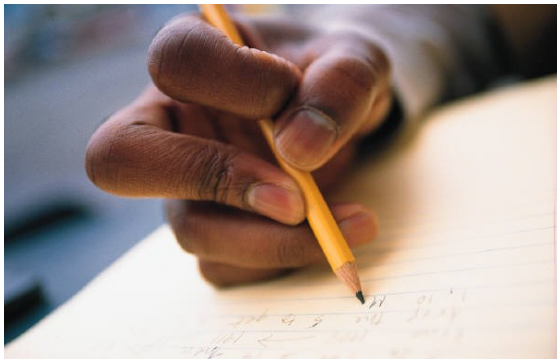
Benefits

Employee Guide 2012

Bartholomew Consolidated School Corporation
BCSC
A Learning Community Pursuing Excellence



SIHO INSURANCE SERVICES

INTRODUCTION

The Bartholomew Consolidated School Corporation administration, the health trust and teachers have worked with SIHO, your employee benefits administration company, to develop a benefits plan for you and your eligible dependents.

One of the advantages of SIHO is their focus on and attention to customer service. SIHO's helpful staff is ready to assist you with any questions or concerns you may have. Employees are encouraged to contact SIHO by phone at (812) 378-7070 or (800) 443-2980 toll free.

The local customer service staff includes:

- **Member Services**—Representatives who will help you understand your health care benefits and walk you through the claims process with phone and walk-in accessibility.
- **Medical Management**—Nurses are available on-site in Columbus to answer any medical questions you might have or to work with your physician to ensure you receive the highest quality health care.
- **Account Management**—These individuals work with your employer and claims representatives to help them improve the benefit program and to resolve any concerns during the contract period.

Though BCSC cannot avoid the impact of rising health care costs, we believe this health care plan will provide many advantages while living within the corporation's budget demands.

Advantages of the BCSC Plan:

- Two health plans - offering a choice in health care coverage
- Preventive health care coverage, with required educational meetings
- Copays for Retail and Mail Order prescription coverage
- Chiropractic Limit

Working Spouse Rule:

The purpose of the Working Spouse Rule is to share the costs of the medical, dental and vision expenses with other plans or insurance carriers when the spouse of an Employee is eligible for medical, dental and vision coverage where the spouse is employed. It is the Employer's responsibility to determine who is eligible for this coverage on a non-discriminatory basis.

1. If a spouse of an eligible Employee is employed with a company which offers group medical, dental and vision insurance coverage and that spouse is eligible for that plan, that spouse will not be eligible for this Plan.
2. If the spouse is employed with a company that does not offer group medical, dental and vision coverage and is eligible to be enrolled, the spouse may be enrolled in this Plan as primary at the family rate which is currently in effect. (A statement from the spouse's employer that verifies they have no coverage available with that employer will be required.)*

If an employee and spouse are found to be in violation of the provision, claims for the spouse will be the responsibility of the employee from the time the violation began.

**Note: Medicare does not count as an employer-sponsored plan for the purposes of this rule.*

TERMS IN THIS BENEFITS GUIDE

Copays – The flat fee charged by the plan for certain services such as emergency room visits or office visits. Copays do not apply to the annual deductible and do not count toward your out-of-pocket maximum.

Annual Deductible – The amount you pay first before the plan begins paying expenses for covered services.

Coinsurance Stop-Loss – The amount you pay each year in coinsurance before covered expenses are paid at 100% by the Plan. This amount does not include the annual deductible.

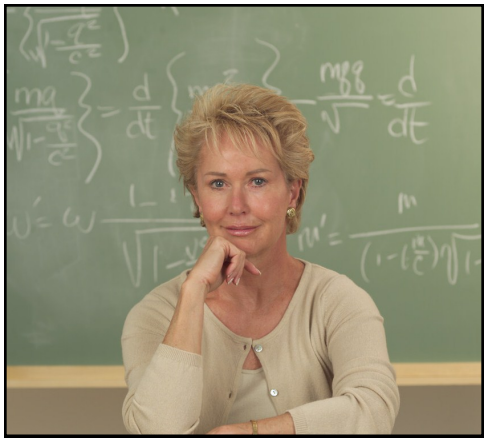
Coinsurance – The percentage you pay when you receive care once you have met the annual deductible.

Balance Billing – Provider practice of billing the patient for the difference (or balance) of charges above the amount reimbursed by the health plan. Your plan prohibits participating providers from balance billing except for allowed copayments, coinsurance and deductibles.

Reasonable & Customary – A payment rate based on the fees for medical services charged by health care providers in a specified area (usually a zip code or group of related zip codes).

Primary and Secondary Benefit Coverage (Benefit Less Benefit) – The integration of benefits payable under more than one health insurance plan that the insured may have. For BCSC members with health insurance coverage from more than one plan, the claim is processed with the primary carrier's benefit levels. In the event the primary benefit is less than secondary coverage, additional payment will be made to the claim.

Annual Max—Maximum payable under the employer's plan per person per calendar year.



Customer Service:

SIHO has customer service representatives available to answer your questions relating to eligibility, benefits and claim status. You can also log on to their website and click on *Contact Us* to reach a customer service representative.

Phone: 812-378-7070
Website: www.siho.org
Address: 417 Washington Street
P.O. Box 1787
Columbus, IN 47202-1787

To find out if your provider is part of the SIHO Network or to find a provider in the SIHO Network, call SIHO Customer Service or log on to the website to do a search: **www.siho.org**

SUMMARY OF HEALTH CARE BENEFITS

Your Plan Features	Option 1		Option 2	
	Network Provider	Out-of-Network Provider	Network Provider	Out-of-Network Provider
Annual Maximum	**$2,000,000**		**$2,000,000**	
Calendar Year Deductible Individual Family	$1,000 $2,000		$750 $1,500	
Calendar Year Coinsurance Stop Loss Maximum Individual Family	$4,000 $8,000		$2,000 $4,000	
Hospital Room, Services, Supplies	80% after deductible	60% after Deductible	90% after deductible	60% after Deductible
Inpatient Surgery	80% after deductible	60% after Deductible	90% after deductible	60% after Deductible
Emergency Room Facility Charges	$100 copay, then 80% after Deductible	$100 copay, then 60% after Deductible	$100 copay, then 80% after Deductible	$100 copay, then 60% after Deductible
Urgent Care	$40 copay, then 80% after Deductible	$40 copay, then 60% after Deductible	80% after deductible	60% after deductible
Outpatient Surgery	80% after deductible	60% after Deductible	90% after deductible	60% after Deductible
Office Visits	$20 copay, then 80% after deductible	$20 copay, then 60% after deductible	80% after deductible	60% after deductible
Preventive Health Benefit	100% covered-subject to Preventive Health Benefits Guidelines		100% covered-subject to Preventive Health Benefits Guidelines	
Diagnostic X-Ray and Lab	80% after deductible	60% after Deductible	80% after deductible	60% after Deductible
Ambulance	80% after deductible	60% after Deductible	80% after deductible	60% after Deductible

Note: This is only a brief description available under the plans. For a more detailed description of coverage, benefits, limitations and exclusions, please refer to the applicable certificate of coverage or the summary plan description.

SUMMARY OF HEALTH CARE BENEFITS

Your Plan Features	Option 1		Option 2	
	Network Provider	Out-of-Network Provider	Network Provider	Out-of-Network Provider
Inpatient Mental Health and Substance Abuse	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Outpatient Mental Health and Substance Abuse	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Physical, Speech & Occupational Therapy	80% after deductible	60% after deductible	80% after deductible	60% after deductible
Chiropractic Services	80% after deductible	60% after deductible	80% after deductible	60% after deductible
	Annual Maximum: 6 visits		Annual Maximum: 20 visits	
Durable Medical Equipment	80% after deductible	60% after deductible	80% after deductible	60% after deductible
	Precertification required for purchases over $200 and all rentals		Precertification required for purchases over $200 and all rentals	
Inpatient Hospice	80% after deductible	60% after deductible	90% after deductible	60% after deductible
	Precertification required; combined Calendar year maximum: 3 months outpatient; 6 months inpatient		Precertification required; combined Calendar year maximum: 3 months outpatient; 6 months inpatient	
Home Health Care Outpatient	80% after deductible	60% after deductible	90% after deductible	60% after deductible
	Precertification required; Annual max 60 visits		Precertification required; Annual max 60 visits	
Other Covered Benefits	80% after deductible	60% after deductible	80% after deductible	60% after deductible

Note: This is only a brief description available under the plans. For a more detailed description of coverage, benefits, limitations and exclusions, please refer to the applicable certificate of coverage or the summary plan description.

SUMMARY OF PRESCRIPTION DRUG COVERAGE

Your Plan Features*	Option 1		Option 2	
	Retail Service (30 day supply)	Mail Order Service (90 day supply)	Retail Service (30 day supply)	Mail Order Service (90 day supply)
Generic	$12	$24	$12	$24
Brand	$36	$60	$24	$48
Non Formulary Brand	$60	$100	$48	$80

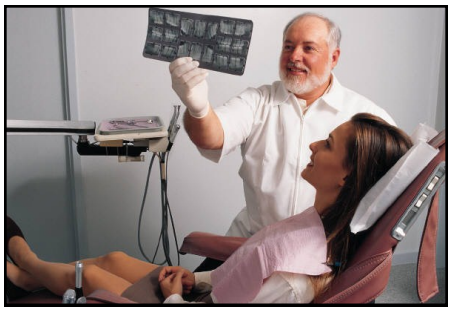
An important part of any medical plan is prescription drug coverage. You receive coverage for both generic and brand name drugs, but you pay less for brand name drugs that are a part of the plan's formulary, or preferred drug list. The plan's formulary drugs are chosen by the plan based on their quality, safety, and cost-effectiveness.

You also have the option to take advantage of the Mail Order Service program. By using the mail order program you can receive 90 days of medication for the price of 60 days of medication from the retail pharmacy. This saves you time and money.

*Effective January 1, 2012, pharmacy copays will no longer apply to your deductible or coinsurance.

SUMMARY OF DENTAL COVERAGE

Another advantage of the BCSC plan is dental coverage through Delta Dental. This plan includes a comprehensive dental plan that emphasizes preventive care, covering 100% of the preventive dental care, 80% of basic and major services and 60% of orthodontic services.



Please refer to the Delta Dental brochures for further details on benefits, limitations and procedures for obtaining benefits under the Plan. This coverage is not associated with the BCSC health insurance plan through SIHO. For benefit questions or to find a participating provider, call Delta Dental at (800) 524-0149 or go to their website at www.deltadentalin.com.

Here is an overview of some of the services and coverage you receive:

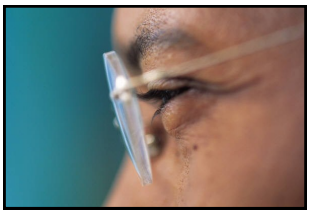
Annual Deductible Individual Family	 $50 $100
Maximum Annual Benefit per Person	$1,500
Maximum Lifetime benefit for Orthodontia	$1,000

Benefit	Participating Provider	Non-Participating Provider
Preventive / Diagnostic Services	100%, no deductible	90%, no deductible
Basic Services	80% after deductible	60% after deductible
Major Services	80% after deductible	60% after deductible
Orthodontia for Children under age of 19	60% after deductible	50% after deductible

SUMMARY OF VISION COVERAGE

Vision coverage through BCSC uses the VSP provider network and provides each covered employee and dependent with:

- One eye exam every 12 months
- One set of lenses every 24 months
- One pair of frames every 24 months
  OR One set of contact lenses every 24 months



Please refer to the Vision Service Plan brochures for further details on benefits, limitations and procedures for obtaining benefits under the Plan. This coverage is not associated with the BCSC health insurance plan with SIHO. For benefit questions or to find a participating provider, call VSP at (800) 877-7195 or go to their website at www.vsp.com.

Your Plan Features	You Coverage from a VSP Doctor	Additional Details
Exam Copay	$10 copay Covered in Full after copay (Every 12 months)	
Prescription Glasses	$15 copay Covered in Full after copay (Every 24 months) Lenses covered in full (every 24 months) Frames covered in full (every 24 months)	Lenses: • Single vision, lined bifocal and lined trifocal lenses • Photochromic and Tinted lenses • Polycarbonate lenses for dependent children Frames: • Frame of your choice up to $120 • 20% off any out of pocket costs
Contact Lenses	No copay (every 24 months)	When selecting contacts instead of glasses, $120 allowance applies to cost of contacts and contact lens exam

VSP also offers extra discounts and savings on: laser vision correction; 20% savings on lens extras (such as scratch resistance and anti-reflective coatings and progressives); 20% off additional prescription glasses and sunglasses*; and 15% off a contact lens exam, when using the same VSP doctor who provided you eye exam in the last 12 months.

YOUR COST FOR COVERAGE

Your cost for **medical coverage** is based upon the plan you choose an your level of coverage. The following table shows your contribution for each plan:

Employee Premiums	Option 1	Option 2
Individual Coverage		
26 pay periods	$40.07	$61.09
20 pay periods	$52.09	$79.42
Family Coverage		
26 pay periods	$107.03	$150.59
20 pay periods	$139.14	$195.77

The following table shows your contribution for **dental coverage**:

Employee Premiums	Certified (26 pay periods)	Support/ Technology (26 pay periods)	Support/ Custodians (26 pay periods)	Support/ Adm. Assistants (20+ pay periods)	Support (9 month employees)
Individual Coverage	$6.10	$10.67	$12.21	$13.87	$15.87
Family Coverage	$17.31	$30.78	$34.63	$40.01	$45.02

We know the health care decisions you make are very important. You deserve all the information you need to make the right choices for you and your family. After reviewing this benefit guide, please feel free to contact Columbus SIHO Member Services at **(812) 378-7070** or **Toll Free (800) 443-2980** with any questions**.**

This brochure is for informational purposes only and it is not intended to serve as a legal interpretation of benefits. The entire provisions of benefits and exclusions are contained in the Summary Plan Description (SPD), Certificate and Schedule of Benefits. In the event of a conflict between the SPD and this Guide, the terms of the SPD will prevail.

SIHO INSURANCE SERVICES

www.siho.org

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