aetna™

East Side Union High School
Effective Date: 07-01-2023
Aetna Choice® POS II -- ASC

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 Applies to all expenses unless otherwise stated.	10%	20%
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.		
Routine Mammograms	Covered 100%; deductible waived	20%; after deductible
Women's Health	Covered 100%; deductible waived	20%; after deductible
Includes: Screening for gestational diabetes, HPV (Human- Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for human immunodeficiency virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies and counseling. Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.		
Routine Digital Rectal Exam	Covered 100%; deductible waived	20%; after deductible
Recommended: For covered males age 40 and over.		
Prostate-specific Antigen Test	Covered 100%; deductible waived	20%; after deductible
Recommended: For covered males age 40 and over.		
Colorectal Cancer Screening	Covered 100%; deductible waived	20%; after deductible
Recommended: For all members age 45 and over.		
Routine Eye Exams	Not Covered	Not Covered
Routine Hearing Screening	Covered 100%; deductible waived	20%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to Non-Specialist	$20 office visit copay; deductible waived	20%; after deductible
Specialist Office Visits	$20 office visit copay; deductible waived	20%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician if the physician is not the member's selected PCP.		
Hearing Exams	Not Covered	Not Covered
Pre-Natal Maternity	Covered 100%; deductible waived	20%; after deductible
Walk-in Clinics	$20 copay; deductible waived **Designated Walk-in Clinics** Covered 100%; deductible waived	20%; after deductible
Walk-in Clinics are free-standing health care facilities that (a) may be located in or with a pharmacy, drug store, supermarket or other retail store; and (b) provide limited medical care and services on a scheduled or unscheduled basis. Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices are not considered to be Walk-in Clinics.		
Allergy Testing	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
Allergy Injections	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
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray	10%; after deductible	20%; after deductible
(other than Complex Imaging Services) If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.		
Diagnostic Laboratory	10%; after deductible	20%; after deductible
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.		
Diagnostic Complex Imaging	10%; after deductible	20%; after deductible
If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.		
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	$20 copay; deductible waived	20%; after deductible

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Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	10%; after deductible	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	10%; after deductible	Same as in-network care
Non-Emergency Use of Ambulance	10%; after deductible	Same as in-network care
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage	10%; after deductible	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	10%; after deductible	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient Hospital Expenses	10%; after deductible	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Hospital	10%; after deductible	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Surgery - Freestanding Facility	10%; after deductible	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	10%; after deductible	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Mental Health Office Visits	$20 copay; deductible waived	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Mental Health Services	Covered 100%; deductible waived	20%; after deductible
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	10%; after deductible	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	10%; after deductible	20%; after deductible
Substance Abuse Office Visits	$20 copay; deductible waived	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Substance Abuse Services	Covered 100%; deductible waived	20%; after deductible
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled Nursing Facility	Covered 100%; deductible waived for the first 10 days 20%; after deductible thereafter	Covered 100%; deductible waived for the first 10 days 20%; after deductible thereafter
Limited to 180 days maximum per lifetime Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Home Health Care	20%; after deductible	20%; after deductible
Limited to 100 visits per year. Home health care services include private duty nursing Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs. or less.		
Hospice Care - Inpatient	10%; after deductible	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Hospice Care - Outpatient	10%; after deductible	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		

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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	10%; after deductible	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Acupuncture	20%; after deductible	20%; after deductible.
$35 maximum per visit; $350 maximum per year		
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**

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Infertility Treatment	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
Diagnosis and treatment of the underlying medical condition only.		
Comprehensive Infertility Services	Not Covered	Not Covered
Artificial insemination and ovulation induction		
Advanced Reproductive Technology (ART)	Not Covered	Not Covered
In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery		
Vasectomy	Your cost sharing is based on the type of service and where it is performed	20%; after deductible
Tubal Ligation	Covered 100%; deductible waived	20%; after deductible
PHARMACY	**IN-NETWORK**	**OUT-OF-NETWORK**
Pharmacy Plan Type	Aetna Standard Open Formulary	
Generic Drugs		
Retail	$15 copay	20% of submitted cost; after applicable copay
Mail Order	$15 copay	Not Applicable
Brand-Name Drugs		
Retail	$30 copay	20% of submitted cost; after applicable copay
Mail Order	$30 copay	Not Applicable
Pharmacy Day Supply and Requirements		
Retail	Up to a 30 day supply from Aetna National Network Percentage copays will not be doubled	
Mail Order	A 31-90 day supply from CVS Caremark® Mail Service Pharmacy	
Specialty	Up to a 30 day supply All prescription fills must be through our preferred specialty pharmacy network. Aetna Specialty Performance Network Drug List	

Choose Generics with Dispense as Written (DAW) override - The member pays the applicable copay. If the physician requires brand-name, member will pay brand-name copay. If the member requests brand-name when a generic is available, the member pays the applicable copay plus the difference between the generic price and the brand-name price.

Plan Includes: Diabetic supplies, blood glucose monitors, prescription weight loss drugs and contraceptive drugs and devices obtainable from a pharmacy.
Includes sexual dysfunction drugs for females and males, including daily dose, additional 8 tablets a month for males for erectile dysfunction.
Oral fertility drugs included.
Precertification for specialty drugs included
Seasonal Vaccinations covered 100% in-network
Preventive Vaccinations covered 100% in-network
Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.

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Prescription Drug Annual Out of Pocket Maximum	
Certificated, Adult Ed, Management/Admin/ Confidential	$500 Individual / $1,000 Family
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 traduccion 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.

California

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