

READING SCHOOL DISTRICT MANAGED CARE PLAN

**Summary Plan Description
As Revised and Restated
Effective January 1, 2009**

SCHEDULE OF MEDICAL BENEFITS

Maximum Lifetime Benefit for In-Network Medical Care	Unlimited
Maximum Lifetime Benefit for Out-of-Network Medical Care	\$1,000,000

--Non-Referred Care at a Non-Participating Provider will not be covered under this Plan--

	PPO	Non-Referred Care at a Par Provider	Comments
Calendar Year Deductible: Per Covered Person Per Family	\$250 N/A	\$1,000 N/A	Deductibles for PPO and Non-PPO accumulate to one another.
Benefit Percentage: Medical Plan Pays Covered Person Pays	90% 10%	60% 40%	
Out-of-Pocket Maximum: <i>(Including Deductible)</i> Per Covered Person Per Family	\$850 N/A	\$4,000 N/A	Out-of-Pocket Maximums for PPO and Non-PPO accumulate to one another.
<p>The charges for the following do not accrue to the Out-of-Pocket Maximum and are never reimbursed at 100% by the Plan:</p> <ul style="list-style-type: none"> • Mental Health Treatment & Substance Abuse Treatment • Cost Containment Penalties • Co-pays • Expenses incurred for Non-Covered Services 			

--Non-Referred Care at a Non-Participating Provider will not be covered under this Plan--

Benefits and Services	In-Network Plan Pays *Allowed Amount (After Deductible)	Non-Referred Care at a Par Provider Pays*UCR (After Deductible)	Comments
HOSPITAL BENEFIT			
Inpatient Hospital Services	90%	\$500 Co-pay per admission, then 60%	<i>Pre-notification required.</i> Benefit based on Semi-private room rate.
Outpatient Hospital	90%	60%	
Skilled Nursing Facility	90%	60%	<i>Pre-notification required.</i> Limited to 180 days per calendar year.
Inpatient Physical Rehabilitation	90%	60%	
Emergency Room	\$40 Co-pay, then 100% <i>(Deductible Waived)</i>	\$40 Co-pay, then 100% <i>(Deductible Waived)</i>	Co-pay is waived if admitted

Benefits and Services	In-Network Plan Pays *Allowed Amount (After Deductible)	Non-Referred Care at a Par Provider Pays*UCR (After Deductible)	Comments
MENTAL HEALTH & SUBSTANCE ABUSE BENEFITS			
Inpatient Mental Health Treatment	90%	60%	<i>Pre-notification required.</i> Limited to 30 days per calendar year.
Outpatient Mental Health Treatment	\$25 Co-pay, then 100% <i>(Deductible Waived)</i>	\$50 Co-pay, then 100% <i>(Deductible Waived)</i>	Limited to 60 visits per calendar year.
Inpatient Substance Abuse Treatment / Residential Care / Detoxification	90%	60%	<i>Pre-notification required.</i> Limited to 30 days per calendar year (detoxification limited to 7 days). Limited to 90 days per lifetime.
Outpatient Substance Abuse Treatment / Detoxification / Rehab	\$25 Co-pay, then 100% <i>(Deductible Waived)</i>	Not Covered	Limited to 60 visits per calendar year. Limited to 120 visits per lifetime.
Partial Hospitalization	90%	60%	<i>Two partial hospitalization days will apply as one inpatient day.</i>
MISCELLANEOUS SERVICES AND SUPPLIES			
Home Health Care	90%	60%	Limited to 100 visits per calendar year.
Hospice Care	90%	60%	Limited to \$2,500 per lifetime.
Ambulance Service	90%	60%	
Durable Medical Equipment	90%	60%	Limited to \$7,500 per calendar year.
Pre-Admission Testing	90%	60%	
Other Covered Expenses	90%	60%	
PROFESSIONAL SERVICES BENEFIT			
Physician's Visits			
• Office Visit	\$20 Co-pay, then 100% <i>(Deductible waived)</i>	60%	Office visit co-pay does not include other services rendered in the office.
• Inpatient Hospital Visit or Consultation	90%	60%	
• Allergy Treatment	90%	60%	
• Second Surgical Opinion	90%	60%	

Benefits and Services	In-Network Plan Pays *Allowed Amount (After Deductible)	Non-Referred Care at a Par Provider Pays*UCR (After Deductible)	Comments
PROFESSIONAL SERVICES BENEFIT (continued)			
Maternity <ul style="list-style-type: none"> • Obstetrical Care <i>Including pre/post natal care and delivery</i> • Newborn Care <i>Physician and hospital services</i> 	\$20 Co-pay, then 100% <i>(Deductible waived)</i>	60%	No coverage for a dependent daughter age 19 and over.
Surgical Services	90%	60%	Includes oral surgery for partial or boney impacted teeth.
Transplant Services	90%	60%	
Diagnostic X-ray & Laboratory	90%	60%	
REHABILITATION THERAPY			
Chiropractic Care	90%	60%	2 weeks of acute care following accident or injury where treatment sought within 1 week
Chemotherapy	90%	Not Covered	
Radiation Therapy	90%	60%	
Dialysis Treatment	90%	60%	
Speech Therapy	90%	60%	Limited to 60 visits per condition per lifetime.
Physical Therapy	90%	60%	Limited to 30 visits per calendar year. <i>Additional visits will be eligible upon recommendation from a Physician.</i>
Occupational Therapy	90%	60%	Limited to 60 visits per condition per lifetime.
PREVENTIVE CARE			
Well Child Care	\$20 Co-pay, then 100% <i>(Deductible Waived)</i>	Not Covered	As recommended up to the age of 2
Childhood Immunizations	100% <i>(Deductible Waived)</i>	Not Covered	Limited through age 24
Well Adult Care	\$20 Co-pay, then 100% <i>(Deductible Waived)</i>	Not Covered	Limited to an annual exam beginning at age 2.
Mammogram	100% <i>(Deductible Waived)</i>	Not Covered	Limited to one exam per calendar year beginning at age 40 unless recommended by a physician.

Benefits and Services	In-Network Plan Pays *Allowed Amount (After Deductible)	Non-Referred Care at a Par Provider Pays*UCR (After Deductible)	Comments
PREVENTIVE CARE (continued)			
GYN Exam	\$20 Co-pay, then 100% <i>(Deductible Waived)</i>	Not Covered	Limited to one per calendar year.
Pap Test	100% <i>(Deductible Waived)</i>	Not Covered	Limited to one per calendar year.
Prostate Blood Test	100% <i>(Deductible Waived)</i>	Not Covered	Limited to one test per calendar year beginning at age 50.
Colonoscopy	100% <i>(Deductible Waived)</i>	Not Covered	Limited to one every ten years beginning at age 50.
Fecal Occult Screening	100% <i>(Deductible Waived)</i>	Not Covered	

- Allowed amount - The Plan will consider the allowed amount designated by the Preferred Provider Organization.
- UCR -The Plan will consider the Usual, Customary and Reasonable amount of the services based on the geographic location of the provider of service.

SCHEDULE OF VISION BENEFITS

Benefits and Services	Plan Pays *UCR	Comments
Vision Care		
Exam	100% <i>(No Deductible)</i>	Exams are limited to one every two years.
Supplies	100% <i>(No Deductible)</i>	Supplies are limited to a one-time purchase every two years of a combined \$200 for glasses, frames and contact lenses.

* UCR -The Plan will consider the Usual, Customary and Reasonable amount of the services based on the geographic location of the provider of service.

SCHEDULE OF PRESCRIPTION DRUG BENEFITS

PRESCRIPTION DRUG BENEFITS (Available through a separate Pharmacy Benefit Manager)			
	Retail <i>30-day supply</i>	Mail-Order <i>90-day supply</i>	
Generic	\$5	\$10	Generic enforcement requires the use of generic equivalent when available, unless physician required.
Preferred Brand	\$20	\$30	
Non Preferred	\$35	\$50	

Members who are prescribed “maintenance drugs” shall be required to obtain the drugs through a mail order provider and pay the co-pays as set forth under the column entitled mail order. Should the member obtain “maintenance drugs” from a non-approved retail provider, the co-pay for such drugs shall be triple the co-pay as set forth above under the column entitled retail. The employer must have at least one approved local provider (such as CVS) where members can purchase 90 day supplies of “maintenance drugs” at the mail order co-pays.

SCHEDULE OF DENTAL BENEFITS

Members who elect to use an out of network dental provider will only receive reimbursement for the amount paid to United Concordia providers for the same procedure.

Calendar Year Maximum	
Class I, II, and III Expenses Combined	\$1,750
Lifetime Maximum	
Class IV Expenses Orthodontia	\$1,500
Calendar Year Deductible	
Classes I, II and III combined	None
Class IV	\$50 Per Person
Plan Payment Percent	
Class I-Preventive	100%
Class II-Basic	100%
Class III-Major	60%
Class IV-Orthodontia	50%

