Valley School District RE-1
Proposed Effective Date: 07-01-2023
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PLAN DESIGN & BENEFITS
MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY

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)	$4,000 Individual $8,000 Family	$8,000 Individual $16,000 per Family
Covered expenses in-network add up towards your in-network deductible. Covered expenses out-of-network add up towards your 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.	You pay 30%	You pay 50%
Payment Limit (per calendar year)	$6,450 per Individual $12,900 per Family	$20,000 per Individual $40,000 per Family
All covered expenses accumulate separately toward the in-network or out-of-network Payment Limit. Certain member cost sharing elements may not apply toward the Payment Limit. Pharmacy expenses apply towards the 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. 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.		
Payment for out-of-network care**	Not Applicable	Provider: 105% of Medicare Facility: 140% of Medicare
Primary care physician selection	Optional	Does not apply
Precertification 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	Not required	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%; no deductible	50%; 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%; no deductible	50%; after deductible
Routine gynecological care exams 1 obgyn exam and pap smear per calendar year Includes routine tests and related lab fees.	Covered 100%; no deductible	50%; after deductible
Virtual primary care (VPC) preventive care consultations	Covered 100%; no deductible	Not Covered

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Includes screening and counseling services for members age 18 and older		
Routine mammogram	Covered 100%; no deductible	50%; after deductible
Women's health	Covered 100%; no deductible	50%; 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%; no deductible	50%; after deductible
Recommended: For covered males age 40 and over.		
Prostate-specific antigen test	Covered 100%; no deductible	50%; after deductible
Recommended: For covered males age 40 and over.		
Colorectal cancer screening	Covered 100%; no deductible	50%; after deductible
Recommended: For all members age 45 and over.		
Routine eye exams	Covered 100%; no deductible	50%; after deductible
1 routine exam per 24 months.		
Routine hearing screening	Covered 100%; no deductible	50%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office visits to primary care physician (PCP)	$30 office visit copay; no deductible	50%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Virtual primary care (VPC) consultations	Covered 100%; no deductible	Not Covered
Includes basic medical service consultations for members age 18 and older		
Specialist office visits	$60 office visit copay; no deductible	50%; after deductible
Hearing exams	Covered 100%; no deductible	50%; after deductible
1 routine exam per 24 months.		
Pre-Natal Maternity	Covered 100%; no deductible	50%; after deductible
Walk-in clinics	$30 copay; no deductible	50%; after deductible
Allergy testing	Your cost sharing amount depends on the type of service and where you receive it.	Your cost sharing amount depends on the type of service and where you receive it.
Allergy injections	Your cost sharing amount depends on the type of service and where you receive it.	Your cost sharing amount depends on the type of service and where you receive it.
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray	30%; after deductible	50%; 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 laboratory	30%; after deductible	50%; 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	30%; after deductible	50%; 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	$75 office visit copay; no deductible	50%; after deductible
Non-urgent use of urgent care provider	Not Covered	Not Covered
Emergency room	$350 copay; no deductible	$350 copay; no deductible
Copay waived if admitted		

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Non-emergency care in an emergency room	Not Covered	Not Covered
Emergency use of ambulance	Covered 100%; no deductible	Covered 100%; no deductible
Non-emergency use of ambulance	Not Covered	
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient coverage	30%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Inpatient maternity coverage (includes delivery and postpartum care)	30%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient hospital	30%; after deductible	50%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient stay.		
Outpatient surgery - hospital	30%; after deductible	50%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient stay.		
Outpatient surgery - freestanding facility	30%; after deductible	50%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient stay.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	30%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Mental health office visits	$60 copay; no deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Crisis intervention services	$60 copay; no deductible	50%; after deductible
Other mental health services	30%; after deductible	50%; after deductible
SUBSTANCE ABUSE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	30%; after deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential treatment facility	30%; after deductible	50%; after deductible
Substance abuse office visits	$60 copay; no deductible	50%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other substance abuse services	30%; after deductible	50%; after deductible
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Spinal manipulation therapy	$60 copay; no deductible	50%; after deductible
Limited to 20 visits per year		
Outpatient short-term rehabilitation	$60 copay; no deductible	50%; after deductible
Limited to 60 visits per year Includes physical, occupational, and speech therapies.		
Habilitative physical therapy	30%; after deductible	50%; after deductible
Habilitative occupational therapy	30%; after deductible	50%; after deductible
Habilitative speech therapy	30%; after deductible	50%; after deductible
Autism related physical therapy	30%; after deductible	50%; after deductible
Autism related occupational therapy	30%; after deductible	50%; after deductible
Autism related speech therapy	30%; after deductible	50%; after deductible
Autism related behavioral therapy	$60 copay; no deductible	50%; after deductible
Covered same as any other Outpatient Mental Health benefit		
Autism related applied behavior analysis	30%; after deductible	50%; after deductible
Covered same as any other Outpatient Mental Health All Other benefit		

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Skilled nursing facility Limited to 60 days per year Your cost sharing applies to all covered benefits incurred during your inpatient stay.	30%; after deductible	50%; after deductible
Home health care Limited to 120 visits per year Private duty nursing not included. Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less.	30%; after deductible	50%; after deductible
Hospice care - inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	30%; after deductible	50%; after deductible
Hospice care - outpatient Your cost sharing applies to all covered benefits incurred during your outpatient visit.	30%; after deductible	50%; after deductible
Private duty nursing	Not Covered	Not Covered
Durable medical equipment	30%; after deductible	50%; after deductible
Prosthetics	20%; no deductible	50%; after deductible
Diabetic supplies -- (if not covered under the prescription drug benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
Affordable Care Act mandated women's contraceptives	Covered 100%; no deductible	Covered same as any other expense.
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; no deductible	Covered same as any other medical expense.
Infusion therapy Administered in the home or physician's office	$60 copay; no deductible	50%; after deductible
Infusion therapy Administered in an outpatient hospital department or freestanding facility	30%; after deductible	50%; after deductible
Hearing aids Covered up to age 18 for initial and replacement hearing aids not more frequently than every five years and new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the child. Includes the initial assessment, fitting and adjustments, and auditory training (within accepted professional standards).	30%; after deductible	50%; after deductible
Transplants	30%; after deductible Preferred coverage is provided at an IOE contracted facility only.	50%; after deductible
Bariatric surgery	Not Covered	Not Covered
Acupuncture Limited to 10 visits per year	$30 copay; no deductible	50%; after deductible
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility treatment Diagnosis and treatment of the underlying medical condition only.	Your cost sharing amount depends on the type of service and where you receive it.	Your cost sharing amount depends on the type of service and where you receive it.
Comprehensive infertility services	Your cost sharing amount depends on the type of service and where you receive it.	Applicable cost sharing based on the type of service performed and place of service where rendered

Coverage includes artificial insemination and ovulation induction limited to six courses of treatment per member lifetime. Lifetime maximum applies to all procedures covered by any of our plans except where prohibited by law.

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Advanced Reproductive Technology (ART)	Your cost sharing amount depends on the type of service and where you receive it.	Applicable cost sharing based on the type of service performed and place of service where rendered
Limited to 3 oocyte retrievals per lifetime. Unlimited embryo transfers. Includes coverage for cryopreservation and storage only for iatrogenic infertility. Iatrogenic infertility is infertility that may occur as a result of certain types of medical treatment.		
Vasectomy	Your cost sharing amount depends on the type of service and where you receive it.	50%; after deductible
Tubal ligation	Covered 100%; no deductible	50%; after deductible
PHARMACY	**IN-NETWORK**	**OUT-OF-NETWORK**
Pharmacy plan type	Advanced Control Plan	
Value Drugs Tier 1A		
Retail	$3 copay	30% of submitted cost; after applicable in-network cost share
Mail order	$6 copay	Not Applicable
Preferred generic drugs		
Retail	$10 copay	30% of submitted cost; after applicable in-network cost share
Mail order	$20 copay	Not Applicable
Preferred brand-name drugs		
Retail	$35 copay	30% of submitted cost; after applicable in-network cost share
Mail order	$70 copay	Not Applicable
Non-preferred generic and brand-name drugs		
Retail	$75 copay	30% of submitted cost; after applicable in-network cost share
Mail order	$150 copay	
Specialty drugs		
Preferred specialty	10% Maximum $250	30% of submitted cost; after applicable in-network cost share
Non-preferred specialty	10% Maximum $250	30% of submitted cost; after applicable in-network cost share
Pharmacy day supply and requirements		
Retail	Up to a 30 day supply from Aetna National Network	
Mandatory maintenance choice	After two retail fills, you'll need to fill 90-day supplies with CVS Caremark Mail Service Pharmacy™ or at CVS Pharmacy stores. Otherwise, the member will be responsible for 100 percent of the cost-share.	
Opt Out	The member must notify us of whether they want to continue to fill at a network retail pharmacy by calling the number on the member ID card.	
Specialty	Up to a 30 day supply All prescription fills must be through our preferred specialty pharmacy network. Advanced Control Formulary Aetna Insured List	

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Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy.
A limited list of over-the-counter medications are covered when filled with a prescription.
Oral and injectable fertility drugs included (physician charges for injections are not covered under RX, medical coverage is limited).
Contraceptives covered up to a 12 month supply. Contraceptive copay strategy applies.
Oral chemotherapy drugs covered 100%
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.
Precertification and quantity limits included
Advanced Control Formulary Aetna Insured Step Therapy
One transition fill allowed within 90 days of member's effective date

Choose Generics with Dispense as Written (DAW) override - The member pays the applicable copay. If the physician requires brand-name, member would 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.

GENERAL PROVISIONS

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

**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.
You may choose a provider (doctor or hospital) in our network. You may choose to visit an out-of-network provider. If you choose a doctor who is out of network, your health plan may pay some of that doctor's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor or hospital.

When you choose out-of-network care, we limit the amount it will pay. This limit is called the "recognized" or "allowed" amount.
• For doctors and other professionals the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

• For hospitals and other facilities, the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

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Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your plan "recognizes." Your doctor may bill you for the dollar amount that we don't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit our website.
You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to www.aetna.com and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Navigator member site.
This applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident, or for other emergency services), we will pay the bill as if you got care in network. You pay cost sharing and deductibles for your in-network level of benefits. Contact us if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your cost sharing and deductibles.
This way of paying out-of-network doctors and hospitals applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident), we will pay the bill as if you got care in-network. You pay your plan's copayments and deductibles for your in-network level of benefits. Contact us if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your copayments and deductibles.

Plans are provided by: Aetna Health Inc. 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.

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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.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

Translation of this material into another language may be available. Please call Member Services at the number on the back of your ID card.

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.