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Ashland School District
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2017 Benefits Summary

(Grandfathered Plan)

Ashland School District – Medical Benefits		
	In-Network	**Out-of-Network**
Deductible		
Individual	N/A	$300
Family	N/A	$900
Out-of-Pocket Maximum (includes copays and coinsurance)		
Individual	$2,500	N/A
Family	$7,500	N/A

	Applies to Out of Pocket Maximum	**Network Providers**	**Non-Network Providers**
Allergy Care (testing and injections)	In Network Only	80%	50% after deductible
Alternative Care Maintenance therapy is not covered			
• Acupuncture	In Network Only	100% after $25 copay	50% after deductible
• Chiropractic Care 20 Visits / Per Calendar Year	In Network Only	100% after $25 copay	50% after deductible
• Massage Therapy (Medically Necessary - Prescription Required) (12 visits PCY)	In Network Only	100% after $25 copay	50% after deductible
Ambulance Services FCHA pre-authorization required for non-emergent air ambulance and inter-facility transport.	In Network Only	80% (no copay)	80% deductible waived
Anesthesia	In Network Only	80%	80% deductible waived (if provided at a network facility)

	Applies to Out of Pocket Maximum	Network Providers	Non-Network Providers
			50% deductible waived (if provided at a non-network facility)
Autologous Blood Donation/Blood Transfusion	In Network Only	80%	80% deductible waived
Bariatric Surgery/Weight loss	Not Covered		
Biofeedback Limited benefit, see *Biofeedback* for details.	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 deductible applies
• **Inpatient** (professional)	In Network Only	80%	50% after deductible
• **Outpatient** (facility and professional)	In Network Only	80%	50% after deductible
• **Office Visit related charges**	In Network Only	100% after $25 copay	50% after deductible
Clinical Trials	Covered as specifically outlined under *Clinical Trials*.		
Dental Trauma FCHA pre-authorization required for follow-up services.	In Network Only	80%	80% deductible waived
Diabetic Education and Diabetic Nutrition Education	In Network Only	80%	50% after deductible
Durable Medical Equipment FCHA pre-authorization required if purchases exceed $2,000 or $500 per month rental.			
• **Durable Medical Equipment**	In Network Only	80%	80% after deductible
• **Medical Supplies**	In Network Only	80%	80% after deductible

	Applies to Out of Pocket Maximum	Network Providers	Non-Network Providers
• **Oral Appliances** When related to TMJ, applies to the TMJ plan year and lifetime maximums.	In Network Only	80%	80% after deductible
• **Orthopedic Appliances**	In Network Only	80%	80% after deductible
• **Prosthetic Devices**	In Network Only	80%	80% after deductible
End Stage Renal Disease (ESRD/Dialysis) FCHA pre-authorization required	Covered as specifically outlined under End Stage Renal Disease/Dialysis in the *Medical Benefits* section below.		
Emergency Care			
• **Emergency Room** (facility and professional)	In Network Only	80% after $100 copay (copay waived if admitted)	80% after $100 copay deductible waived (copay waived if admitted)
• **Urgent Care**	In Network Only	100% after $25 copay	80% deductible waived
Family Planning			
• **Office visits (2 visits PCY)**	N/A	100%	50% after deductible
• **Devices, implants and injections**	N/A	100%	50% after deductible
• **Sterilizations and termination of pregnancy**	In Network Only	80%	50% after deductible
Foot Orthotics	In Network Only	80%	50% after deductible
Genetic Services FCHA pre-authorization required if over $500.			
• **BRCA Testing** (genetic breast testing)	In Network Only	80%	50% after deductible
• **All other Genetic Testing**	In Network Only	80%	50% after deductible
• **Genetic Counseling**	In Network Only	100% after $25 copay	50% after deductible

	Applies to Out of Pocket Maximum	Network Providers	Non-Network Providers
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 deductible applies
• **Outpatient** (facility and professional)	In Network Only	80%	50% after deductible
• **In office**	In Network Only	100% after $25 copay	50% after deductible
Hearing			
• **Routine Hearing Exams – No age limit** (1PCY)	In Network Only	80% after $25 copay	50% after deductible
• **Medically necessary Hearing Exams**	In Network Only	80% after $25 copay	50% after deductible
• **Hearing aids**	N/A	Not covered	Not Covered
Home Health Care FCHA pre-authorization required.			
• **Home Health Care** (100 visits per calendar year)	N/A	100%	100% deductible waived
• **Hourly Nursing Services** (560 hours Per Calendar Year)	N/A	100%	100% deductible waived
• **Phototherapy (home)** (photo lights for newborn)	N/A	100%	100% deductible waived
Hospice FCHA pre-authorization required			
• **Hospice Care (at home)**	In Network Only	80%	80% deductible waived
• **Respite Care**	N/A	Not covered	Not covered

	Applies to Out of Pocket Maximum	Network Providers	Non-Network Providers
• **Hospice Inpatient and Outpatient facility**	In Network Only	80%	80% deductible waived
• **Professional Hospice and services**	In Network Only	80%	80% deductible waived
Hospital Inpatient Medical and Surgical Care FCHA pre-authorization required.			
• **Facility services**	In Network Only	80%	50% after $250 copay per confinement deductible applies
• **Inpatient doctor visits/ consultations**	In Network Only	80%	50% after deductible
• **Inpatient professional services** (surgeon)	In Network Only	80%	50% after deductible
• **Inpatient professional services** (assistant surgeon, radiologist, pathologist and anesthesia)	In Network Only	80%	80% deductible waived (if provided at a network facility)
			50% deductible waived (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.			
• **Surgical (facility & professional services)**	In Network Only	80%	50% after deductible
• **Ambulatory Surgery Center (ASC)**	In Network Only	80%	50% after deductible
• **Outpatient (facility and professional services)** (assistant surgeon, radiologist, pathologist and anesthesia)	In Network Only	80%	80% deductible waived (if provided at a network facility)

	Applies to Out of Pocket Maximum	Network Providers	Non-Network Providers
			50% deductible waived (if provided at a non-network facility)
Infertility Diagnostic Services (Initial diagnosis only)	In Network Only	80%	50% after deductible
Infertility Diagnostic Office Visits (diagnosis only)	In Network Only	80% after $25 copay	50% after deductible
Infusion Therapy **FCHA pre-authorization required** (includes infusion therapy provided in the home)	In Network Only	80%	50% after deductible
Lab and Radiology Services (non-routine, facility and professional services) FCHA pre-authorization required for PET scans.			
• **Hospital inpatient** (professional fees)	In Network Only	80%	50% after deductible
• **Hospital outpatient** (facility and professional fees)	In Network Only	80%	50% after deductible
• **Lab or x-ray facility**	In Network Only	80%	50% after deductible
• **Doctor's office**	In Network Only	80%	50% after deductible
Maternity and Newborn Care			
• **Inpatient Facility**	In Network Only	80%	50% after $250 copay per confinement deductible applies
• **Inpatient professional**	In Network Only	80%	50% after deductible
Birthing Centers			
• **Birthing Center facility**	In Network Only	80%	50% after $250 copay per confinement deductible applies
• **Home Births**	In Network Only	80%	50% after deductible

	Applies to Out of Pocket Maximum	Network Providers	Non-Network Providers
• **Birthing Center Professional**	In Network Only	80%	50% after deductible
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 deductible applies
• **Inpatient professional**	In Network Only	80%	50% after deductible
• **Partial Day Treatment (PDT)**	In Network Only	80%	50% after deductible
• **Outpatient** (facility and professional)	In Network Only	80%	50% after deductible
• **Office visit**	In Network Only	100% after $25 copay	50% after deductible
Nutritional Counseling (medical conditions requiring a special diet)	In Network Only	100% after $25 copay	50% after deductible
Nutritional and Dietary Formulas (Please refer to Summary Plan Description)	In Network Only	80%	50% after deductible
Oral Surgery (medical diagnosis only – please refer to Summary Plan Description)	In Network Only	80%	80% after deductible
Pharmacy Administered by MedImpact			
Retail (30 day supply)			
Generic	N/A	$15	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	$30	
Non-Preferred Brands	N/A	$45	
Retail (90 day supply) RX by Participating Retail Pharmacy – Choice 90 Program			
Generic	N/A	$45	Reimbursement For Covered Prescription

	Applies to Out of Pocket Maximum	Network Providers	Non-Network Providers
Preferred Brands	N/A	$90	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.
Non-Preferred Brands	N/A	$135	
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	$60	
Non-Preferred Brands	N/A	$90	
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.			
Generic	N/A	$15	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	$30	
Non-Preferred Brands	N/A	$45	
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.	In Network Only	80%	50% after deductible
• **Inpatient Facility Services**	In Network Only	80%	50% after $250 copay per confinement deductible applies

	Applies to Out of Pocket Maximum	Network Providers	Non-Network Providers
• **Inpatient doctor visits/ consultations**	In Network Only	80%	50% after deductible
• **Outpatient (facility and professional services)** (assistant surgeon, radiologist, pathologist and anesthesia)	In Network Only	80%	80% deductible waived (if provided at a network facility)
			50% deductible waived (if provided at a non-network facility)
Podiatric Care See *Podiatric Care* for details on routine foot care.	In Network Only	80%	50% after deductible
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. See *Preventive Care* for details. FluMist covered. Travel immunizations are not covered.	In Network Only	100% after $25 copay	50% after deductible
• **Periodic Exams** (age 3 to adult , 1 PCY)	In Network Only	100% after $25 copay	50% after deductible
• **Well Child Exam** (first 12 months, 7 visits PCY)	In Network Only	100% after $25 copay	50% after deductible
• **Well Child Exam** (age 2 through 3 , 3 visits PCY)	In Network Only	100% after $25 copay	50% after deductible
Nutritional Counseling - first 3 visits per calendar year For visits 4 and beyond, refer to *Nutritional Counseling or Diabetic Education.*	In Network Only	100% after $25 copay	50% after deductible
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.			

	Applies to Out of Pocket Maximum	Network Providers	Non-Network Providers
• **Bone Density Screening**	In Network Only	100% after $25 copay	50% after deductible
• **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	N/A	100% no copay	50% after deductible
• **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	N/A	100% no copay	50% after deductible
• **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	In Network Only	100% after $25 copay	50% after deductible
• **Pap Test**	N/A	100% no copay	50% after deductible
• **Prostate Cancer Screening (PSA)**	N/A	100% no copay	50% after deductible
• **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	N/A	100% no copay	50% after deductible
• **All Other Screening Tests**	In Network Only	100% after $25 copay	50% after deductible
Professional Services – including Naturopath			
• **Office Visit/Office Surgery**	In Network Only	100% after $25 copay	50% after deductible

	Applies to Out of Pocket Maximum	Network Providers	Non-Network Providers
• **All other related Office Visit Services**	In Network Only	80%	50% after deductible
Rehabilitation Therapy (physical therapy, speech therapy, occupational therapy – see Summary Plan Description for listing of other rehabilitation services)			
• **Inpatient** (facility) **Pre-authorization required**	In Network Only	80%	50% after $250 copay per confinement deductible applies
• **Inpatient** (professional)	In Network Only	80%	50% after deductible
• **Outpatient** (facility and professional; includes physical, speech, occupational) 25 visits per calendar year.	In Network Only	100% after $25 copay	50% After deductible
Sleep Apnea	In Network Only	80%	50% after deductible
Skilled Nursing Facility **Pre-authorization required** 90 days per calendar year	N/A	100%	100% deductible waived
Temporomandibular Joint (TMJ) Disorder (Maximum Benefit per lifetime $1,200) FCHA pre-authorization required if inpatient.			
• **TMJ Services**	In Network Only	80% after $25 copay	50% after deductible
• **TMJ Surgery Treatment**	Not Covered		
Tobacco Cessation	N/A	100%	50% after deductible
Transplants (organ and bone marrow) FCHA pre-authorization required.			
• **Recipient services** (facility and professional)	N/A	100%	50% after $250 copay per confinement deductible applies
• **Recipient services per admission** (office visits)	In Network Only	100% after $25 copay	50% after deductible

	Applies to Out of Pocket Maximum	Network Providers	Non-Network Providers
• **Donor services** (facility and professional)	N/A	100%	50% after deductible
• **Donor Services** (office visit)	In Network Only	100% after $25 copay	50% after deductible
• **Transportation and lodging** $10,000 maximum	N/A	100%	50% after deductible
Vision (routine eye exams) 1 PCY	N/A	100%	100% of allowed amount

Ashland School District – Vision Benefits			
	Applies to Out of Pocket Maximum	**Network Providers**	**Non-Network Providers**
Vision Hardware ($350 limit PCY) 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

	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