

# Schedule of Benefits

**Employer:** Blue Springs R-IV School District  
**ASA:** 885527  
**Issue Date:** December 8, 2008  
**Effective Date:** July 1, 2009  
**Schedule:** 2B  
**Booklet Base:** 2

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

## 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

<i>Lifetime Maximum Benefit per person</i>	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
<i>Routine Physical Exams</i>	\$25 exam <b>copay</b> then the plan pays
Adults only.	100%
Includes coverage for immunizations	

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

\$25 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***

\$25 exam **copay** then the plan pays 100%

Maximum exams per Calendar Year 1 exam

***Hearing Exam***

\$25 exam **copay** then the plan pays 100%

Maximum exams per 24 month period 1 exam

PLAN FEATURES	NETWORK
<b><i>Routine Cancer Screening</i></b>	
<b><i>Routine Mammography</i></b> For covered females age 40 and over	\$25 test <b>copay</b> then the plan pays 100%
Maximum tests per Calendar Year	1 test
<b><i>Prostate Specific Antigen Test</i></b> 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
<b><i>Routine Digital Rectal Exam</i></b> 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
<b><i>Routine Pap Smears</i></b>	100%
Maximum tests per Calendar Year	1 test
<b><i>Fecal Occult Blood Test</i></b>	Payable in accordance with the type of expense incurred and the place where service is provided.
Maximum tests per Calendar Year	1 test
<b><i>Sigmoidoscopy</i></b> 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

<b><i>Double Contrast Barium Enema</i></b> (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
---	--------

<b><i>Colonoscopy</i></b> 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
---------------	---------

<b><i>Vision Care</i></b>	
---------------------------	--

<b><i>Eye Examinations</i></b> (including refraction)	\$25 exam <b>copay</b> then the plan pays 100%
---	--

Maximum Benefit per 24 consecutive month period	1 exam
---	--------

PLAN FEATURES	NETWORK
---------------	---------

<b><i>Physician Services</i></b>	
----------------------------------	--

<b><i>Office Visits to Primary Care Physician</i></b> Office visits (non-surgical) to non-specialist	\$25 visit <b>copay</b> then the plan pays 100%
---	---

<b><i>Specialist Office Visits</i></b> <i>All specialists except those specifically listed in this schedule.</i>	\$25 visit <b>copay</b> then the plan pays 100%
---	---

<b><i>Physician Office Visits-Surgery</i></b>	\$25 visit <b>copay</b> then the plan pays 100%
---	---

<b><i>Physician Services for Inpatient Facility and Hospital Visits</i></b>	80% per visit
---	---------------

<b><i>Administration of Anesthesia</i></b>	80%
--	-----

<i>Allergy Testing and Treatment</i>	Payable in accordance with the type of expense incurred and the place where service is provided.
<i>Allergy Injections</i>	Payable in accordance with the type of expense incurred and the place where service is provided.
<i>Immunizations when not part of the physical exam</i>	100%
<i>Prenatal Visits</i>	Payable in accordance with the type of expense incurred and the place where service is provided.
<b>PLAN FEATURES</b>	<b>NETWORK</b>
<i>Emergency Medical Services</i>	
<i>Hospital Emergency Facility</i>	80% per visit
<i>Non-Emergency Care in a Hospital Emergency Room</i>	Not Covered
<i>Urgent Care Services</i>	
<i>Urgent Medical Care (at a non-hospital free standing facility)</i>	80%
<i>Non-Urgent Use of Urgent Care Provider (at a non-hospital free standing facility)</i>	Not Covered
<b>PLAN FEATURES</b>	<b>NETWORK</b>
<i>Outpatient Diagnostic and Preoperative Testing</i>	
<i>Diagnostic and Preoperative Testing (except complex imaging services)</i>	\$25 per procedure copay then the plan pays 100%

<b>Complex Imaging Services</b>	
<b>Complex Imaging</b>	\$25 per test then the plan pays 100%

<b>Diagnostic Laboratory Testing</b>	
<b>Performed at a Hospital</b>	\$25 per procedure then the plan
<b>Outpatient Facility</b>	pays 100%

<b>Diagnostic X-Rays</b>	
<b>Diagnostic X-Rays (except Complex Imaging Services)</b>	\$25 per procedure then the plan pays 100%

<b>PLAN FEATURES</b>	<b>NETWORK</b>
<b>Outpatient Surgery</b>	
<b>Outpatient Surgery</b>	80%

<b>PLAN FEATURES</b>	<b>NETWORK</b>
<b>Inpatient Facility Expenses</b>	
<b>Birthing Center</b>	Payable in accordance with the type of expense incurred and the place where service is provided.

<b>Hospital Facility Expenses</b>	80%
Room and Board (including maternity)	
Other than Room and Board	80%

<b>Skilled Nursing Inpatient Facility</b>	80%
---	-----

Maximum Days per Calendar Year	100 days
--------------------------------	----------

<b>PLAN FEATURES</b>	<b>NETWORK</b>
<b>Specialty Benefits</b>	
<b>Home Health Care(Outpatient)</b>	100% per visit

Maximum Visits per Calendar Year	120 visits
----------------------------------	------------

### ***Hospice Benefits***

<b><i>Hospice Care –Facility Expenses</i></b> (Room & Board)	80% per admission
<b><i>Hospice Care – Other Expenses during a stay</i></b>	80% per admission

Maximum Benefit per lifetime	30 days
------------------------------	---------

<b><i>Hospice Outpatient Visits</i></b>	80% per visit
---	---------------

### **PLAN FEATURES**

### **NETWORK**

#### ***Infertility Treatment***

<b><i>Basic Infertility Expenses</i></b> 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***

<b><i>Mental Disorder</i></b>	80%
-------------------------------	-----

Maximum Benefit per Calendar Year	30 days
-----------------------------------	---------

#### ***Outpatient Treatment Of Mental Disorders***

<b><i>Mental Disorder</i></b>	\$25 per visit then the plan pays 100%
-------------------------------	--

Maximum Visits per Calendar Year	20 visits
----------------------------------	-----------

### **PLAN FEATURES**

### **NETWORK**

#### ***Inpatient Treatment of Alcoholism and Substance Abuse***

<b><i>Inpatient Treatment</i></b>	80%
-----------------------------------	-----

Maximum Days per Calendar Year	30 days
--------------------------------	---------

#### ***Outpatient Treatment of Alcoholism and Substance Abuse***

<b><i>Outpatient Treatment</i></b>	\$25 per visit copay then the plan pays 100%
------------------------------------	--

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.

<b>PLAN FEATURES</b>	<b>NETWORK (IOE Facility)</b>	<b>NETWORK (Non-IOE Facility)</b>	<b>OUT-OF-NETWORK</b>
<i>Facility Expenses</i>	80% per admission	Not Covered	Not Covered
<i>Physician</i> (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
<b><i>*Short Term Outpatient Rehabilitation Therapies</i></b>	
<i>Outpatient Physical, Occupational, and Speech Therapy</i>	\$25 per visit
Combined Physical, Occupational and Speech Therapy Maximum visits per Calendar Year	60 visits
<i>*Please refer to your benefit booklet regarding additional information on coverage for these services.</i>	

<b><i>*Spinal Manipulation</i></b>	
	\$25 per visit
<i>*Please refer to your benefit booklet regarding additional information on coverage for these services.</i>	

**Pharmacy Benefit**

**Copays/Deductibles**

PER PRESCRIPTION COPAY/DEDUCTIBLE	NETWORK
<b><i>Preferred Generic Prescription Drugs</i></b>	
For each 30 day supply	\$10
For more than a 30 day supply but less than a 91 day supply	\$20
<b><i>Preferred Brand-Name Prescription Drugs</i></b>	
For each 30 day supply	\$20
For more than a 30 day supply but less than a 91 day supply	\$40
<b><i>Non-Preferred Brand-Name Prescription Drugs</i></b>	
For each 30 day supply	\$35
For more than a 30 day supply but less than a 91 day supply	\$70

**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.