

Schedule of Benefits

Employer: Blue Springs R-IV School District

ASA: 885527

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Schedule: 4A

Booklet Base: 4

For: Aetna Choice POS II High Deductible Health 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 the plan.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Calendar Year Deductible*		
Individual Deductible*	\$2,500	\$3,000
Family Deductible*	\$5,000	\$6,000

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

Plan Maximum Out of Pocket Limit includes plan **deductible** and **all 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: \$3,500.
- For **out-of-network** expenses: \$4,000.

Calendar Year Family Maximum Out of Pocket Limit:

- For **network** expenses: \$7,000.
- For **out-of-network** expenses: \$8,000.

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

All Covered Expenses Are Subject To The Calendar Year Deductible Unless Otherwise Noted In The Schedule Below.

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.	100% per exam No deductible applies.	70% 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	100% per exam No deductible applies.	70% 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	100% per exam No deductible applies.	70% per exam after Calendar Year deductible
Maximum exams per Calendar Year		1 exam

Hearing Exam	100% per exam No deductible applies.	70% per exam after Calendar Year deductible
Maximum exams per 24 month period		1 exam
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Routine Cancer Screenings	No deductible applies.	
Routine Mammography For covered females age 40 and over.	100% per test No deductible applies.	70% per test after Calendar Year deductible
Maximum tests per Calendar Year		1 test
Prostate Specific Antigen Test For covered males age 40 and over.	100% per test No deductible applies.	70% per test after Calendar Year deductible
Maximum tests per Calendar Year		1 test
Routine Digital Rectal Exam For covered males age 40 and over.	100% per test No deductible applies.	70% per test after Calendar Year deductible
Maximum tests per Calendar Year		1 test
Routine Pap Smears	100% per test No deductible applies.	70% per test after Calendar Year deductible
Maximum tests per Calendar Year		1 test
Fecal Occult Blood Test	100% per test No deductible applies.	70% per test after Calendar Year deductible
Maximum tests per Calendar Year		1 test
Sigmoidoscopy Age 50 and over	100% per test No deductible applies.	70% per test after Calendar Year deductible
Maximum Tests per 5 consecutive year period		1 test

Double Contrast Barium Enema (DCBE) Age 50 and over	100% per test No deductible applies.	70% per test after Calendar Year deductible
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Maximum Tests per 5 consecutive year period	1 test
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Colonoscopy age 50 and over	100% per test No deductible applies.	70% per test after Calendar Year deductible
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Maximum Tests per 10 consecutive year period	1 test
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Vision Care		
Eye Examinations including refraction	100% per exam No deductible applies.	70% 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
Physician Services		
Office Visits to Primary Care Physician Office visits (non-surgical) to non-specialist	100% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible

Specialist Office Visits <i>All Specialists except those specifically listed in this schedule.</i>	100% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible
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Physician Office Visits-Surgery	100% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible
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<i>Physician Office Visits-Surgery</i>		
<i>Physician</i>	100% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible
<i>Specialist</i>	100% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible
<i>Walk-in Clinics Non-Emergency Visit</i>	100% per visit after Calendar Year deductible	Not Covered
<i>Physician Services for Inpatient Facility and Hospital Visits</i>	100% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible.
<i>Administration of Anesthesia</i>	100% per procedure after Calendar Year deductible	70% per procedure after Calendar Year deductible
<i>Allergy Testing and Treatment</i>	100% per procedure after Calendar Year deductible	70% per procedure after Calendar Year deductible
<i>Allergy Injections</i>	100% per procedure after Calendar Year deductible	70% per procedure after Calendar Year deductible
<i>Immunizations (when not part of the physical exam)</i>	100% per visit No deductible applies.	70% per visit after Calendar Year deductible
<i>Prenatal Visits</i>	100% per procedure after Calendar Year deductible	70% per procedure after Calendar Year deductible
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Emergency Medical Services</i>		
<i>Hospital Emergency Facility</i>	100% per visit after the Calendar Year deductible	70% per visit after the Calendar Year deductible
<i>Non-Emergency Care in a Hospital Emergency Room</i>	Not covered	Not covered

Urgent Care Services		
Urgent Medical Care <i>(at a non-hospital free standing facility)</i>	100% after Calendar Year deductible	70% after Calendar Year deductible
Non-Urgent Use of Urgent Care Provider <i>(at a non-hospital free standing facility)</i>	Not covered	Not covered
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Diagnostic and Preoperative Testing		
Diagnostic and Preoperative Testing <i>(except complex imaging services)</i>	100% per procedure after Calendar Year deductible	70% per procedure after Calendar Year deductible
Complex Imaging Services		
Complex Imaging	100% per test after Calendar Year deductible	70% per test after Calendar Year deductible
Diagnostic Laboratory Testing		
Diagnostic Laboratory Testing	100% per visit after Calendar Year deductible	70% per procedure after Calendar Year deductible
Diagnostic X-Rays (except Complex Imaging Services)		
Performed at a Hospital Outpatient Facility	100% per visit after Calendar Year deductible	70% per procedure after Calendar Year deductible
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Surgery		
Outpatient Surgery	100% per procedure after Calendar Year deductible	70% per procedure after Calendar Year deductible
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Facility Expenses		
Birth Center	100% per procedure after Calendar Year deductible	70% per procedure after Calendar Year deductible

<i>Hospital Facility Expenses</i>	100% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible
Room and Board (including maternity)		
Other than Room and Board	100% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible

<i>Skilled Nursing Inpatient Facility</i>	100% per admission after Calendar Year deductible	70% 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
<i>Specialty Benefits</i>		
<i>Home Health Care (Outpatient)</i>	100% per visit after the Calendar Year deductible	70% per visit after the Calendar Year deductible

Maximum Visits per Calendar Year	120 visits
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<i>Private Duty Nursing (Outpatient)</i>	100% per visit after the Calendar Year deductible	70% 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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<i>Hospice Benefits</i>		
<i>Hospice Care - Facility Expenses (Room & Board)</i>	100% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible
<i>Hospice Care - Other Expenses during a stay</i>	100% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible

Maximum Benefit per lifetime	30 days
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<i>Hospice Outpatient Visits</i>	100% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Infertility Treatment</i>		
<i>Basic Infertility Expenses</i> Coverage is for the diagnosis and treatment of the underlying medical condition causing the infertility only.	100% after Calendar Year deductible	70% after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Inpatient Treatment of Mental Disorders</i>		
<i>Mental Disorders</i>	100% per admission after the Calendar Year deductible	70% per admission after the Calendar Year deductible
Maximum Benefit per Calendar Year	30 days	

<i>Outpatient Treatment Of Mental Disorders</i>		
<i>Mental Disorders</i>	100% per visit after the Calendar Year deductible	70% per visit after the Calendar Year deductible
Maximum Visits per Calendar Year	20 visits	

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Inpatient Treatment of Alcoholism and Substance Abuse</i>		
<i>Inpatient Treatment</i>	100% per admission after the Calendar Year deductible	70% per admission after the Calendar Year deductible
Maximum Days per Calendar Year	30 days	

<i>Outpatient Treatment of Alcoholism and Substance Abuse</i>		
<i>Outpatient Treatment</i>	100% per visit after the Calendar Year deductible	70% per visit after the Calendar Year deductible
Maximum Visits per Calendar Year	20 visits	

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>	100% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible
<i>Physician Services</i> (including office visits)	100% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible	70% per admission after Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
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Other Covered Health Expenses

<i>Ground, Air or Water Ambulance</i>	100% per trip after Calendar Year deductible	70% per trip after Calendar Year deductible
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<i>Durable Medical and Surgical Equipment</i>	100% per item after the Calendar Year deductible	70% per item after the Calendar Year deductible
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Maximum Benefit per Calendar Year	\$10,000	\$10,000
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<i>Prosthetic Devices</i>	100% per item after the Calendar Year deductible	70% per item after the Calendar Year deductible
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Oral and Maxillofacial Treatment (Medical in nature only - Mouth, Jaws and Teeth)</i>	100% per item after the Calendar Year deductible	70% per item after the Calendar Year deductible

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
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Outpatient Therapies

<i>Chemotherapy</i>	100% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible
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<i>Infusion Therapy</i>	100% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible
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<i>Radiation Therapy</i>	100% per visit after Calendar Year deductible	70% per visit after Calendar Year deductible
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
*Short Term Outpatient Rehabilitation Therapies		
<i>Outpatient Physical, Occupational and Speech Therapy combined</i>	100% per visit after the Calendar Year deductible	70% per visit after the Calendar Year deductible

Combined Physical, Occupational and Speech Therapy Maximum visits per Calendar Year 60 visits

**Please refer to your benefit booklet regarding additional information on coverage for these services.*

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
*Spinal Manipulation		
	100% per visit after the Calendar Year deductible	70% per visit after the Calendar Year deductible
<i>*Please refer to your benefit booklet for additional information regarding coverage for these services.</i>		

Pharmacy Benefit

The full cost of the prescription is first applied to the calendar year deductible. Once the calendar year deductible has been met, the applicable copayment will apply.

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

Non-Preferred Brand-Name Prescription Drugs

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

Network Calendar Year Deductible

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

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.

Covered expenses applied to the **out-of-network deductible** will be applied to satisfy the **network deductible** and **covered expenses** applied to the **network deductible** will be applied to satisfy the **out-of-network deductible**.

Individual Deductible

The Individual **deductible** is the amount of **network** or **out of network covered expenses** you must incur in a Calendar Year before benefits are paid. For purposes of this Plan, an individual means a single covered person enrolled for self only coverage.

Family Deductible

The Family **deductible** is the amount of **network** or **out of network covered expenses** that you and your covered dependents must incur in a Calendar Year before benefits are paid during the Calendar Year for any family members. For purposes of this Plan, a family means a covered person enrolled with one or more dependents

Network Family Deductible Limit

When you incur **network covered expenses** that apply toward the **network** Calendar Year **deductibles** for you and each of your covered dependents these expenses will also count toward the **network** Calendar Year family **deductible** limit. Your **network** family **deductible** limit will be considered to be met for the rest of the Calendar Year once the combined **covered expenses** reach the **network** family **deductible** limit in a Calendar Year.

Out-of-Network Family Deductible Limit

When you incur **out-of-network covered expenses** that apply toward the **out-of-network** Calendar Year **deductibles** for you and each of your covered dependents these expenses will also count toward the **out-of-network** Calendar Year family **deductible** limit. Your **out-of-network** family **deductible** limit will be considered to be met for the rest of the Calendar Year once the combined **covered expenses** reach the **out-of-network** family **deductible** limit in a Calendar Year.

Covered expenses applied to the **out-of-network deductible** will be applied to satisfy the **network deductible** and **covered expenses** applied to the **network deductible** will be applied to satisfy the **out-of-network deductible**.

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

This plan has an Individual and Family **Payment/Maximum Out-of-Pocket Limit**. For purposes of the provision an individual means a person enrolled for self only coverage with no dependent coverage and a Family means a person enrolled with one or more dependents.

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.

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 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**;
- Certain other **covered expenses** (see list in the *Schedule of Benefits*), and
- Expenses that are not paid, or **precertification** benefit reductions because a required **precertification** for the service(s) or supply was not obtained from **Aetna**.

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.

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.