



PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY - SELF FUNDED

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Benefit Limitations - For any service or supply that is subject to a maximum visit, day, or dollar limitation on a per year basis, the benefit year begins on January 1st unless otherwise mandated. Refer to your plan documents for more information.		
Deductible (per calendar year)	\$100 Individual \$300 Family	\$100 Individual \$300 Family
All covered expenses accumulate separately toward the in-network and out-of-network Deductible. Unless otherwise indicated, the deductible must be met prior to benefits being payable. Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible. Pharmacy expenses do not apply towards the Deductible. The family Deductible is a cumulative Deductible for all family members. The family Deductible can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Deductible amount.		
Member Coinsurance	10%	20%
Applies to all expenses unless otherwise stated.		
Payment Limit (per calendar year)		
Certificated, Adult Ed, Management/Admin/ Confidential	\$1,000 Individual \$2,000 Family	\$1,000 Individual \$2,000 Family
Classified	\$500 Individual \$15,800 Family	\$1,000 Individual Unlimited Family
All covered expenses accumulate separately toward the in-network or out-of-network Payment Limit. Only those out-of-pocket expenses resulting from the application of coinsurance percentage, copays, and deductibles (except any penalty amounts) may be used to satisfy the Payment Limit. Pharmacy expenses do not apply towards the Payment Limit. The family Payment Limit is a cumulative Payment Limit for all family members. The family Payment Limit can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Payment Limit amount.		
Lifetime Maximum Unlimited except where otherwise indicated.		
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements - Certification for certain types of Out-of-Network care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is \$400 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	IN-NETWORK	OUT-OF-NETWORK
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months up to age 65, 1 exam every 12 months age 65 and older	Covered 100%; deductible waived	20%; after deductible
Routine Well Child Exams/Immunizations 7 exams first 12 months, 3 exams 13th - 24th months, 3 exams 25th - 36th months, 1 exam per 12 months thereafter to age 22.	Covered 100%; deductible waived	20%; after deductible
Routine Gynecological Care Exams	Covered 100%; deductible waived	20%; after deductible



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1 exam and pap smear per calendar year, includes related fees.

Table with 3 columns: Service Name, In-Network Coverage, and Out-of-Network Coverage. Rows include Routine Mammograms, Women's Health, Routine Digital Rectal Exam, Prostate-specific Antigen Test, Colorectal Cancer Screening, Routine Eye Exams, Routine Hearing Screening, Physician Services, Office Visits to Non-Specialist, Specialist Office Visits, Hearing Exams, Pre-Natal Maternity, Walk-in Clinics, Allergy Testing, Allergy Injections, Diagnostic Procedures, Diagnostic X-ray, Diagnostic Laboratory, Diagnostic Complex Imaging, Emergency Medical Care, and Urgent Care Provider.



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Table with 3 columns: Service Category, In-Network, and Out-of-Network. Rows include: Non-Urgent Use of Urgent Care Provider, Emergency Room, Non-Emergency Care in an Emergency Room, Emergency Use of Ambulance, Non-Emergency Use of Ambulance, HOSPITAL CARE (Inpatient Coverage, Inpatient Maternity Coverage, Outpatient Hospital Expenses, Outpatient Surgery - Hospital, Outpatient Surgery - Freestanding Facility), MENTAL HEALTH SERVICES (Inpatient, Mental Health Office Visits, Other Mental Health Services), SUBSTANCE ABUSE (Inpatient, Residential Treatment Facility, Substance Abuse Office Visits, Other Substance Abuse Services), OTHER SERVICES (Skilled Nursing Facility, Home Health Care, Hospice Care - Inpatient, Hospice Care - Outpatient).



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Private Duty Nursing	Covered as part of Home Health Care	Covered as part of Home Health Care
Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.		
Spinal Manipulation Therapy Limited to 25 visits per year	20%; after deductible	20%; after deductible
Outpatient Short-Term Rehabilitation Includes speech, physical, occupational therapy	20%; after deductible	20%; after deductible
Habilitative Physical Therapy	Refer to MBH Outpatient Mental Health All Other	Refer to MBH Outpatient Mental Health All Other
Habilitative Occupational Therapy	Refer to MBH Outpatient Mental Health All Other	Refer to MBH Outpatient Mental Health All Other
Habilitative Speech Therapy	Refer to MBH Outpatient Mental Health All Other	Refer to MBH Outpatient Mental Health All Other
Autism Behavioral Therapy Combined with outpatient mental health visits	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Autism Applied Behavior Analysis Covered same as any other Outpatient Mental Health All Other benefit	Refer to MBH Outpatient Mental Health All Other	Refer to MBH Outpatient Mental Health All Other
Autism Physical Therapy	Refer to MBH Outpatient Mental Health All Other	Refer to MBH Outpatient Mental Health All Other
Autism Occupational Therapy	Refer to MBH Outpatient Mental Health All Other	Refer to MBH Outpatient Mental Health All Other
Autism Speech Therapy	Refer to MBH Outpatient Mental Health All Other	Refer to MBH Outpatient Mental Health All Other
Durable Medical Equipment	10%; after deductible	20%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
Affordable Care Act Mandated Women's Contraceptives	Covered 100%; deductible waived	Covered same as any other expense.
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered same as any other medical expense.
Infusion Therapy Administered in the home or physician's office	\$20 copay; deductible waived	20%; after deductible
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Vision Eyewear	Not Covered	Not Covered
Transplants	10%; after deductible Preferred coverage is provided at an IOE contracted facility only.	20%; after deductible
Bariatric Surgery Your cost sharing applies to all covered benefits incurred during your inpatient stay.	10%; after deductible	20%; after deductible
Acupuncture \$35 maximum per visit; \$350 maximum per year	20%; after deductible	20%; after deductible.
FAMILY PLANNING	IN-NETWORK	OUT-OF-NETWORK



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Table with 3 columns: Service, In-Network, and Out-of-Network. Rows include Infertility Treatment, Comprehensive Infertility Services, Advanced Reproductive Technology (ART), Vasectomy, Tubal Ligation, PHARMACY, Pharmacy Plan Type, Generic Drugs, Brand-Name Drugs, Pharmacy Day Supply and Requirements, and Plan Includes details.



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**Prescription Drug Annual Out of
 Pocket Maximum**

Certificated, Adult Ed,
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Classified \$4,500 Individual / \$9,000 Family

GENERAL PROVISIONS

Dependents Eligibility Spouse, children from birth to age 26 regardless of student status.

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and health insurance plans contain exclusions and limitations. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.

The following is a list of services and supplies that are *generally* not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

- All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
- Cosmetic surgery, including breast reduction.
- Custodial care.
- Dental care and dental X-rays.
- Donor egg retrieval
- Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
- Hearing aids
- Home births
- Immunizations for travel or work, except where medically necessary or indicated.
- Implantable drugs and certain injectable drugs including injectable infertility drugs.
- Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.
- Long-term rehabilitation therapy.
- Non-medically necessary services or supplies.
- Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies.
- Radial keratotomy or related procedures.
- Reversal of sterilization.
- Services for the treatment of sexual dysfunction/enhancement, including therapy, supplies or counseling or prescription drugs.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.
- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.



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Aetna, or its affiliate(s), receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates may reduce the amount a member pays the pharmacy for covered prescriptions. CVS Caremark® Mail Service Pharmacy refers to CVS Caremark® Mail Service Pharmacy, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with CVS Caremark® Mail Service Pharmacy may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility. Translation of the material into another language may be available. Please call Member Services at **1-888-982-3862**. Puede estar disponible la traducción de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862**.

Plan features and availability may vary by location and group size. For more information about Aetna plans, refer to **www.aetna.com**.

Aetna and MinuteClinic, LLC (which either operates or provides certain management support services to MinuteClinic-branded walk-in clinics) are both within the CVS Health family.

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California

All contract state benefits shown above will match for this ancillary state.