



**PLAN DESIGN & BENEFITS**  
**MEDICAL PLAN PROVIDED BY AETNA LIFE INSURANCE COMPANY**

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
<b>Benefit Limitations</b> - 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.		
<b>Deductible</b> (per calendar year)	\$250 Individual \$500 Family	\$750 Individual \$1,500 Family
All covered expenses accumulate simultaneously toward both 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.		
<b>Member Coinsurance</b>	5%	40%
Applies to all expenses unless otherwise stated.		
<b>Payment Limit</b> (per calendar year)	\$2,100 Individual \$4,200 Family	\$10,000 Individual \$20,000 Family
All covered expenses accumulate simultaneously toward both the in-network and out-of-network Payment Limit. Certain member cost sharing elements may not apply toward the Payment Limit. Pharmacy expenses do not 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.		
<b>Lifetime Maximum</b>		
Unlimited except where otherwise indicated.		
<b>Payment for Out-of-Network Care**</b>	Not Applicable	Professional: 105% of Medicare Facility: 140% of Medicare
<b>Primary Care Physician Selection</b> Calendar Year	Optional	Not Applicable
<b>Certification Requirements -</b>		
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 \$500 per occurrence.		
<b>Referral Requirement</b>	None	None



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<b>PREVENTIVE CARE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Routine Adult Physical Exams/ Immunizations</b> 1 exam every 12 months up to age 65, 1 exam every 12 months age 65 and older	Covered 100%; deductible waived	Not Covered
<b>Routine Well Child Exams/Immunizations</b> 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	40%; after deductible
<b>Routine Gynecological Care Exams</b> 1 obgyn exam and pap smear per year	Covered 100%; deductible waived	40%; after deductible
<b>Routine Mammograms</b>	Covered 100%; deductible waived	40%; after deductible
<b>Women's Health</b>  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.	Covered 100%; deductible waived	Covered according to standard claim practice.
<b>Routine Digital Rectal Exam</b> Recommended: For covered males age 40 and over.	Covered 100%; deductible waived	40%; after deductible
<b>Prostate-specific Antigen Test</b> Recommended: For covered males age 40 and over.	Covered 100%; deductible waived	40%; after deductible
<b>Colorectal Cancer Screening</b> Recommended: For all members age 45 and over.	Covered 100%; deductible waived	40%; after deductible
<b>Routine Eye Exams</b> 1 routine exam per 24 months.	Covered 100%; deductible waived	Not Covered
<b>Routine Hearing Screening</b>	Covered 100%; deductible waived	Not Covered
<b>PHYSICIAN SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Office Visits to non-Specialist</b>  Includes services of an internist, general physician, family practitioner or pediatrician.	5% after \$15 office visit copay; deductible waived	40%; after deductible
<b>Specialist Office Visits</b>	5% after \$15 office visit copay; deductible waived	40%; after deductible
<b>Hearing Exams</b>	Not Covered	Not Covered
<b>Pre-Natal Maternity</b>	Covered 100%; deductible waived	40%; after deductible
<b>Walk-in Clinics</b>  <b>Designated Walk-in Clinics</b> Covered 100%; deductible waived	5% after \$15 office visit copay; deductible waived	40%; after deductible
<b>Allergy Testing</b>	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
<b>Allergy Injections</b>	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



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<b>DIAGNOSTIC PROCEDURES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Diagnostic X-ray</b> (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.	5%; after deductible	40%; after deductible
<b>Diagnostic Laboratory</b> 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.	5%; after deductible	40%; after deductible
<b>Diagnostic Complex Imaging</b> 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.	5%; after deductible	40%; after deductible
<b>EMERGENCY MEDICAL CARE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Urgent Care Provider</b>	5% after \$35 office visit copay; deductible waived	40%
<b>Non-Urgent Use of Urgent Care Provider</b>	Not Covered	Not Covered
<b>Emergency Room</b> Copay waived if admitted	5% after \$100 copay; deductible waived	Same as in-network care
<b>Non-Emergency Care in an Emergency Room</b>	Not Covered	Not Covered
<b>Emergency Use of Ambulance</b>	10%; after deductible	Same as in-network care
<b>Non-Emergency Use of Ambulance</b>	Not Covered	Not Covered
<b>HOSPITAL CARE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Inpatient Coverage</b> Your cost sharing applies to all covered benefits incurred during your inpatient stay.	5%; after deductible	40%; after deductible
<b>Inpatient Maternity Coverage</b> (includes delivery and postpartum care) Your cost sharing applies to all covered benefits incurred during your inpatient stay.	5%; after deductible	40%; after deductible
<b>Outpatient Hospital Expenses</b> Your cost sharing applies to all covered benefits incurred during your outpatient visit.	5%; after deductible	40%; after deductible
<b>Outpatient Surgery - Hospital</b> Your cost sharing applies to all covered benefits incurred during your outpatient visit.	5% after \$100 copay; deductible waived	40%; after deductible
<b>Outpatient Surgery - Freestanding Facility</b> Your cost sharing applies to all covered benefits incurred during your outpatient visit.	5% after \$100 copay; deductible waived	40%; after deductible
<b>MENTAL HEALTH SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Mental Health Inpatient</b> Your cost sharing applies to all covered benefits incurred during your inpatient stay.	5%; after deductible	40%; after deductible
<b>Mental Health Office Visits</b> Your cost sharing applies to all covered benefits incurred during your outpatient visit.	5% after \$15 copay; deductible waived	40%; after deductible
<b>Other Mental Health Services</b>	5%; after deductible	40%; after deductible
<b>SUBSTANCE ABUSE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Substance Abuse Inpatient</b> Your cost sharing applies to all covered benefits incurred during your inpatient stay.	5%; after deductible	40%; after deductible
<b>Residential Treatment Facility</b>	5%; after deductible	40%; after deductible



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<b>Substance Abuse Office Visits</b>	5% after \$15 copay; deductible waived	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
<b>Other Substance Abuse Services</b>	5%; after deductible	40%; after deductible
<b>OTHER SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Skilled Nursing Facility</b>	5%; after deductible	40%; after deductible
Limited to 60 days per year Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
<b>Home Health Care</b>	5%; after deductible	40%; after deductible
Limited to 120 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.		
<b>Hospice Care - Inpatient</b>	5%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
<b>Hospice Care - Outpatient</b>	5%; after deductible	40%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
<b>Private Duty Nursing - Outpatient</b>	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.		
<b>Outpatient Rehabilitative Speech Therapy</b>	5% after \$15 copay; deductible waived	40%; after deductible
<b>Outpatient Physical and Occupational Therapy</b>	5% after \$15 copay; deductible waived	40%; after deductible
<b>Spinal Manipulation Therapy</b>	5% after \$15 copay; deductible waived	40%; after deductible
Limited to 20 visits per year		
<b>Habilitative Physical Therapy</b>	5%; after deductible	40%; after deductible
<b>Habilitative Occupational Therapy</b>	5%; after deductible	40%; after deductible
<b>Habilitative Speech Therapy</b>	5%; after deductible	40%; after deductible
<b>Autism Behavioral Therapy</b>	5% after \$15 copay; deductible waived	40%; after deductible
Covered same as any other Outpatient Mental Health benefit		
<b>Autism Applied Behavior Analysis</b>	5%; after deductible	40%; after deductible
Covered same as any other Outpatient Mental Health Other Services benefit		
<b>Autism Physical Therapy</b>	5%; after deductible	40%; after deductible
<b>Autism Occupational Therapy</b>	5%; after deductible	40%; after deductible
<b>Autism Speech Therapy</b>	5%; after deductible	40%; after deductible
<b>Durable Medical Equipment</b>	50%; after deductible	50%; after deductible
<b>Orthotics</b>	10%; after deductible	40%; after deductible
Orthotics and special footwear covered for persons with foot disfigurement.		
<b>Diabetic Supplies -- (if not covered under Pharmacy benefit)</b>	Covered same as any other medical expense.	Covered same as any other medical expense.
<b>Affordable Care Act andated Women's Contraceptives</b>	Covered 100%; deductible waived	Covered same as any other expense.
<b>Women's Contraceptive drugs and devices not obtainable at a pharmacy</b>	Covered 100%; deductible waived	Covered same as any other expense.
<b>Infusion Therapy</b>	5% after \$15 copay; deductible waived	40%; after deductible
Administered in the home or physician's office		



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<b>Infusion Therapy</b> Administered in an outpatient hospital department or freestanding facility	5%; after deductible	30%; after deductible
<b>Vision Eyewear</b>	Not Covered	Not Covered
<b>Transplants</b>	5%; after deductible Preferred coverage is provided at an IOE contracted facility only.	40%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
<b>Bariatric Surgery</b>	Not Covered	Not Covered
<b>Acupuncture</b>	5% after \$15 copay; deductible waived	40%; after deductible

Limited to 20 visits per year

**"Other" Health Care** -- 20% member coinsurance, after deductible, for services that are neither in-network nor out-of-network.

<b>FAMILY PLANNING</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Infertility Treatment</b>	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.		
<b>Comprehensive Infertility Services</b> Artificial insemination and ovulation induction	Not Covered	Not Covered



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<b>Advanced Reproductive Technology (ART)</b>	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		
<b>Vasectomy</b>	Your cost sharing is based on the type of service and where it is performed	40%; after deductible
<b>Tubal Ligation</b>	Covered 100%; deductible waived	40%; after deductible
<b>PHARMACY</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Pharmacy Plan Type</b>	Advanced Control Plan - Aetna	
<b>Value Drugs Tier 1A</b>		
	<b>Retail</b>	Covered 100%
	<b>Mail Order</b>	Covered 100%
		40% of submitted cost
		Not Applicable
<b>Preferred Generic Drugs</b>		
	<b>Retail</b>	\$10 copay
	<b>Mail Order</b>	\$20 copay
		40% of submitted cost Maximum \$250
		40% of submitted cost
<b>Preferred Brand-Name Drugs</b>		
	<b>Retail</b>	\$35 copay
	<b>Mail Order</b>	\$70 copay
		40% of submitted cost Maximum \$250
		40% of submitted cost
<b>Non-Preferred Generic and Brand-Name Drugs</b>		
	<b>Retail</b>	\$50 copay
	<b>Mail Order</b>	\$100 copay
		40% of submitted cost Maximum \$250
		40% of submitted cost
<b>Pharmacy Day Supply and Requirements</b>		
	<b>Retail</b>	Up to a 30 day supply from Aetna National Network
<b>Mandatory Maintenance Choice</b>		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 meeting a greater cost-sharing (i.e. penalty)
	<b>Opt Out</b>	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.
<b>Specialty</b>		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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**Choose Generics** - If the member or the physician requests brand when generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.

**Plan Includes:** Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy. Contraceptives covered up to a 12 month supply. Contraceptive copay strategy applies.

Includes sexual dysfunction drugs for females and males, including daily dose, additional 6 tablets a month for males for erectile dysfunction.

A limited list of over-the-counter medications are covered when filled with a prescription.

Oral chemotherapy drugs covered 100%

Precertification and quantity limits included

Step Therapy included

Seasonal Vaccinations covered 100% in-network

Preventive Vaccinations covered 100% in-network

One transition fill allowed within 90 days of member's effective date

Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.

<b>Prescription Drug Annual Out of Pocket Maximum</b>	\$400 Individual	Not Applicable
	\$800 Family	

**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.

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](http://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.





Fresno Unified School District  
Effective Date: 07-01-2023  
Open Choice® PPO

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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, coinsurance 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, coinsurance and deductibles.

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. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. 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.

If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.





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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 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](http://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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