Youngstown City Schools
Traditional Vision Plan
Anthem Blue Cross/Blue Shield

Benefits	
Benefit Period	January 1st through December 31st
Dependent Age Limit	19 Dependent / 25 Student Removal upon Birthdate
Examinations	One per benefit period
Vision Examinations	$35 per exam
Frames	One Frame every 24 Months
Basic Frames	$30 per frame
Prescription Lenses	One Pair every 24 Months
Single Vision Lenses	$30 per pair
Bifocal Lenses	$30 per pair
Trifocal Lenses	$30 per pair
Progressive Lenses	$30 per pair
Lenticular Single Lenses	$30 per pair
Lenticular Bifocal Lenses	$30 per pair
Lenticular Trifocal Lenses	$30 per pair
Contacts In Lieu of Lenses	One Pair every 24 Months
Medically Necessary	$55 per pair
Cosmetic	$55 per pair

Disclaimer: This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate, and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the former shall

SCHEDULE OF BENEFITS

The Schedule of Benefits is a summary of the amount of benefits the Plan will pay when you receive Covered Services from a Provider. Please refer to the **Covered Services** section for a more complete explanation of the specific dental services covered by the Plan. All Covered Services are subject to the conditions, exclusions, limitations, terms and provisions of this Benefit Booklet including any attachments or riders.

Benefit Period	Calendar Year
Dependent Age Limit for all Dental Services	To the end of the month in which the child attains age 19; or to the end of the month in which the child attains age 25 if the child is enrolled as a full-time student at an accredited school or college
Deductible	
Per Person	$25
Per Family	$75

Note: Any amounts applied to the Deductible for expenses incurred during the last three months of the Benefit Period will be applied to the next Benefit Period's Deductible.

Annual Maximum per Member	$2,500
Orthodontic Lifetime Maximum (Does not apply to the Annual Maximum)	$1,787

Youngstown City Schools
Summary of Benefits
Modified Traditional Plan 7/1/09

Network Type	**Anthem - Blue Access PPO** *Hospital Only Network*	
Benefits	Network Facility / AND Professional Provider	Non-Network Facility Only
Benefit Period	January 1st through December 31st	
Dependent Age Limit	19 Dependents/ 25 Full-time Students; Removal upon End of Month	
Lifetime Maximum	$1,750,000	
Human Organ Transplant Maximum per Transplant	$1,000,000	
Benefit Period Deductible - Single/Family [1]	$50 / $100	
Coinsurance	90%	80%
Coinsurance Out-of-Pocket Maximum (Excluding Deductible) - Single/Family	$225 Per Covered Person	$2,000 Per Covered Person
Physician/Office Services		
Office Visit (Illness/Injury)	90% after deductible	
Urgent Care Facility Services	90% after deductible	
Allergy Testing	90% after deductible	80% after deductible
Allergy Treatments	90% after deductible	
Immunizations (tetanus toxoid, rabies vaccine, and meningococcal polysaccharide vaccine are covered services)	90% after deductible	
Voluntary Second Surgical Opinion	90% after deductible	
Preventive Services		
Routine OB/GYN Physical Exam in conjunction with PAP Test (One per benefit period)	90% after deductible	
Well Child Care Services including Exam and Immunizations (Birth to Age 9 - $500 maximum per benefit period)	90% after deductible	
Well Child Care Laboratory Tests - Birth to Age 9	90% after deductible	80% after deductible
Routine Mammogram (One per benefit period)	90% after deductible	80% after deductible
Routine PAP (One per benefit period)	90% after deductible	80% after deductible
Routine PSA Test	90% after deductible	80% after deductible
Routine Tuberculosis Tests	90% after deductible	80% after deductible
Routine Hearing Test & Evaluation	90% after deductible	80% after deductible
Outpatient Services		
Surgical Services	90% after deductible	80% after deductible
Diagnostic Services (X-rays, Lab & Medical tests)	90% after deductible	80% after deductible
Physical / Chiropractic / Occupational Therapy Facility and Professional (26 visits combined, then subject to Medical Review, per benefit period.)	90% after deductible	80% after deductible
Speech Therapy - Facility and Professional (10 visits per calendar year)	90% after deductible	80% after deductible
Cardiac Rehabilitation	90% after deductible	80% after deductible
Professional Medical/Surgical Services	90% after deductible	
Emergency use of an Emergency Room	90% after deductible	
Non-Emergency use of an Emergency Room	90% after deductible	
Inpatient Facility		
Semi-Private Room and Board	90% after deductible	80% after deductible
Inpatient Consultations	90% after deductible	
Maternity	90% after deductible	80% after deductible
Inpatient Newborn Care	90% after deductible	
Additional Services		
Ambulance (includes air if medically necessary)	90% after deductible	
Supplemental Accident Care (Limited to the first $300 of services received within 90 days after an accident)	First $300 covered at 100%, then	
Durable Medical Equipment	90% after deductible	80% after deductible
Home Healthcare	90% after deductible	80% after deductible
Hospice	90% after deductible	80% after deductible
Human Organ Transplants	90% after deductible	80% after deductible
Prescription Drug Deductibles & Injectble Insulin	90% after deductible	80% after deductible
Private Duty Nursing	90% after deductible	
Skilled Nursing Facility	90% after deductible	
Mental Health and Substance Abuse	90% after deductible	80% after deductible
Inpatient Mental Health and Substance Abuse Services.	100% up to 30 days then, 90% up to 60 days per benefit period	90% up to 30 days then, 80% up to 60 days per benefit period
Outpatient Mental Health Services	100% up to 5 visits then, 90% up to 23 visits per benefit period	90% up to 5 visits then, 80% up to 23 visits per benefit period
Outpatient Substance Abuse Services	100% up to 5 visits then, 90% up to 23 visits per benefit period	90% up to 5 visits then, 80% up to 23 visits per benefit period

[1] Three (3) month deductible carryover applies.

Disclaimer: This summary of benefits is intended to be a brief outline of coverage. The entire provisions of benefits and exclusions are contained in the Group Contract, Certificate, and Schedule of Benefits. In the event of a conflict between the Group Contract and this description, the terms of the Group Contract will prevail.

Youngstown City Schools
Summary of Benefits
PPO Plan 7/1/09

Network Type	**Anthem -Blue Access PPO** *Hospital & Physician Network*	
BASE BENEFITS	**Network**	**Non-Network**
Benefit Period	January 1st through December 31st	
Dependent Age Limit	19 Dependents/ 25 Full-time Students Removal upon End of Month	
Lifetime Maximum	$1,750,000	
Human Organ Transplant Maximum per Transplant	$1,000,000	
BASE Deductible - Single/Family	None	
BASE Coinsurance	100%	70%
BASE Coinsurance Out-of-Pocket Maximum (Excluding Deductible) - Single/Family	None	$2,000 Per Covered Person
Physician/Office Services		
Allergy Testing	100%	70%
Preventive Services		
Routine EKG, Chest X-ray, Comlete Blood Count, Comprehensive Metabolic Panel, Urinalysis (One each per benefit period)	100%	70%
Routine Mammogram (One per benefit period)	100%	70%
Routine PAP (One per benefit period)	100%	70%
Routine PSA Test	100%	70%
Routine Hearing Test & Evaluation	100%	70%
Outpatient Services		
Surgical Services	100%	70%
Diagnostic Services (X-rays, Lab & Medical tests)	100%	70%
Chemotheraphy (includes oral)	100%	70%
Dialysis Treatment	100%	70%
Radiation Treatment	100%	70%
Respiratory & Pulmonary Therapy	100%	70%
Emergency Accident Services within 48 hours of accident first treatment only	100%	
Emergency Medical Services	100%	
Supplemental Accident Benefit within 90 days of accident; $300 Maximum	100%	
Inpatient Facility		
Semi-Private Room and Board - includes Ancillaries (365 days per in-hospital benefit period; Limit combined with inpatient Mental health and Substance Abuse [1]	100%	70%
Inpatient Medical Care Visits (365 visits per in-hospital benefit period [1]	100%	70%
Maternity Services	100%	70%
Additional Services		
Ambulance (includes air if medically necessary)	100%	70%
Human Organ Transplant Services	100%	70%
Initial Newborn Exam	100%	70%
Voluntary 2nd Surgical Opinion	100%	70%
Mental Health and Substance Abuse		
Inpatient Mental Health and Substance Abuse Services (90 days per in-hospital benefit period; limit is combined with Semi-Private Room and Board) [1]	100% to 30 days, then 90% up to 60 days	70%
Outpatient Mental Health Services (5 visits per benefit period)	100%	70%
Outpatient Alcohol Abuse Services (5 visits per benefit period); Outpatient Drug Abuse Not Covered	100%	70%