BLACKWATER COMMUNITY SCHOOL
EMPLOYEE BENEFIT PLAN
PPO PLAN OPTION
PLAN AMENDMENT #2

Blackwater Community School hereby amends the Blackwater Community School Employee Benefit Plan PPO Plan Option, hereinafter referred to as "***Plan***", as it was previously adopted on October 1, 2015. This amendment shall be effective on July 1, 2016.

WHEREAS, Blackwater Community School elects to include a second benefit schedule within the PPO Plan Option for eligible ***employees*** to enroll for coverage.

- The current benefit schedule shall be named the PPO High Deductible Plan.
- The second benefit schedule shall be named the PPO Low Deductible Plan.
- The PPO Low Deductible Plan option shall have a ***preferred provider*** deductible of $500 for individual, and $1,000 for family.
- The ***nonpreferred provider*** deductible shall be $1,000 for individual, and $2,000 for family.
- The ***Plan's coinsurance*** for ***preferred provider covered expenses*** shall be seventy percent (70%), and the ***nonpreferred provider Plan coinsurance*** shall be fifty percent (50%).

Therefore, within the section titled, *Schedule of Benefits, Medical Benefits,* prior to the existing benefits schedule, the following heading shall be included:

PPO High Deductible Plan

Within the section titled, *Schedule of Benefits, Medical Benefits,* the following shall be inserted after the benefits schedule for the PPO High Deductible Plan:

BENEFIT DESCRIPTION & BENEFIT LIMITATION	PREFERRED PROVIDER	NONPREFERRED PROVIDER
The ***benefit year*** is January 1st through December 31st.	After the ***benefit year*** deductible is satisfied, the ***Plan*** shall pay the listed percentage of the ***negotiated rate.***	After the ***benefit year*** deductible is satisfied, the ***Plan*** shall pay the listed percentage of the ***customary and reasonable amount.***
Precertification Penalty Failure to obtain precertification for services requiring precertification shall result in a $300 penalty deductible applying to ***covered expenses*** first, then any applicable ***benefit year*** deductible, then the ***Plan's coinsurance*** applies. No benefits payable for transplants without precertification.		
Benefit Year **Deductible** Individual (Per Person) Family (Aggregate)	$500 $1,000	$1,000 $2,000
Out-of-Pocket Expense Limit Per *Benefit Year*: (includes medical and prescription ***copays*** and ***coinsurance***) Individual Family (Aggregate) Refer to *Medical Expense Benefit, **Benefit Year** Out-of-Pocket Expense Limit* for a listing of charges not applicable to the out-of-pocket expense limit.	$6,000 $12,000	$8,000 $16,000
Inpatient Hospital Precertification required.	70%	50%
Outpatient Hospital/Ambulatory Surgical Facility Specified procedures require precertification. See *Utilization Review.*	70%	50%
Ambulance Service	70% after ***PPO*** deductible	70% after ***PPO*** deductible.
Emergency Room Services	70% after ***PPO*** deductible	70% after ***PPO*** deductible
Physician's Services Home, Inpatient, Office Visit Surgery - Physician's Office Surgery - Other Pathology Anesthesiology Radiology	 70% 70% 70% 70% 70% 70%	 50% 50% 50% 50% 50% 50%
Extended Care Facility Precertification required. Limitation: 90 days ***maximum benefit*** per ***benefit year***	70%	50%
Home Health Care Precertification required.	70%	50%
Hospice Care Precertification required.	70%	50%
Durable Medical Equipment	70%	50%

BENEFIT DESCRIPTION & BENEFIT LIMITATION The ***benefit year*** is January 1st through December 31st.	PREFERRED PROVIDER After the ***benefit year*** deductible is satisfied, the ***Plan*** shall pay the listed percentage of the ***negotiated rate.***	NONPREFERRED PROVIDER After the ***benefit year*** deductible is satisfied, the ***Plan*** shall pay the listed percentage of the ***customary and reasonable amount.***

Preventive Care Services All preventive care services as recommended by the U.S. Preventive Services Task Force	100%; deductible waived	Not Covered
	For a complete listing, go to: www.healthcare.gov/coverage/preventive-care-benefits	
Pediatric Health Care	100%; deductible waived	Not Covered
	For a complete listing, go to: www.healthcare.gov/coverage/preventive-care-benefits	
Immunizations	100%, deductible waived	Not Covered
	For a complete listing, go to: www.healthcare.gov/coverage/preventive-care-benefits	
Preventive Care: Well Woman Preventive Services Includes: Well Woman Visits; Screening for gestational diabetes; Human Papillomavirus testing; counseling for sexually transmitted infections; counseling & screening for human immune-deficiency virus; contraceptive methods & counseling; breast-feeding support, supplies and counseling; screening & counseling for interpersonal & domestic violence;	100%; deductible waived	Not Covered
	For a complete listing, go to: www.healthcare.gov/coverage/preventive-care-benefits	
Routine Mammogram	100%: deductible waived	50%: deductible waived
Mental & Nervous Disorders/Chemical Dependency ***Inpatient*** Services Precertification required	70%	50%
Outpatient Services	70%	50%
Therapy Services (Radiology, Chemotherapy, Dialysis)	70%	50%
Rehabilitative Services (Physical, Speech, Occupational)	70%; deductible waived The deductible is not waived for evaluations prior to therapy.	50%; deductible waived The deductible is not waived for evaluations prior to therapy.
	Limited to 20 visits per ***benefit year*** for ***outpatient*** physical and occupational therapy combined. Limited to 20 visits per ***benefit year*** for ***outpatient*** speech therapy. Additional benefits for services of a ***preferred provider*** that exceed the annual maximum may be available if determined to be ***medically necessary*** by the ***Utilization Review Organization.*** Such benefits shall be payable at 50% up to a maximum out-of-pocket expense of $500. After the maximum out-of-pocket has been reached, benefits shall be payable at 100%.	

BENEFIT DESCRIPTION & BENEFIT LIMITATION The ***benefit year*** is January 1st through December 31st.	PREFERRED PROVIDER After the ***benefit year*** deductible is satisfied, the ***Plan*** shall pay the listed percentage of the ***negotiated rate.***	NONPREFERRED PROVIDER After the ***benefit year*** deductible is satisfied, the ***Plan*** shall pay the listed percentage of the ***customary and reasonable amount***
Chiropractic Care Limitation: 20 visits ***maximum benefit*** per ***benefit year***	70%	50%
Prosthetics	70%	50%
Dental Injury	70%	70%
Transplants **Limited to $200 per day/$10,000 while covered by this Plan for travel and lodging with no deductible or coinsurance**	70%	50%
Temporomandibular Joint Dysfunction Limited to $1,000 ***maximum benefit*** while covered by this ***Plan.***	70%	50%
Diagnostic Testing, Lab and X-ray Services	70%	50%
Neuropsychological and Cognitive Testing Limited to 10 hours of testing per calendar year	70%	50%
Cataract Surgery Limited to $500 ***maximum benefit*** for initial pair of eyeglasses or contacts following surgery	70%	50%
Hearing Services and Devices Limited to $25,000 while covered by this ***Plan.***	70%	50%
All Other Covered Expenses	70%	50%

All remaining provisions shall prevail unless subsequently amended.

BY: Peggy Schiff DATE: April 28, 2016