

Schedule of Benefits

Employer: Blue Springs R-IV School District

ASA: 885527

Issue Date: December 8, 2008

Effective Date: July 1, 2009

Schedule: 3A

Booklet Base: 3

For: Aetna Choice POS II Buy UP Plan

Aetna Choice POS II Medical Plan

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 services are covered and to what extent. Consult your benefit booklet to determine exclusions and limitations related to this plan.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Calendar Year Deductible*		
Individual Deductible*	None	\$500
Family Deductible*	None	\$1,000

*Unless otherwise indicated, any applicable **deductible** must be met before benefits are paid.

Plan Maximum Out of Pocket Limit includes coinsurance, deductible 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: \$1,500.
- For **out-of-network** expenses: \$3,000.

Calendar Year Family Maximum Out of Pocket Limit:

- For **network** expenses: \$3,000.
- For **out-of-network** expenses: \$6,000.

Lifetime Maximum Benefit per person	Unlimited	\$1,000,000
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Payment Percentages listed in the Schedule below reflects the Plan Payment Percentage. This is the amount the Plan pays. You are responsible to pay any deductibles, copayments, and the remaining payment percentage. You are responsible for full payment of any non-covered expenses you incur.

Maximums for specific covered expenses, including visit, day and dollar maximums are combined maximums between network and out-of-network, unless specifically stated otherwise.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Wellness Benefit		
Routine Physical Exams Adults only. Includes coverage for immunizations.	\$30 exam copay then the plan pays 100%	60% per exam after Calendar Year deductible
Maximum Exams per 24 consecutive month period		
Adults age 18 to 50		1 exam
Maximum Exams per 12 consecutive month period		
Adults age 50 and over		1 exam
Well Child Exams Includes coverage for immunizations	\$30 exam copay then the plan pays 100%	60% per exam after Calendar Year deductible
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	\$30 exam copay then the plan pays 100%	60% per exam after Calendar Year deductible
Maximum exams per Calendar Year		1 exam

<i>Hearing Exam</i>	\$30 exam copay then the plan pays 100%	60% per exam after Calendar Year deductible
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Maximum exams per 24 month period	1 exam
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
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<i>Routine Cancer Screenings</i>		
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<i>Routine Mammography</i> For covered females age 40 and over.	\$30 test copay then the plan pays 100%	60% per test after Calendar Year deductible
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Maximum tests per Calendar Year	1 test
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<i>Prostate Specific Antigen Test</i> For covered males age 40 and over.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
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Maximum tests per Calendar Year	1 test
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<i>Routine Digital Rectal Exam</i> For covered males age 40 and over.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
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Maximum tests per Calendar Year	1 test
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<i>Routine Pap Smears</i>	100% per test	60% per test after Calendar Year deductible
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Maximum tests per Calendar Year	1 test
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<i>Fecal Occult Blood Test</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
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Maximum tests per Calendar Year	1 test
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<i>Sigmoidoscopy</i> Age 50 and over	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
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Maximum Tests per 5 consecutive year period	1 test
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<i>Double Contrast Barium Enema (DCBE)</i> Age 50 and over	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
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Maximum Tests per 5 consecutive year period	1 test
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<i>Colonoscopy</i> age 50 and over	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
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Maximum Tests per 10 consecutive year period	1 test
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Vision Care</i>		
<i>Eye Examinations</i> including refraction	\$30 exam copay then the plan pays 100%	60% per exam after Calendar Year deductible

Maximum Benefit per 24 consecutive month period	1 exam
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Physician Services</i>		
<i>Office Visits to Primary Care Physician</i> Office visits (non-surgical) to non-specialist	\$30 visit copay then the plan pays 100%	60% per visit after Calendar Year deductible
<i>Specialist Office Visits</i> <i>All Specialists except those specifically listed in this schedule.</i>	\$30 visit copay then the plan pays 100%	60% per visit after Calendar Year deductible

<i>Physician Office Visits-Surgery</i>		
<i>Physician</i>	\$30 visit copay then the plan pays 100%	60% per visit after Calendar Year deductible
<i>Specialist</i>	\$30 visit copay then the plan pays 100%	60% per visit after Calendar Year deductible
<i>Walk-In Clinics Non-Emergency Visit</i>		
	\$30 visit copay then the plan pays 100%	Not Covered
<i>Physician Services for Inpatient Facility and Hospital Visits</i>		
	90% per visit	60% per visit after Calendar Year deductible
<i>Administration of Anesthesia</i>		
	90% per procedure	60% per procedure after Calendar Year deductible
<i>Allergy Testing and Treatment</i>		
	Payable in accordance with the type of expense incurred and the place where service is provided.	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.	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>		
	90% per visit	60% per visit after Calendar Year deductible
<i>Prenatal Visits</i>		
	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Emergency Medical Services		
Hospital Emergency Facility	\$75 copay per visit then the plan pays 100%	\$75 copay per visit then the plan pays 100% after Calendar Year deductible
Non-Emergency Care in a Hospital Emergency Room	Not covered	Not covered

Important Notice:

A separate **hospital** emergency room **deductible** or **copay** applies for each visit to an emergency room for emergency care. If you are admitted to a **hospital** as an inpatient immediately following a visit to an emergency room, your deductible is waived.

Covered expenses that are applied to the emergency room **deductible** or **copay** cannot be applied to any other **deductible** or **copay** under your plan. Likewise, covered expenses that are applied to any of your plan's other **deductibles** or **copays** cannot be applied to the emergency room **deductible** or **copay**.

Urgent Care Services		
Urgent Medical Care <i>(at a non-hospital free standing facility)</i>	\$35 copay per visit then the plan pays 100%	60% after Calendar Year deductible
Non-Urgent Use of Urgent Care Provider <i>(at a non-hospital free standing facility)</i>	Not covered	Not covered

Important Notice:

A separate **urgent care copay** or **deductible** applies for each visit to an **urgent care provider** for **urgent care**. If you are admitted to a **hospital** as an inpatient immediately following a visit to an **urgent care provider**, this **copay/deductible** is waived.

Covered expenses that are applied to the **urgent care copay/deductible** cannot be applied to any other **copay/deductible** under your plan. Likewise, covered expenses that are applied to your plan's other **copays/deductibles** cannot be applied to the **urgent care copay/deductible**.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Diagnostic and Preoperative Testing		
Diagnostic and Preoperative Testing <i>(except complex imaging services)</i>	\$30 per procedure copay then the plan pays 100%	60% per procedure after Calendar Year deductible

Complex Imaging Services		
Complex Imaging	\$30 per test copay then the plan pays 100%	60% per test after Calendar Year deductible

Diagnostic Laboratory Testing		
Diagnostic Laboratory Testing	\$30 per procedure copay then the plan pays 100%	60% per procedure after Calendar Year deductible

Diagnostic X-Rays(except Complex Imaging Services)		
Diagnostic X-Rays	\$30 per procedure copay then the plan pays 100%	60% per procedure after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Surgery		
Outpatient Surgery	90% per procedure	60% per procedure after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Facility Expenses		
Birthing Center	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

Hospital Facility Expenses	90% per admission	60% per admission after Calendar Year deductible
Room and Board (including maternity)		
Other than Room and Board	90% per admission	60% per admission after Calendar Year deductible

Skilled Nursing Inpatient Facility	90% per admission	60% per admission after Calendar Year deductible
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Maximum Days per Calendar Year	100 days
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Specialty Benefits		
Home Health Care (Outpatient)	90% per visit	60% per visit after the Calendar Year deductible

Maximum Visits per Calendar Year	120 visits
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Private Duty Nursing (Outpatient)	90% per visit	60% per visit after the Calendar Year deductible
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Maximum Visit Limit per <i>Calendar Year</i>	70 Private Duty Nursing Shifts. Eight (8) hours equal one shift.	
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Hospice Benefits

Hospice Care - Facility Expenses (Room & Board)	90% per admission	60% per admission after Calendar Year deductible
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Hospice Care - Other Expenses during a stay	90% per admission	60% per admission after Calendar Year deductible
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Maximum Benefit per lifetime	30 days	
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Hospice Outpatient Visits	90% per visit	60% per visit after Calendar Year deductible
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PLAN FEATURES NETWORK OUT-OF-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.	Payable in accordance with the type of expense incurred and the place where service is provided.
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PLAN FEATURES NETWORK OUT-OF-NETWORK

Inpatient Treatment of Mental Disorders

Mental Disorders	90% per admission	60% per admission after the Calendar Year deductible
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Maximum Benefit per Calendar Year	30 days	
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Outpatient Treatment Of Mental Disorders

Mental Disorders	\$30 per visit copay then the plan pays 100%	60% per visit after the Calendar Year deductible
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Maximum Visits per Calendar Year	20 visits	
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Inpatient Treatment of Alcoholism and Substance Abuse</i>		
<i>Inpatient Treatment</i>	90% per admission	60% per admission after the Calendar Year deductible

Maximum Days per Calendar Year	30 days
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<i>Outpatient Treatment of Alcoholism and Substance Abuse</i>		
<i>Outpatient Treatment</i>	\$30 per visit copay then the plan pays 100%	60% per visit after the Calendar Year deductible

Maximum Visits per Calendar Year	20 visits
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Important Notice:
Both **network** and **out of network** alcoholism and substance abuse and mental illness treatment expenses accumulate toward any maximum shown above for alcoholism and substance abuse and mental illness treatment expenses.

Transplant Services Facility and Non-Facility Expenses
Your coverage will be considered 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
<i>Facility Expenses</i>	90% per admission	60% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible
<i>Physician Services</i> (including office visits)	90% per admission	60% per admission after Calendar Year deductible	60% per admission after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Other Covered Health Expenses</i>		

<i>Ground, Air or Water Ambulance</i>	100% per trip	60% per trip after Calendar Year deductible
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<i>Durable Medical and Surgical Equipment</i>	90% per item	60% per item after the Calendar Year deductible
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Maximum Benefit per Calendar Year	\$10,000
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<i>Prosthetic Devices</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Oral and Maxillofacial Treatment (Medical in nature only - Mouth, Jaws and Teeth)</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Outpatient Therapies</i>		
<i>Chemotherapy</i>	90% per visit	60% per visit after Calendar Year deductible
<i>Infusion Therapy</i>	90% per visit	60% per visit after Calendar Year deductible
<i>Radiation Therapy</i>	90% per visit	60% per visit after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>*Short Term Outpatient Rehabilitation Therapies</i>		
<i>Outpatient Physical, Occupational and Speech Therapy combined</i>	\$30 per visit copay then the plan pays 90%	60% per visit after the Calendar Year deductible

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>		

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
*Spinal Manipulation		
	\$30 per visit copay then the plan pays 90%	60% per visit after the Calendar Year deductible
<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	OUT-OF-NETWORK
<i>Preferred Generic Prescription Drugs</i>		
For each 30 day supply	\$15	Not Covered
For more than a 30 day supply but less than a 91 day supply	\$30	Not Covered
<i>Preferred Brand-Name Prescription Drugs</i>		
For each 30 day supply	\$25	Not Covered
For more than a 30 day supply but less than a 91 day supply	\$50	Not Covered
<i>Non-Preferred Brand-Name Prescription Drugs</i>		
For each 30 day supply	\$40	Not Covered
For more than a 30 day supply but less than a 91 day supply	\$80	Not Covered

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.

Deductible Provisions

Out-of-Network Calendar Year Deductible

This is an amount of **out-of-network covered expenses** incurred each Calendar Year for which no benefits will be paid. The **out-of-network** Calendar Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach the **out-of-network** Calendar Year **deductible**, the plan will begin to pay benefits for **covered expenses** for the rest of the Calendar Year.

Copayments and Benefit Deductible 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”. Once applicable **deductibles** have been met, 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. The **Payment/Maximum Out-of-Pocket Limit** applies to both network and out-of-network benefits.

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.

The **Payment/Maximum Out-of-Pocket Limit** applies to both network and out-of-network benefits. **Covered expenses** applied to the out-of-network **Payment/Maximum Out-of-Pocket limit** will be applied to satisfy the in-network **Payment/Maximum Out-of-Pocket limit** and **covered expenses** applied to the in-network **Payment/Maximum Out-of-Pocket limit** will be applied to satisfy the out-of-network **Payment/Maximum Out-of-Pocket limit**.

Expenses That Do Not Apply to Your Payment Limit

Certain covered expenses do not apply toward your plan payment 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.

The Lifetime Maximum Benefit applies to **network** and **out-of-network** expenses combined.

Precertification Benefit Reduction

The Booklet contains a complete description of the **precertification** program. Refer to the “Understanding Precertification” section for a list of services and supplies that require **precertification**.

Failure to precertify your **covered expenses** when required will result in a benefits reduction as follows:

- A \$400 benefit reduction will be applied separately to each type of expense.

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.