Schedule of Benefits

Employer:	**Blue Springs R-IV School District**
ASA:	885527
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Schedule:	2A
Booklet Base:	2

For: Access Exclusive Provider Organization (EPO) Medical Plan-Core

Access Exclusive Provider Organization (EPO) Medical Plan

PLAN FEATURES	NETWORK

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care expenses are covered and to what extent. Consult your benefit booklet to determine exclusions and limitations related to the plan.

Plan Maximum Out of Pocket Limit includes coinsurance and copayments. Please refer to your benefit booklet for expenses that do not apply to the Out of Pocket Maximum.

Calendar Year Individual Maximum Out of Pocket Limit:

- For **network** expenses: $2,500

Calendar Year Family Maximum Out of Pocket Limit:

- For **network** expenses: $5,000

Lifetime Maximum Benefit per person	Unlimited

Payment Percentage listed in the Schedule below reflects the Plan Payment Percentage. This is the amount the Plan pays. You are responsible to pay any copayments, and the remaining payment percentage. You are responsible for full payment of any non-covered expenses you incur.

PLAN FEATURES	NETWORK
Routine Physical Exams Adults only. Includes coverage for immunizations	$40 exam **copay** then the plan pays 100%

Maximum exams per 24 consecutive month period		
Adult age 18 to 50	1 exam	
Maximum exams per 12 consecutive month period		
Adult age 50 and over	1 exam	

Well Child Exams Includes coverage for immunizations	$40 exam **copay** then the plan pays 100%	
Maximum exams per 24 consecutive month period		
Under age 2		
first 12 months of life	7 exams	
13th-24th months of life	2 exams	
Maximum exams per 12 consecutive month period		
For age 2 to 18	1 exam	

Routine Gynecological Exam	$40 exam **copay** then the plan pays 100%	
Maximum exams per Calendar Year	1 exam	

Hearing Exam	$40 exam **copay** then the plan pays 100%	
Maximum exams per 24 month period	1 exam	

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Routine Cancer Screening		
Routine Mammography For covered females age 40 and over	$40 test **copay** then the plan pays 100%	
Maximum tests per Calendar Year	1 test	

Prostate Specific Antigen Test For covered males age 40 and over	Payable in accordance with the type of expense incurred and the place where service is provided.
Maximum tests per Calendar Year	1 test
Routine Digital Rectal Exam For covered males age 40 and over	Payable in accordance with the type of expense incurred and the place where service is provided.
Maximum tests per Calendar Year	1 test
Routine Pap Smears	100%
Maximum tests per Calendar Year	1 test
Fecal Occult Blood Test	Payable in accordance with the type of expense incurred and the place where service is provided.
Maximum tests per Calendar Year	1 test
Sigmoidoscopy Age 50 and over	Payable in accordance with the type of expense incurred and the place where service is provided.
Maximum tests per 5 consecutive year period	1 test
Double Contrast Barium Enema (DCBE) Age 50 and over	Payable in accordance with the type of expense incurred and the place where service is provided.
Maximum tests per 5 consecutive year period	1 test
Colonoscopy age 50 and over	Payable in accordance with the type of expense incurred and the place where service is provided.

Maximum tests per 10 consecutive year period	1 test

PLAN FEATURES	NETWORK
Vision Care	
Eye Examinations (including refraction)	$40 exam **copay** then the plan pays 100%
Maximum Benefit per 24 consecutive month period	1 exam

PLAN FEATURES	NETWORK
Physician Services	
Office Visits to Primary Care Physician Office visits (non-surgical) to non-**specialist**	$40 visit **copay** then the plan pays 100%
Specialist Office Visits *All specialists except those specifically listed in this schedule.*	$40 visit **copay** then the plan pays 100%
Physician Office Visits-Surgery	$40 visit **copay** then the plan pays 100%
Physician Services for Inpatient Facility and Hospital Visits	80% per visit
Administration of Anesthesia	80% per procedure
Allergy Testing and Treatment	Payable in accordance with the type of expense incurred and the place where service is provided.
Allergy Injections	Payable in accordance with the type of expense incurred and the place where service is provided.
Immunizations when not part of the physical exam	100%
Prenatal Visits	Payable in accordance with the type of expense incurred and the place where service is provided.

PLAN FEATURES	NETWORK
Emergency Medical Services	
Hospital Emergency Facility	80% per visit
Non-Emergency Care in a Hospital Emergency Room	Not Covered
Urgent Care Services	
Urgent Medical Care *(at a non-hospital free standing facility)*	80%
Non-Urgent Use of Urgent Care Provider *(at a non-hospital free standing facility)*	Not Covered

PLAN FEATURES	NETWORK
Outpatient Diagnostic and Preoperative Testing	
Diagnostic and Preoperative Testing (except complex imaging services)	$40 per procedure
Complex Imaging Services	
Complex Imaging	$40 per test
Diagnostic Laboratory Testing	
Performed at a Hospital Outpatient Facility	$40 per procedure
Diagnostic X-Rays	
Diagnostic X-Rays (except Complex Imaging Services)	$40 per procedure

PLAN FEATURES	NETWORK
Outpatient Surgery	
Outpatient Surgery	80%

PLAN FEATURES	NETWORK
Inpatient Facility Expenses	
Birthing Center	Payable in accordance with the type of expense incurred and the place where service is provided.
Hospital Facility Expenses Room and Board (including maternity)	80%
Other than Room and Board	80%
Skilled Nursing Inpatient Facility	80%
Maximum Days per Calendar Year	100 days

PLAN FEATURES	NETWORK
Specialty Benefits	
Home Health Care(Outpatient)	100%
Maximum Visits per Calendar Year	120 visits
Hospice Benefits	
Hospice Care –Facility Expenses (Room & Board)	80% per admission
Hospice Care – Other Expenses during a stay	80% per admission
Maximum Benefit per lifetime	30 days
Hospice Outpatient Visits	80% per visit

PLAN FEATURES	NETWORK
Infertility Treatment	
Basic Infertility Expenses Coverage is for the diagnosis and treatment of the underlying medical condition causing the infertility only.	Payable in accordance with the type of expense incurred and the place where service is provided.

PLAN FEATURES	NETWORK
Inpatient Treatment of Mental Disorders	

Mental Disorder	80%
Maximum Benefit per Calendar Year	30 days

Outpatient Treatment Of Mental Disorders	
Mental Disorder	$40 per visit
Maximum Visits per Calendar Year	20 visits

PLAN FEATURES	**NETWORK**
Inpatient Treatment of Alcoholism and Substance Abuse	
Inpatient Treatment	80%
Maximum Days per Calendar Year	30 days
Outpatient Treatment of Alcoholism and Substance Abuse	
Outpatient Treatment	$40 per visit **copay**
Maximum Visits per Calendar Year	20 visits

Transplant Services Facility and Non-Facility Expenses

Your coverage will be considered in-network if provided at a participating Institutes of Excellence facility only. Your coverage will be considered out-of-network if it is not provided at an Institutes of Excellence facility.

PLAN FEATURES	**NETWORK (IOE Facility)**	**NETWORK (Non-IOE Facility)**	**OUT-OF-NETWORK**
Facility Expenses	80% per admission	Not Covered	Not Covered
Physician (including office visits)	80% per admission	Not Covered	Not Covered

PLAN FEATURES	**NETWORK**
Other Covered Health Expenses	
Ground, Air or Water Ambulance	100%
Durable Medical and Surgical Equipment	100% per item
Maximum Benefit per Calendar Year	$10,000

Prosthetic Devices	Payable in accordance with the type of expense incurred and the place where service is provided.

PLAN FEATURES	NETWORK
Oral and Maxillofacial Treatment (Medical in nature only - Mouth, Jaws and Teeth)	Payable in accordance with the type of expense incurred and the place where service is provided.

PLAN FEATURES	NETWORK
Outpatient Therapies	
Chemotherapy	80% per visit
Infusion Therapy	80% per visit
Radiation Therapy	80% per visit

PLAN FEATURES	NETWORK
****Short Term Outpatient Rehabilitation Therapies***	
Outpatient Physical, Occupational, and Speech Therapy	$40 per visit
Combined Physical, Occupational and Speech Therapy Maximum visits per Calendar Year ****Please refer to your benefit booklet regarding additional information on coverage for these services.***	60 visits

****Spinal Manipulation***	
****Please refer to your benefit booklet regarding additional information on coverage for these services.***	$40 per visit

Pharmacy Benefit

Copays/Deductibles

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK
Preferred Generic Prescription Drugs	
For each 30 day supply	$15
For more than a 30 day supply but less than a 91 day supply	$30
Preferred Brand-Name Prescription Drugs	
For each 30 day supply	$25
For more than a 30 day supply but less than a 91 day supply	$50
Non-Preferred Brand-Name Prescription Drugs	
For each 30 day supply	$40
For more than a 30 day supply but less than a 91 day supply	$80

Precertification and **step therapy** for certain **prescription drugs** is required. If **precertification** is not obtained, the **prescription drug** will not be covered.

Expense Provisions

The following provisions apply to your health expense plan.
This section describes cost sharing features, benefit maximums and other important provisions that apply to your Plan. The specific cost sharing features and the applicable dollar amounts or benefit percentages are contained in the attached health expense sections of this *Schedule of Benefits*.

This *Schedule of Benefits* replaces any *Schedule of Benefits* previously in effect under your plan of health benefits.

KEEP THIS SCHEDULE OF BENEFITS WITH YOUR BOOKLET.

Copayments and Benefit Provisions

Copayment, Copay
This is a specified dollar amount or percentage of the **negotiated charge** required to be paid by you at the time you receive a covered service from a **network provider**. It represents a portion of the applicable expense.

Payment Provisions

Payment Percentage

This is the percentage of your **covered expenses** that the plan pays and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as the "Plan Payment Percentage". Your plan will pay a percentage of the **covered expenses**, and you will be responsible for the rest of the costs. The payment percentage may vary by the type of expense. Refer to your *Schedule of Benefits* for payment percentage amounts for each covered benefit.

Payment/Maximum Out-of-Pocket Limit

The **Payment/Maximum Out-of-Pocket Limit** is the maximum amount you are responsible to pay for **covered expenses** during the Calendar Year. Once you satisfy the **Payment/Maximum Out-of-Pocket limit**, the plan will pay 100% of the **covered expenses** that apply toward the limit for the rest of the Calendar Year.

This plan has an Individual **Payment/Maximum Out-of-Pocket limit**. This means once the amount of eligible expenses you or your covered dependent have paid during the Calendar Year meets the individual **Payment/Maximum Out-of-Pocket limit**, the plan will pay 100% of **covered expenses** for the remainder of the Calendar Year for that person.

There is also a Family **Payment/Maximum Out-of-Pocket limit**. This means once the amount of eligible expenses you or your covered dependent have paid during the Calendar Year meets two times the individual **Payment/Maximum Out-of-Pocket Limit**, the plan will pay 100% of **covered expenses** for the remainder of the Calendar Year for all covered family members.

Expenses That Do Not Apply to Your Out-of-Pocket Limit

Certain covered expenses do not apply toward your plan **out-of-pocket** limit. These include:

- Charges over the **recognized charge**;
- Non-covered expenses;
- Expenses for non-emergency use of the emergency room;
- Expenses incurred for non-urgent use of an **urgent care provider**;
- Expenses that are not paid, or **precertification** benefit reductions because a required **precertification** for the service(s) or supply was not obtained from **Aetna**.
- Pharmacy copayments

Maximum Benefit Provisions

Lifetime Maximum Benefit

The most the plan will pay for covered expenses incurred by any one covered person during their lifetime is called the Lifetime Maximum Benefit.

General

This Schedule of Benefits replaces any similar Schedule of Benefits previously in effect under your plan of benefits. Requests for coverage other than that to which you are entitled in accordance with this Schedule of Benefits cannot be accepted. This Schedule is part of your Booklet and should be kept with your Booklet.