Outpatient Consultations	Covered at 90% after deductible
Outpatient Diabetes Management Program (ODPM)	Covered at 90% after deductible
Inpatient Consultations	Covered at 100%
Physical Therapy	Covered at 90% after deductible
Pre-Natal (billed with delivery)	Covered at 100%
Pre-Natal (billing without delivery)	Covered at 90% after deductible
Radiation Therapy	Covered at 90% after deductible
Radiology (including EKG)	Covered at 100%
Speech Therapy	Covered at 90% after deductible
Therapeutic Injections	Covered at 90% after deductible
Vision Therapy	Not Covered
Weight Loss Program (three year benefit period and \$700 maximum payable benefit)	Covered at 90% after deductible

Supplies and Services

Blood and Plasma	Covered at 90% after deductible
Durable Medical Equipment	Covered at 90% after deductible
Hearing Aids (one every three years)	Covered at 90% after deductible
Miscellaneous Appliances	Covered at 90% after deductible
Orthopedic Shoes (two pair annually)	Covered at 90% after deductible
Orthotics	Covered at 90% after deductible
Oxygen	Covered at 90% after deductible
Prosthetics	Covered at 90% after deductible
Supplies (colostomy, diabetic, etc.)	Covered at 90% after deductible

Prescription Drugs (Retail)

Copays:	(Per Prescription)
Generic (Formulary)	\$10.00
DAW	\$20.00
Multi Source	\$20.00
Singlesource	\$20.00
Mail Order	\$20.00 or \$40.00
Insulin, Needles, Syringes	\$10.00 or \$20.00
Oral Contraceptives	\$10.00 or \$20.00
Injectibles (excluding Insulin)	\$10.00 or \$20.00
Second Submission	For Single Subscribers the Board will pay \$ 5.00 per prescription up to a maximum of \$100. For Two Person and Full Family the Board will pay \$5.00 per prescription up to a maximum of \$200.

Deductibles and Copayments

Deductible (per Benefit Year)	\$100 per person / \$200 per family
Copayments	
* For Fixed (per service)	None
* For Percent (% of allowable charge)	10%
Out of Pocket Maximum	
* Fixed	\$1,000
* Percent, excludes mental health care, substance abuse and private duty nursing copayments	Not Applicable

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

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

Riders Included:

MHP - Eliminates annual and lifetime maximums for mental health care.

PATIENT OPTIONS, COST & REIMBURSEMENT SCHEDULE

When you use a:
For the following services:

PREFERRED PROVIDER

NON-PREFERRED PROVIDER

Vision Examination

Optometrist	You pay \$0.00	Limited to \$35.00 - you pay balance
Ophthalmologist	You pay \$0.00	Limited to \$45.00 - you pay balance

Lenses (pair)

Single Vision	You pay \$0.00	Limited to \$38.00 - you pay balance
Bifocal Lenses	You pay \$0.00	Limited to \$60.00 - you pay balance
Trifocal Lenses	You pay \$0.00	Limited to \$72.00 - you pay balance
Lenticular Lenses	You pay \$0.00	Limited to \$108.00 - you pay balance

Frames

You pay amount over retail value of \$80.00	You pay amount over retail value of \$66.00
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Contact Lenses (pair, including exam fee)

Medically necessary	Covered in full	Limited to \$200.00 - you pay balance
Cosmetic	Covered up to \$200.00 additional 20% off balance	Limited to \$150.00 - you pay balance

Lenses with Extras

Photochromics, Sun or Gradient Tints, and Tinted or Color-Coated		
Single Vision	Covered in full	Limited to \$42.00 - you pay balance
Bifocal Lenses	Covered in full	Limited to \$70.00 - you pay balance
Trifocal Lenses	Covered in full	Limited to \$84.00 - you pay balance
Lenticular Lenses	Covered in full	Limited to \$118.00 - you pay balance

Polaroid

Single Vision	Covered in full	Limited to \$56.00 - you pay balance
Bifocal Lenses	Covered in full	Limited to \$90.00 - you pay balance
Trifocal Lenses	Covered in full	Limited to \$110.00 - you pay balance
Lenticular Lenses	Covered in full	Limited to \$138.00 - you pay balance

Oversize

Covered in full	Included with above lens allowance You pay balance
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Rimless

Covered in full	Included with above lens allowance You pay balance
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In addition to the above, Preferred Providers have agreed to limit their charges for other options which are not covered by this Plan.

BENEFIT SERVICE FREQUENCY

Vision Examination:.....	Once every 12 Months from last date of service
Lenses:.....	Once every 12 Months from last date of service
Frames:.....	Once every 12 Months from last date of service

SELF FUNDED DENTAL
SCHEDULE OF BENEFITS

BIG RAPIDS PUBLIC SCHOOLS

Non-Certified and AFSCME Members
Effective September 1, 2003

Type I	Preventative Services		
	Percentage	100%
Type II	Restorative Services		
	Percentage	90%
Type III	Replacement Services		
	Percentage	90%
Type IV	Orthodontic Services (Applicable only for Covered Individuals under age 19)		
	Percentage	90%

Plan Maximums

Type I, II, and III Services:

Maximum Annual Benefit Per Covered Member \$1,000.00

Type IV Services:

Maximum Lifetime Benefit Per Covered Member \$1,500.00

Plan Modifications

The following Plan Modifications have been included:

Adult Flouride
Missing Tooth Waiver
5 Year Denture Waiver
Orthodontic Pre-Existing Waiver