OLYMPIA CUSD # 16

SCHEDULE OF BENEFITS

Lifetime Maximum Benefits	**Preferred Provider/ Non-Preferred Provider**
Individual Lifetime Maximum Benefit	Unlimited
~~Substance Abuse Treatment (Combined – IP/OP, In-Net, OON)~~	~~$25,000 per member~~
Gastric Bypass/Lap Band Surgery	One per lifetime per member

The term "Lifetime" refers to the time a person is actually a Beneficiary of a welfare benefit plan sponsored by the Group and is not intended to suggest benefits beyond an individual's termination date.

Essential Health Benefits Maximum Benefits (September – August)	**Preferred Provider/ Non-Preferred Provider**
Essential Health Benefits Individual Medical Maximum	~~$2,000,000 per member~~ Unlimited

The following services do not apply to the Essential Health Benefit Maximum, and may be subject to a separate calendar year or lifetime maximum as noted: Temporomandibular Joint Syndrome (TMJ) treatment, spinal manipulations, and Substance Abuse treatment.

Calendar Year Maximum Benefits	
Home Health Care	100 days/visits combined
~~Mental Health Care/Substance Abuse Treatment~~	~~30 days/visits (IP/OP, In-Net, OON) combined~~
Spinal Manipulations	~~$300 per member~~ 24 visits per member
Temporomandibular Joint (TMJ) Disorder	$1000 per member
Non- Preferred Well Adult Care	$400 per member
Non-Preferred Well Child Care	$400 per member
Retail Prescription Drugs	Unlimited

The maximum benefits allowed for Preferred and Non-Preferred services are combined.

Plan Year Deductibles	**Preferred Provider/Non-Preferred Provider**
Employee	$500
Employee + 1	$1,000
Family Unit	$1,500

Deductibles apply to all covered services except emergency room treatment, gastric bypass and lap band surgery, Prescription Drugs, and the following services when received from a Preferred Provider: Hospital satellite urgent care clinic, office visits (exams only), and preventative services. A new Deductible will apply each Calendar Year. Each Individual must meet the Single Deductible in order for the Family Deductible to be met.

The Deductibles for Preferred and Non-Preferred services are combined.

Calendar Year Out-of-Pocket Maximum	**Preferred Provider**	**Non-Preferred Provider**
Employee	$1,000	$2,000
Employee + 1	$2,000	$6,000
Family Unit	$3,000	$6,000

All Deductible, Co-payments, and Coinsurance apply to the Out-of-Pocket Maximum. ~~Copays, Outpatient Mental Illness/Substance Abuse charges~~, Dental charges, Vision charges, Prescription Drug copays, Preauthorization Penalties, Non-Covered services and charges over the Usual, Customary and Reasonable (UCR) do not apply to the Out-of-Pocket Maximum.
There is no individual OOPM, unless Employee has elected Employee Only coverage. If the Employee has elected Employee + 1 coverage, the Employee + 1 OOPM applies to both persons and is cumulative. If the Employee has elected Family coverage, the Family OOPM applies to all family members combined and is cumulative.

The Out-of-Pocket Maximum for Preferred and Non-Preferred services are combined.

Preauthorization Penalty	Preferred Provider/ Non-Preferred Provider	
Failure to Preauthorize	Lesser of actual benefits payable or $1,000	Lesser of actual benefits payable or $1,000

Inpatient Services/Benefits	You Pay Preferred Provider	You Pay Non-Preferred Provider
Physician Services	10% coinsurance	30% coinsurance
Hospital Care	10% coinsurance	30% coinsurance
Inpatient Rehabilitation	10% coinsurance	30% coinsurance
Skilled Nursing Care (Limited to 120 days per Sickness or Injury).	10% coinsurance	30% coinsurance
Human Organ Transplant	10% coinsurance	30% coinsurance
Mental Health Care	10% coinsurance	30% coinsurance
Substance Abuse Treatment	10% coinsurance	30% coinsurance

Outpatient Services/Benefits		
Office Visit-Primary Care (exam only)	$20 copay	30% coinsurance
Office Visit-Specialty Care (exam only)	$20 copay	30% coinsurance
Routine Prenatal Care	Subject to Office Visit copay/Hospital Care Coinsurance	Subject to Office Visit copay/Hospital Care Coinsurance
Wellness Benefit Program- Be Healthy Wellness Program (Age 16 and over)	0% coinsurance (Deductible waived)	0% coinsurance up to $400 per calendar year, then deductible and 10% coinsurance
Well Child Care (Birth through age 15)	0% coinsurance (Deductible waived)	0% coinsurance up to $400 per calendar year, then deductible and 10% coinsurance
Routine Mammograms	0% coinsurance	30% coinsurance
Routine Colonoscopies	0% coinsurance	30% coinsurance
Routine Hearing Exams	$20 copay	Not Covered
Routine Eye Exams	Not Covered	Not Covered
Outpatient Surgery	10% coinsurance	30% coinsurance
Diagnostic Testing (X-rays and laboratory services)	10% coinsurance	30% coinsurance
Mental Health Care	$20 copay	30% coinsurance
Substance Abuse Treatment	$20 copay	30% coinsurance
Home Health Care/Home Infusion	10% coinsurance	30% coinsurance
Hospice Care	10% coinsurance	30% coinsurance

NOTES:

Outpatient Services/Benefits	You Pay Preferred Provider	You Pay Non-Preferred Provider
Rehabilitative Therapy Services (Occupational, speech and physical therapies)	10% coinsurance	30% coinsurance
Emergency Services (copay waived if admitted)	$100 copay, then 10% coinsurance	$100 copay, then 30% coinsurance
Ambulance Services (must be medically necessary)	20% coinsurance	20% coinsurance
Urgent Care	$20 copay	30% coinsurance
Durable Medical Equipment and Prosthetic Devices	10% coinsurance	30% coinsurance
TMJ Disorder	Subject to Office Visit copay/Hospital Care Coinsurance	Subject to Office Visit copay/Hospital Care Coinsurance
Chiropractic Services/~~Spinal Manipulations~~	20% coinsurance	20% coinsurance
Spinal Manipulations	$20 co-payment	$20 co-payment
Private Duty Nursing	10% coinsurance	30% coinsurance
Gastric Bypass Surgery	$5,000 copayment, then 10% coinsurance	$5,000 copayment, then 30% coinsurance
Lap Band Surgery	$2,500 copayment, then 10% coinsurance	$2,500 copayment, then 30% coinsurance
Autism Spectrum Disorder (Limited to the maximum benefit amount required by law.)	10% coinsurance	30% coinsurance
Retail Prescription Drugs (Limited to a maximum 30-day supply)	$10 Tier 1 $20 Tier 2 $40 Tier 3	Not covered
Mail-Order Prescription Drugs (Limited to a maximum 90-day supply)	$15 Tier 1 $30 Tier 2 $60 Tier 3	Not covered
Infertility Services	Not Covered	Not Covered
Specialty Prescription Drugs	10%	30% coinsurance
Other Covered Services	10% coinsurance	30% coinsurance

NOTES:

Retail and specialty prescription drugs may be prescribed by a Non-Preferred Provider but must be dispensed at a Preferred pharmacy or provided by a Preferred Provider.

Your Non-Preferred Provider Coinsurance is based on Usual, Customary and Reasonable (UCR) fees. In addition to the Coinsurance, you also pay any charges in excess of the UCR amount.

Preferred Provider Coinsurance, if any, is based on the allowed or discounted amount.

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DENTAL BENEFITS

Deductible	
Single	Not applicable
Family	Not applicable
Benefits	
Preventive Services	~~20%~~ 0% coinsurance
General Services	20% coinsurance
Major Services	20% coinsurance
Orthodontic Services (Limited to persons between the ages of 6 and 19)	50% coinsurance
Maximum Calendar Year Benefit (excluding Orthodontic Services)	$2,500
Maximum Lifetime Benefit for Orthodontic Services	$2,500

VISION BENEFITS

Maximum Calendar Year Benefit	$500 (Exams, frames, lenses and contact lenses combined)

Medical Exclusions

In addition to any limitations or exclusions stated elsewhere, no medical benefits are payable under this Plan for Expenses Incurred:

A. for charges which exceed the Reasonable and Customary charge for the service rendered or charges for which payment is not legally required;

B. for treatment paid for by any agency of the United States Government or any state or political subdivision, or provided by or in a Hospital operated by any agency of the United States Government or any state or political subdivision, unless the Covered Person or Covered Dependent is legally required to pay such charges;

C. for or in connection with:

1. Sickness or Injury for which the Covered Person or Covered Dependent is entitled to benefits under any workers' compensation law, employers' liability law or similar laws;

2. Hospital, surgical and medical services or supplies unless such expense is incurred upon the recommendation of a Physician for diagnosis or treatment of an Injury or Sickness;

3. Injury or Sickness arising out of war (declared or undeclared) or service in any military forces or civilian non-combatant unit serving with such forces;

4. Injury or Sickness sustained (i) during the voluntary participation in a riot or the commission of an illegal act or crime, or (ii) while under the influence of alcohol or other drug or controlled substance which is not prescribed by a Physician. For purposes of this section, a person shall be presumed to be under the influence of alcohol if his or her blood alcohol level equals or exceeds the limit for driving under the influence of alcohol as determined by the law of the state in which the Injury occurred. In addition, a person may be considered to be under the influence of alcohol or other drug or controlled substance if objective evidence suggests such condition, as determined pursuant to the reasonable exercise of discretion by the Plan Administrator. Expenses for the treatment of Substance Abuse as specified in this Plan are covered. This exclusion does not apply if the Injury or Sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

   The limitations of this section shall not apply unless there is a direct causal relationship between the activity described in (i) or (ii) and the Sickness or Injuries sustained;

5. services or supplies which constitute personal comfort or beautification items, television or telephone use, education or training, or expenses actually incurred by persons who are not Covered Persons or Covered Dependents;

6. cosmetic surgery, except for treatment necessitated by accidental Injury or for correction of a congenital malformation of a Dependent child;

7. services performed by any person who is a member of the Covered Person's or Covered Dependent's Immediate Family, or who normally resides in the Covered Person's or Covered Dependent's home;

8. suicide, attempted suicide or intentionally self-inflicted Injury or Sickness (to the extent allowed by law);

9. services, supplies or treatments not Medically Necessary for the diagnosis and/or treatment of an active Sickness or Injury; or charges for procedures, surgical or otherwise, which are specifically listed by the American Medical Association as having no medical value; or drugs not approved for use by the U.S. Food and Drug Administration;

10. charges incurred outside the United States if the Covered Person or Covered Dependent traveled to such a location for the sole purpose of obtaining medical services, drugs or supplies;

11. hospitalization when such confinement occurs primarily for physiotherapy, hydrotherapy, convalescent or rest care, or any routine physical examinations, immunizations or tests not connected with the actual Sickness or Injury, except as otherwise specified herein;

12. the purchase or fitting of eyeglasses, contact lenses, hearing aids or such similar aid devices except as otherwise specified herein. This exclusion shall not apply to the initial purchase of eyeglasses or contact lenses following cataract surgery;

13. replacement of cataract lenses when a prescription change is not required;

14. professional nursing services if rendered by other than a Registered Nurse or Licensed Practical Nurse, unless such care was vital as a safeguard of the Covered Person's or Covered Dependent's life, and unless such care is specifically listed as a benefit elsewhere in the Plan;

15. treatment of obesity and weight reduction by diet control, Surgery (except as otherwise specifically provided herein with prior authorization of Medical Necessity) or behavior modification with or without medication;

16. diagnosis or treatment of infertility, or restoration or enhancement of fertility, including, but not limited to, therapeutic injections, fertility and other drugs, Surgery, artificial insemination, in-vitro fertilization or surgical reversal of elective sterilization;

17. contraceptive medications, devices or appliances, including the administration of any contraceptive medication, unless Medically Necessary, except as otherwise specified;

18. IQ testing or educational testing;

19. vitamins or dietary supplements;

20. elective abortions, except where necessary to preserve the life of the mother;

21. housekeeping or custodial care;

22. weak, unstable or flat feet, or bunions, unless an open cutting operation is performed; or for treatment of corns, calluses or toenails, unless at least part of the nail root is removed; or purchase of orthopedic shoes or other devices for support of the feet;

23. enrollment in a health, athletic or similar club or weight loss, non-smoking or similar programs, except as otherwise specifically provided herein;

24. purchase or rental of supplies of common use such as: exercise cycles, air purifiers, air conditioners, water purifiers, hypoallergenic pillows or mattresses or waterbeds;

25. purchase or rental of: motorized transportation equipment, escalators or elevators, saunas, steam baths, swimming pools or blood pressure kits;

26. sex transformation and hormones related to such treatment;

27. chelation therapy;

28. Expenses Incurred for special education or training for learning disabilities;

29. radial keratotomy, keratoplasty or other eye Surgery to correct near- or far-sightedness;

30. Expenses Incurred for behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness;

31. any taxes or other assessments owed with respect to Expense Incurred for medical services (other than sales tax);

32. any limitations on benefits contained in the Schedule of Benefits; or

33. expenses denied by another health care plan or HMO for lack of pretreatment approval, improper claim filing procedures or lack of additional Physician opinions;

34. Viagra or other treatment for sexual impotence;

35. therapy, services or supplies for sexual dysfunction;

36. removal of benign moles, nevi or lesions;

37. otoplasty or blepharoplasty;

38. dental services except as provided herein;

39. court ordered treatment;

40. smoking cessation programs or medications;

41. hair prostheses (e.g., wigs and hairpieces);

42. admissions for back pain or hospital charges related to the removal of teeth unless approved in writing by the Utilization Manager;

43. Expenses Incurred for care, services or treatment required as a result of complications from a treatment not covered under the Plan;

44. services and supplies not specifically mentioned in the Plan.

D. for "experimental treatment" for a Covered Person or Covered Dependent. For the purpose of this section, a treatment or procedure shall be deemed an "experimental treatment" when the treatment or procedure involved is given that designation or a similar designation in connection with the administration of Medicare. In addition, a transplant procedure shall be deemed an "experimental treatment" if it is not one of the procedures specified in the Transplant Benefits section.

Dental Exclusions

No dental benefits will be provided under the Plann for:

a. dental services not ordered by a Physician or dentist;

b. dental services which do not meet the standards set by the American Dental Association;

c. dental services incurred due to loss or theft of dentures or bridges;

d. dental services obtained from a health department maintained by the Employer, a union, a trustee or a similar type of entity;

e. dental services obtained for cosmetic reasons, including altering or extracting and replacing sound teeth to change appearance;

f. the following items:

i. myofunctional therapy;

ii. athletic mouthguards;

iii. implants or bridges involving implants;

iv. oral hygiene, dietary, plaque control and other educational programs;

v. duplicate prosthetic appliances;

vi. porcelain veneered crowns or pontics placed on or in place of a tooth behind the second bicuspid, to the extent the charges would be more than the charges that would have been a Covered Dental Charge for acrylic veneered crowns or onlays;

vii. the placement of crowns, inlays, bridges or dentures, or the relining of dentures more than once in a consecutive five (5) year period for the same teeth or missing teeth;

viii. dental work of a cosmetic nature, including altering or extracting and replacing sound teeth to change appearance;

ix. charges for failure to keep a scheduled visit with a dentist;

x. maintenance items such as, but not limited to, toothpaste, toothbrushes, floss, polishing paste, soaking solutions;

xi. travel to and from the dentist.

xii. expenses not specifically listed as covered.

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Precertification required on:

- All inpatient surgeries/procedures and admissions
- Acute hospitalization
- Acute rehabilitation
- Hospice
- All potential organ transplants
- Bariatric Surgery
- Emergency admissions (within 48 hours of admission)

Failure to notify the Utilization Administrator or failure to follow the instructions of the Utilization Review Administrator following notification will result in a penalty in the form of a reduction in benefits otherwise computed. The reduction shall be the lesser of (i) actual benefits available under the Plan, or (ii) $1,000.

Pre-determination for Medical Necessity is recommended prior to receiving the following outpatient procedures/services:

Surgical

1. Mammoplasty
2. Mandibular Reconstruction, Osteotomy/Jaw Surgery
3. Maxillary Osteotomy, Orthognathic Surgery
4. Rhinoplasty
5. Septoplasty
6. Uvulopalatopharyngoplasty/Uvulectomy (UPPP)
7. Uvulapalatogoplasty, laser assisted (LAUP)
8. Varicose veins
9. Tonsillectomy for adults 18 and over

Diagnostic

1. All ongoing injectable medication treatment plans greater than $100 (e.g., growth hormones, Epogen®, Neupogen®, BetaSeron®, Lupron®)
2. PET scans
3. Infusion IV/intravenous therapy
4. Pulmonary rehabilitation
5. Durable Medical Equipment greater than $1,000 (e.g., oxygen equipment, CPAP concentrators)
6. Hospice
7. Home Health Care and Services

In the event of an Emergency Admission, the Utilization Review Administrator must be notified within forty-eight (48) hours of admission.