

Section I

Introduction

It has always been the intent of Stark County Schools to provide its Employees with the most comprehensive health care plan available at a reasonable price.

In order to utilize your premium dollars to the best advantage and secure prompt, efficient claims service, Stark County Schools has elected to "Self-Fund" your health Plan and retain Medical Mutual Services of Cleveland, Ohio and AultCare to perform the necessary claims processing and administrative services.

Summary Plan Description

This booklet provides you with a "Summary Plan Description" of your new Health Benefit Plan.

You will notice that a brief description of your benefits is provided for your convenience. Should you have further or more detailed questions regarding the Plan, you are urged to contact your Plan Administrator.

Section II

Schedule of Benefits

Traditional Comprehensive Major Medical Schedule of Benefits (CMM)

(not available to new enrollees after 8/1/09)

Overall Lifetime Maximum Benefits.....	Unlimited
Calendar Year Deductible Amount (p.19)	
Individual.....	\$100.00
Family	\$200.00
Co-payment (after the deductible is satisfied) (p.20).....	80%
Calendar Year Maximum Out of Pocket Amount (p.20)	
Individual.....	\$500.00
Family	\$1,000.00
(maximum out of pocket excludes the deductible)	

After the deductible has been met, the following are considered a Covered Expense each calendar year:

- One Routine Pap Test
- One Routine Mammogram
- One Routine Prostate Screening
- \$1,000 Maximum for Well-Child Care (to age 9)
- Colon Cancer Screening

Outpatient Psychiatric Treatment (**not biologically based mental illness**)

Calendar Year Maximum 15 visits per year
(covered under medical after 7-1-2010)

Outpatient Substance Abuse Treatment (**not biologically based mental illness**)

Calendar Year Maximum 15 visits per year
(covered under medical after 7-1-2010)

Inpatient psychiatric and substance abuse care is limited to 31 days per calendar year. (covered under medical after 7-1-2010)

Biologically Based Mental Illness Services – Any applicable Deductible,

Coinsurance or Copayment corresponds to the type of service received and is payable on the same basis as any other illness.

Preferred Provider Organizations (PPO)

Schedule of Benefits

Overall Lifetime Maximum Benefits..... Unlimited

Calendar Year Deductible Amount

	In Network	Out of Network
Individual	\$100.00	\$200.00
Family	\$200.00	\$400.00

Calendar Year Out of Pocket Amount

	In Network	Out of Network
Individual	\$ 500.00	\$1,000.00
Family	\$1,000.00	\$2,000.00

Co-payment (after the deductible is satisfied) (p.20).....	In Network	Out of Network
	90%	80%

PREVENTIVE CARE

Routine Physical Exam	100% up to \$200 per calendar year	Not Covered
Routine GYN/Pap Exam	100%	Not Covered
(one per calendar year)		
Routine Mammography.....	100%	80% UCR**
(one per calendar year)		
Prostate Screening	100%	80% UCR**
Well Baby Care	100%	80% UCR**
(including immunizations up to 9 years of age)	(up to \$1,000 per calendar year)	

PHYSICIANS OFFICE

Allergy Testing/Injections.....	90%	80% UCR**
Visits for Illness	90%	80% UCR**
Emergency Care	90%	80% UCR**
Minor Surgery	90%	80% UCR**
Diagnostic Testing	90%	80% UCR**

	In Network	Out of Network
Speech/Occupational	90%	80% UCR**
Therapy (illness/injury related)		
Physician/Rehabilitative	90%	80% UCR**
Therapy (illness/injury related)		
Respiratory Therapy.....	90%	80% UCR**

AFFILIATES

Chiropractors	90%	80% UCR**
Podiatrists	90%	80% UCR**

MENTAL HEALTH (not biologically based mental illness)

Outpatient Psychotherapy.....	90%	80% UCR**
	(up to 30 visits per year)	(up to 15 visits per year)
(covered under medical after 7-1-2010)		

ALCOHOL/SUBSTANCE ABUSE

Outpatient Psychotherapy.....	90%	80% UCR**
	(up to 30 visits per calendar year)	(up to 15 visits per year)
(covered under medical after 7-1-2010)		

MENTAL HEALTH/ALCOHOL (not biologically based mental illness)/SUBSTANCE ABUSE

Inpatient Care	90%	80% UCR**
	(up to 45 days per calendar year)	(up to 31 days per calendar year)
(covered under medical after 7-1-2010)		

Routine Colonoscopy 90% 80% UCR**
(Age 50 – every 10 years)

Beginning at age 50, men and women who are at average risk for developing colorectal cancer should have 1 of the 5 screening options below:

- A fecal occult blood test (FOBT)* or fecal immunochemical test (FIT)* every year**, OR
- Flexible sigmoidoscopy every 5 years, OR

- An FOBT* or FIT* every year plus flexible sigmoidoscopy every 5 years**, OR

(Of these first 3 options, the combination of FOBT or FIT every year plus Flexible sigmoidoscopy every 5 years is preferable.)

- Double-contrast barium enema every 5 years**, OR
- Colonoscopy every 10 years

* For FOBT or FIT, the take-home multiple sample method should be used.

**Colonoscopy should be done if the FOBT or FIT shows blood in the stool, if sigmoidoscopy results show a polyp, or if double-contrast barium enema studies show anything abnormal. If possible, polyps should be removed during the colonoscopy.

****The level of benefits payable under these Plans depends upon whether you choose to obtain medical care from an In-Network or Out-of-Network Provider. The plan encourages you to utilize Network Providers in order to receive the highest level of benefits payable. Network Providers will not hold you responsible for amounts exceeding the negotiated amounts.**

Dental Expense Benefits

Calendar Year Deductible Amount

Individual (p.30)	\$25.00
Family (p.30).....	\$75.00

Co-payment (After Deductible Amount is Satisfied)

**Preventative and Diagnostic Services (p.31)	100% of R & C
Basic Restorative Services (p.31)	80% of R & C
Major Restorative Services (p.32)	80% of R & C
**Orthodontic Services (p.33)	60% of R & C

****The Dental Deductible amount is waived for Preventive and Diagnostic Services and Orthodontic Services**

Overall Calendar Year

Maximum Benefit (p.30) \$2,500.00 per person

Orthodontic Lifetime

Maximum Benefit (p.30) \$1,200.00 per person

Section III

Prescription Drug Expense Coverage

Your prescription drug benefit is administered by Caremark.

	Retail	Mail Order
When to use your benefit:	For immediate or short-term medications	For maintenance or long-term** medications
Where:	To locate a CVS Caremark participating retail network pharmacy in your area, simply click on "Find a Local Pharmacy" at www.caremark.com or call a Customer Care representative toll-free at 1-888-202-1654	Simply mail your original prescription and the mail service order form to CVS Caremark. Your medicines will be sent directly to a location of your choice.
Your Copay:	20% of the cost of the medication for generics and brand drugs without a generic. 100% of the cost of brand drugs if a generic is available. 100% of the cost of long-term** drugs that are filled at a retail pharmacy more than 2 times. You must present your I.D. number at the Caremark Pharmacy and may <u>not</u> submit a paper claim for primary coverage. Failure to do so will result in a 100% copay.	
Refill Limits:	One initial fill plus 1 refill for long-term medications**	
Days Supply:	34 Days	90 Days

**A long-term medicine is taken regularly for chronic conditions or long-term therapy. A few examples include medicines for managing high blood pressure, asthma, diabetes, or high cholesterol.