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Ashland School District
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2018 Benefits Summary

Ashland School District		
	In-Network	**Out-of-Network**
Deductible		
Individual	$300	$600
Family	$900	$1,800
Medical and Pharmacy Out-of-Pocket Maximums (includes copays and coinsurance)		
Individual	$4,000	N/A
Family	$12,000	N/A

	Applies to Deductible	Applies to OOP Max	Network Providers	Non-Network Providers
Allergy Care (testing and injections)	✓	✓ In Network Only	80%	50%
Alternative Care – Maintenance therapy is not covered				
• Acupuncture	✓ Non-Network Only	✓ In Network Only	100% after $40 copay	50%
• Chiropractic Care 20 Visits per calendar year.	✓	✓ In Network Only	100% after $40 copay	50%
• Massage Therapy Medically Necessary Prescription Required. 12 visits per calendar year.	✓ Non-Network Only	✓ In Network Only	100% after $40 copay	50%
Anesthesia	✓	✓ In Network Only	80%	80% (if provided at a network facility) 50% (if provided at a non-network facility)

	Applies to Deductible	Applies to OOP Max	Network Providers	Non-Network Providers
Autism Spectrum Disorder FCHA pre-authorization is required for inpatient services and Applied Behavioral Analysis (ABA) Therapy.				
• **Applied Behavioral Analysis (ABA) Therapy**	✓	✓ In Network Only	80%	50%
• **Mental Health**	✓	✓ In Network Only	80%	50%
• **Habilitative Services –** (includes physical, speech and occupational therapy)	✓	✓ In Network Only	80%	50%
Autologous Blood Donation/Blood Transfusion	✓	✓ In Network Only	80%	80%
Bariatric Surgery/Weight loss	Not Covered			
Biofeedback	Not Covered			
Chemical Dependency FCHA pre-authorization required for inpatient, residential and partial hospitalization.				
• **Inpatient** (facility)	✓	✓ In Network Only	80%	50% after $250 per confinement copay
• **Inpatient** (professional)	✓	✓ In Network Only	80%	50%
• **Outpatient** (facility and professional)	✓	✓ In Network Only	80%	50%
• **Office Visit Related Charges**	✓ Non-Network Only	✓ In Network Only	100% after $40 copay	50%
Dental Trauma FCHA pre-authorization required for follow-up services.	✓	✓ In Network Only	80%	80%
Diabetic Education and Diabetic Nutrition Education The first 3 nutritional counseling visits are covered under the preventive benefit, any subsequent visits are covered under this benefit.	✓	✓ In Network Only	80%	50%
Diagnostic Testing (Lab and radiology services, non-routine, facility and professional services) FCHA pre-authorization required for PET scans.				

	Applies to Deductible	Applies to OOP Max	Network Providers	Non-Network Providers
Hospital inpatient (professional fees)	✓ Non-Network Only	✓ In Network Only	80%	50%
Hospital outpatient (facility and professional fees)	✓ Non-Network Only	✓ In Network Only	80%	50%
Lab or x-ray facility	✓ Non-Network Only	✓ In Network Only	80%	50%
PET, MRI & CT scans	✓	✓ In Network Only	80%	50%
Doctor's Office	✓ Non-Network Only	✓ In Network Only	80%	50%
Durable Medical Equipment				
• **Breast Pump** 1 every 3 calendar years.	✓ Non-Network Only	N/A	100%	50%
• **Durable Medical Equipment**	✓	✓ In Network Only	80%	80%
• **Medical Supplies**	✓	✓ In Network Only	80%	80%
• **Oral Appliances** When related to TMJ, applies to the TMJ lifetime maximums.	✓	✓ In Network Only	80%	80%
• **Orthopedic Appliances**	✓	✓ In Network Only	80%	80%
• **Prosthetic Devices**	✓	✓ In Network Only	80%	80%
Dialysis FCHA pre-authorization required.	Covered based on place of service.			

	Applies to Deductible	Applies to OOP Max	Network Providers	Non-Network Providers
Emergency Care				
• **Emergency Room** (facility and professional)	✓	✓ In Network Only	80% after $150 copay (copay waived if admitted)	80% after $150copay (copay waived if admitted)
• **Urgent Care**	✓	✓ In Network Only	100% after $50 copay	80%
Family Planning				
• **Office visits** 2 visits per calendar year.	✓	✓ In Network Only	100%	50%
• **Devices, Implants and Injections**	✓ Non-Network Only	N/A	100%	50%
• **Sterilizations and Termination of Pregnancy**	✓	✓ In Network Only	80%	50%
Foot Orthotics	✓	✓ In Network Only	80%	50%
Genetic Services FCHA pre-authorization required for genetic testing over $500.				
• **BRCA Testing** (genetic breast testing)	✓ Non-Network Only	N/A	100%	50%
• **All other Genetic Testing**	✓	✓ In Network Only	80%	50%
• **Genetic Counseling**	✓ Non-Network Only	✓ In Network Only	100% after $40 copay	50%
Habilitative Services Medical services that promote achieving developmental skills when impairments have caused delaying or blocking of initial acquisition of the skills. Habilitation can include cognitive, social, fine motor, gross motor, or other skills that contribute to mobility, communication, and performance of activities of daily living and enhance quality of life.				
• **Inpatient** (facility and professional) FCHA pre-authorization required.	✓	✓ In Network Only	80%	50% after $250 copay per confinement
• **Outpatient** (facility and professional)	✓	✓ In Network Only	80%	50%

	Applies to Deductible	Applies to OOP Max	Network Providers	Non-Network Providers
• **In Office**	✓ Non-Network Only	✓ In Network Only	100% after $40 copay	50%
Hearing				
• **Routine Hearing Exams** – No age limit 1 per calendar year.	✓	✓ In Network Only	80% after $40 copay	50%
• **Medically Necessary Hearing Exams**	✓	✓ In Network Only	80% after $40 copay	50%
• **Hearing Aids**	Not Covered			
Home Health Care FCHA pre-authorization required for wound therapy.				
• **Home Health Care** 100 visits per calendar year.	N/A	N/A	100%	100%
• **Hourly Nursing Services** 560 hours per calendar year.	N/A	N/A	100%	100%
• **Phototherapy** (home) (photo lights for newborn)	N/A	N/A	100%	100%
Hospice FCHA pre-authorization required.				
• **Hospice Care** (at home)	✓	✓ In Network Only	80%	80%
• **Respite Care**	Not covered			
• **Hospice** (inpatient and outpatient facility)	✓	✓ In Network Only	80%	80%
• **Professional Hospice services**	✓	✓ In Network Only	80%	80%
Hospital Inpatient Medical and Surgical Care FCHA pre-authorization required.				
• **Facility Services**	✓	✓ In Network Only	80%	50% after $250 copay per confinement
• **Inpatient Doctor Visits/ Consultations**	✓	✓ In Network Only	80%	50%
• **Inpatient Professional Services** (surgeon)	✓	✓ In Network Only	80%	50%

	Applies to Deductible	Applies to OOP Max	Network Providers	Non-Network Providers
• **Inpatient Professional Services** (assistant surgeon, radiologist, pathologist and anesthesia)	✓	✓ In Network Only	80%	80% (if provided at a network facility) 50% (if provided at a non-network facility)
Hospital Outpatient Surgery and Services FCHA pre-authorization required for certain outpatient services; see *Pre-authorization Requirements* for details.				
• **Outpatient Facility**	✓	✓ In Network Only	80%	50%
• **Ambulatory Surgery Center** (ASC)	✓	✓ In Network Only	80%	50%
• **Outpatient Professional** (assistant surgeon, radiologist, pathologist and anesthesia)	✓	✓ In Network Only	80%	80% (if provided at a network facility) 50% (if provided at a non-network facility)
Infertility				
• **Diagnostic Services** (initial diagnosis only)	✓ Non-Network Only	✓ In Network Only	80%	50%
• **Diagnostic Office Visits** (initial diagnosis only)	✓ Non-Network Only	✓ In Network Only	80% after $40 copay	50%
Infusion Therapy FCHA pre-authorization required. (includes infusion therapy provided in the home)	✓	✓ In Network Only	80%	50%
Maternity and Newborn Care				
• **Inpatient** (facility)	✓	✓ In Network Only	80%	50% after $250 copay per confinement
• **Inpatient** (professional)	✓	✓ In Network Only	80%	50%

	Applies to Deductible	Applies to OOP Max	Network Providers	Non-Network Providers
Birthing Centers				
• **Birthing Center** (facility)	✓	✓ In Network Only	80%	50% after $250 copay per confinement
• **Birthing Center** (professional)	✓	✓ In Network Only	80%	50%
• **Home Births**	✓	✓ In Network Only	80%	50%
Mental Health Care FCHA pre-authorization required for inpatient, residential and partial hospitalization.				
• **Inpatient** (facility)	✓	✓ In Network Only	80%	50% after $250 copay per confinement
• **Inpatient** (professional)	✓	✓ In Network Only	80%	50%
• **Partial Day Treatment** (PDT)	✓	✓ In Network Only	80%	50%
• **Outpatient** (facility and professional)	✓	✓ In Network Only	80%	50%
• **Office Visit**	✓ Non-Network Only	✓ In Network Only	100% after $40 copay	50%
Nutritional Counseling The first 3 nutritional counseling visits are covered under the preventive benefit; any subsequent visits are covered under this benefit. (medical conditions requiring a special diet)	✓ Non-Network Only	✓ In Network Only	100% after $40 copay	50%
Nutritional and Dietary Formulas (See *Nutritional and Dietary Formulas* in the Summary Plan Document for details.	✓	✓ In Network Only	80%	50%
Oral Surgery (medical diagnosis only) Limited benefit; See *Oral Surgery* in the Summary Plan Document for details.	✓	✓ In Network Only	80%	80%
Pharmacy Administered by MedImpact.				
Retail (30 day supply)				
• **Generic**	N/A	✓	$15	Reimbursement For Covered Prescription
• **Preferred Brands**	N/A	✓	$40	

	Applies to Deductible	Applies to OOP Max	Network Providers	Non-Network Providers
• **Non-Preferred Brands**	N/A	✓	$60	Products Will Be Based On The Lowest Contracted Amount Of A Participating Pharmacy Minus Any Applicable Deductible And/or Retail Co-pay Shown In This Schedule.
Retail (90 day supply) RX by Participating Retail Pharmacy – Choice 90 Program				
• **Generic**	N/A	✓	$45	Reimbursement For Covered Prescription Products Will Be Based On The Lowest Contracted Amount Of A Participating Pharmacy Minus Any Applicable Deductible And/or Retail Co-pay Shown In This Schedule.
• **Preferred Brands**	N/A	✓	$120	
• **Non-Preferred Brands**	N/A	✓	$180	
Mail order (90 day supply)				
• **Generic**	N/A	✓	$30	Reimbursement For Covered Prescription Products Will Be Based On The Lowest Contracted Amount Of A Participating Pharmacy Minus Any Applicable Deductible And/or Retail Co-pay Shown In This Schedule.
• **Preferred Brands**	N/A	✓	$80	
• **Non-Preferred Brands**	N/A	✓	$120	
Specialty Pharmacy Specialty pharmacy focuses on high cost, high touch medication therapy for patients with complex disease states. Medications in specialty pharmacy range from oral to cutting edge injectable and biologic products.				
•	N/A	✓	$80	Reimbursement For Covered Prescription Products Will Be Based On The Lowest Contracted Amount Of A Participating Pharmacy Minus Any Applicable Deductible And/or Retail Co-pay Shown In This Schedule.

	Applies to Deductible	Applies to OOP Max	Network Providers	Non-Network Providers
Compound Drugs Pre-authorization Required for charges greater than $400.				
Plastic and Reconstructive Services FCHA pre-authorization required. **Limited benefit, see *Plastic and Reconstructive Services* for details.**				
• **Inpatient Services** (facility)	✓	✓ In Network Only	80%	50% after $250 copay per confinement
• **Inpatient** (doctor visits/ consultations)	✓	✓ In Network Only	80%	50%
• **Outpatient (**facility and professional services, assistant surgeon, radiologist, pathologist and anesthesia)	✓	✓ In Network Only	80%	80% after deductible (if provided at a network facility) 50% (if provided at a non-network facility)
Podiatric Care See *Podiatric Care* for details on routine foot care.	✓	✓ In Network Only	80%	50%
Preventive Care				
Immunizations Immunizations for children and adults are covered in accordance with the recommendations set forth by the Centers for Disease Control and Prevention. Except for the Shingles Vaccine, this is covered in accordance with the Food and Drug Administration (FDA). See *Preventive Care* for details.				
• **Immunizations** Immunizations done at the pharmacy covered at 100% of billed charges. Shingles Vaccine is covered at age 50. FluMist covered. Travel immunizations are not covered.	✓ Non-Network Only	N/A	100%	50%
• **Periodic Exams** (age 3 to adult)	✓ Non-Network Only	N/A	100%	50%
Well Child Exam	✓ Non-Network Only	N/A	100%	50%
Lactation Counseling 6 visits per calendar year	✓ Non-Network Only	N/A	100%	50%

	Applies to Deductible	Applies to OOP Max	Network Providers	Non-Network Providers
Nutritional Counseling - first 3 visits per calendar year For visits 4 and beyond, refer to *Nutritional Counseling or Diabetic Education.*	✓ Non-Network Only	N/A	100%	50%
Obesity Screening and Counseling 12 visits per calendar year.	✓ Non-Network Only	N/A	100%	50%
Screening Tests Screening tests are covered in accordance with the recommendations set forth by the US Preventive Services Task Force (USPSTF) and the Health Resources and Services Administration (HRSA). Below is a summary of the most commonly obtained preventive screening services (this is not meant to be an all-inclusive list). See *Preventive Care* for more details.				
• **Bone Density Screening**	✓ Non-Network Only	N/A	100%	50%
• **Colonoscopy** The first colonoscopy per calendar year is covered under the Preventive Care benefit, regardless of diagnosis. Subsequent colonoscopies in the same calendar year are covered under the medical benefits, regardless of diagnosis	✓ Non-Network Only	N/A	100%	50%
• **Fecal Occult Blood Test** The first fecal occult blood test per calendar year is covered under the Preventive Care benefit, regardless of diagnosis. Subsequent fecal occult blood tests in the same calendar year are covered under the medical benefits, regardless of diagnosis	✓ Non-Network Only	N/A	100%	50%
• **Mammogram** The first mammogram per calendar year is covered under the Preventive Care benefit, regardless of diagnosis. Subsequent mammograms in the same calendar year are covered under the medical benefits, regardless of diagnosis	✓ Non-Network Only	N/A	100%	50%
• **Pap Test**	✓ Non-Network Only	N/A	100%	50%
• **Prostate Cancer Screening** (PSA)	✓ Non-Network Only	N/A	100%	50%

	Applies to Deductible	Applies to OOP Max	Network Providers	Non-Network Providers
• **Sigmoidoscopy** The first sigmoidoscopy per calendar year is covered under the Preventive Care benefit, regardless of diagnosis. Subsequent sigmoidoscopies in the same calendar year are covered under the medical benefits, regardless of diagnosis	✓ Non-Network Only	N/A	100%	50%
• **All Other Screening Tests**	✓ Non-Network Only	N/A	100%	50%
Professional Services				
• **Office Visit/Office Surgery**				
- Primary Care Physician (PCP)	✓ Non-Network Only	✓ In Network Only	100% after $25 copay	50%
- Specialist	✓ Non-Network Only	✓ In Network Only	100% after $40 copay	50%
All other Related Office Visit Services				
- Primary Care Physician (PCP)	✓	✓ In Network Only	80%	50%
- Specialist	✓	✓ In Network Only	80%	50%
Rehabilitation Therapy (physical therapy, speech therapy, occupational therapy – see *Rehabilitation Therapy* in the Summary Plan Document for listing of other rehabilitation services)				
• **Inpatient** (facility) FCHA pre-authorization required.	✓	✓ In Network Only	80%	50% after $250 copay per confinement
• **Inpatient** (professional)	✓	✓ In Network Only	80%	50%
• **Outpatient** (facility and professional, includes physical, speech, occupational therapies) 25 visits per calendar year, all therapies combined.	✓ Non-Network Only	✓ In Network Only	100% after $40 copay	50%

	Applies to Deductible	Applies to OOP Max	Network Providers	Non-Network Providers
Sleep Apnea	✓	✓ In Network Only	80%	50%
Skilled Nursing Facility FCHA pre-authorization required. 90 days per calendar year.	N/A	N/A	100%	100%
Temporomandibular Joint (TMJ) Disorder (Maximum Benefit per lifetime $1,200) FCHA pre-authorization required if inpatient.				
• **TMJ Services**	✓ Non-Network Only	✓ In Network Only	80% after $40 copay	50%
• **TMJ Surgery Treatment**	Not Covered			
Tobacco Cessation	✓ Non-Network Only	N/A	100%	50%
Transplants (organ and bone marrow) FCHA pre-authorization required.				
• **Recipient Services** (facility and professional)	N/A	N/A	100%	50% after $250 copay per confinement
• **Recipient Services Per Admission** (office visits)	✓ Non-Network Only	✓ In Network Only	100% after $40 copay	50%
• **Donor Services** (facility and professional)	N/A	N/A	100%	50%
• **Donor Services** (office visit)	✓ Non-Network Only	✓ In Network Only	100% after $40 copay	50%
• **Transportation and Lodging** $10,000 maximum per transplant.	✓ Non-Network Only	N/A	100%	50%
Vision				
Routine Eye Exam 1 per calendar year.	✓ Non-Network Only	N/A	100%	100%

Ashland School District – Vision Benefits			
	Applies to Out of Pocket Maximum	**Network Providers**	**Non-Network Providers**
Vision Hardware ($350 every 24 months) Eyeglass lenses, frames and contact lenses (includes contact lens fitting)	N/A	100%	100%

Dental Coverage

Ashland School District – Dental Benefits	
	Deductible
Individual	$50
Family	$150
	Dental Maximum $1,500

	Benefits
Class A Expenses • Preventive and Diagnostic	100% of Usual, Customary & Reasonable
Class B Expenses • Basic Dental	80% of Usual, Customary & Reasonable
Class C Expenses • Major Dental Services	50% of Usual, Customary & Reasonable