aetna®

CHARLOTTESVILLE CITY SCHOOLS – CCS 15
Effective Date: 07-01-2016
Aetna Choice® POS II -- ASC

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

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	None Individual None Family	$400 Individual $800 Family
All covered expenses accumulate separately toward the preferred or non-preferred 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	20%	30%
Applies to all expenses unless otherwise stated.		
Payment Limit (per calendar year)	$2,500 Individual $5,000 Family	$4,250 Individual $8,500 Family
All covered expenses accumulate separately toward the preferred or non-preferred 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 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 Non-Preferred 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	Covered 100%	30%; after deductible
1 exam every 12 months for members age 22 to age 65; 1 exam every 12 months for adults age 65 and older.		
Routine Well Child Exams/Immunizations	Covered 100%	30%; after deductible
7 exams in the first 12 months of life, 3 exams in the second 12 months of life, 3 exams in the third 12 months of life, 1 exam per year thereafter to age 22.		
Routine Gynecological Care Exams	Covered 100%	30%; after deductible
Recommended: One exam per calendar year. Includes routine tests and related lab fees.		
Routine Mammograms	Covered 100%	30%; after deductible

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Women's Health	Covered 100%	30%; 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%	30%; after deductible
Recommended: For covered males age 40 and over.		
Prostate-specific Antigen Test	Covered 100%	30%; after deductible
Recommended: For covered males age 40 and over.		
Colorectal Cancer Screening	Covered 100%	Covered under Routine Adult Exams
Recommended: For all members age 50 and over.		
Routine Eye Exams	Covered 100%	Not Covered
1 routine exam per 12 months.		
Routine Hearing Screening	Covered 100%	30%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to Non-Specialist	$15 copay	30%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Non-Routine OB/GYN Office Visits	$15 copay	40%; after deductible
Non-Routine Mammogram Office Visits	Covered 100%	30%; after deductible
Specialist Office Visits	$25 copay	30%; after deductible
Audiometric Hearing Exam	Not Covered	Not Covered
Pre-Natal Maternity	Covered 100%	Covered according to standard claim practice.
Walk-in Clinics	$15 copay	Not Covered
Walk-in Clinics are network, free-standing health care facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor the outpatient department of a hospital, shall be considered a Walk-in Clinic.		
Allergy Testing	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Allergy Injections	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray	$25 copay	30%; 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	Covered 100%	30%; after deductible

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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	$150 copay	30%; after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	$25 copay	30%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room Copay waived if admitted	$250 copay	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	20%	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	20% after $300 copay	30%; after deductible
Inpatient Maternity Coverage (includes delivery and postpartum care) The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	20% after $300 copay	30%; after deductible
Outpatient Hospital Expenses The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	20%	30%; after deductible
Outpatient Surgery - Hospital The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	$150 copay	30%; after deductible
Outpatient Surgery - Freestanding Facility The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	$150 copay	30%; after deductible
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	20% after $300 copay	30%; after deductible
Outpatient The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	$15 copay	30%; after deductible
ALCOHOL/DRUG ABUSE SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	20% after $300 copay	30%; after deductible
Residential Treatment Facility	20% after $300 copay	30%; after deductible

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Outpatient	$15 copay	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Convalescent Facility	20%	30%; after deductible
Limited to 100 days per calendar year.		
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Home Health Care	20%	30%; after deductible
Limited to 90 visits per calendar year.		
Each visit by a nurse or therapist is one visit. Each visit up to 4 hours by a home health care aide is one visit.		
Hospice Care - Inpatient	Covered 100%	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Hospice Care - Outpatient	Covered 100%	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Private Duty Nursing	Not Covered	Not Covered
Outpatient Speech Therapy	$25 copay	30%; after deductible
Limited to 30 visits per calendar year.		
Outpatient Physical and Occupational Therapy	$25 copay	30%; after deductible
Limited to 30 visits per calendar year combined.		
Spinal Manipulation Therapy	$25 copay	30%; after deductible
Limited to 30 visits per calendar year.		
Autism Behavioral Therapy	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Combined with outpatient mental health visits		
Autism Applied Behavior Analysis	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Autism Physical Therapy	$25 copay	30%; after deductible
Visits combined with Physical and Occupational Combined Therapies.		
Autism Occupational Therapy	$25 copay	30%; after deductible
Visits combined with Physical and Occupational Combined Therapies.		
Autism Speech Therapy	$25 copay	30%; after deductible
Visits combined with Speech Therapy.		
Durable Medical Equipment	20%	30%; after deductible
Diabetic Supplies	Covered same as any other medical expense.	Covered same as any other medical expense.
Generic FDA-approved Women's Contraceptives	Covered 100%	30%; after deductible
Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%	Covered same as any other medical expense.
Transplants	20% after $300 copay Preferred coverage is provided at an IOE contracted facility only.	30%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.

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Bariatric Surgery	Not Covered	Not Covered
Early Intervention Services	Member cost sharing is based on the type of service performed and the place of service where it is rendered.	Member cost sharing is based on the type of service performed and the place of service where it is rendered.
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Diagnosis and treatment of the underlying medical condition.		
Comprehensive Infertility Services	Not Covered	Not Covered
Advanced Reproductive Technology (ART)	Not Covered	Not Covered
Vasectomy	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Tubal Ligation	Covered 100%	Member cost sharing is based on the type of service performed and the place of service where it is rendered
PHARMACY	**IN-NETWORK**	**OUT-OF-NETWORK**
Pharmacy Plan Type	Aetna Value Open Formulary	
Retail (3x copay for 90 day supply of retail prescription drugs).	$10 copay for formulary generic drugs, $30 copay for formulary brand-name drugs, and $50 copay for non-formulary brand-name and generic drugs up to a 30 day supply at participating pharmacies.	Not Covered
Mail Order	$20 copay for formulary generic drugs, $60 copay for formulary brand-name drugs, and $100 copay for non-formulary brand-name and generic drugs. Up to a 31-90 day supply from Aetna Rx Home Delivery®.	Not Covered

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Aetna Value Specialty Drugs	$10 copay for formulary generic drugs, $30 copay for formulary brand-name drugs, and $50 copay for non-formulary brand-name and generic drugs up to a 30 day supply at participating pharmacies.	Not Covered

All prescription fills must be through our preferred Aetna Specialty Pharmacy network.
Value Specialty Drug List

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: Contraceptive drugs and devices obtainable from a pharmacy.
A limited list of over-the-counter medications are covered when filled with a prescription.
Performance Enhancing Drugs limited to 6 tablets per month.
Value Pre-certification included
Value Step Therapy included
One transition fill allowed within 90 days of member's effective date
Formulary Generic FDA-approved Women's Contraceptives and certain over-the-counter preventive medications covered 100% in network.

Prescription Drug Annual Out of Pocket Maximum	$3,850 Individual $7,700 Family	Not Covered

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.

PLAN DESIGN & BENEFITS
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• 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.
• Durable medical Equipment
• 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.
• Orthotics except diabetic orthotics.
• 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 or inadequacies, including therapy, supplies or counseling or prescription drugs.
• Special duty nursing.
• Therapy or rehabilitation other than those listed as covered.
• Treatment of behavioral disorders.
• 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.

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery 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.

PLAN DESIGN & BENEFITS
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For more information about Aetna plans, refer to **www.aetna.com.**

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CHARLOTTESVILLE CITY SCHOOLS-CCS 20
Effective Date: 07-01-2016
Aetna Choice® POS II -- ASC

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

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	None Individual None Family	$500 Individual $1,000 Family
All covered expenses accumulate separately toward the preferred or non-preferred 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	20%	30%
Applies to all expenses unless otherwise stated.		
Payment Limit (per calendar year)	$3,000 Individual $6,000 Family	$4,500 Individual $9,000 Family
All covered expenses accumulate separately toward the preferred or non-preferred 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 Non-Preferred 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	Covered 100%	30%; after deductible
1 exam every 12 months for members age 22 to age 65; 1 exam every 12 months for adults age 65 and older.		
Routine Well Child Exams/Immunizations	Covered 100%	30%; after deductible
7 exams in the first 12 months of life, 3 exams in the second 12 months of life, 3 exams in the third 12 months of life, 1 exam per year thereafter to age 22.		
Routine Gynecological Care Exams	Covered 100%	30%; after deductible
Recommended: One exam per calendar year. Includes routine tests and related lab fees.		
Routine Mammograms	Covered 100%	30%; after deductible

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

Women's Health	Covered 100%	30%; 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%	30%; after deductible
Recommended: For covered males age 40 and over.		
Prostate-specific Antigen Test	Covered 100%	30%; after deductible
Recommended: For covered males age 40 and over.		
Colorectal Cancer Screening	Covered 100%	Covered under Routine Adult Exams
Recommended: For all members age 50 and over.		
Routine Eye Exams	Covered 100%	Not Covered
1 routine exam per 12 months.		
Routine Hearing Screening	Covered 100%	30%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to Non-Specialist	$20 copay	30%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Specialist Office Visits	$40 copay	30%; after deductible
Non-Routine OB/GYN Office Visits	$20 copay	40%; after deductible
Non-Routine Mammogram Office Visits	Covered 100%	30%; after deductible
Audiometric Hearing Exam	Not Covered	Not Covered
Pre-Natal Maternity	Covered 100%	Covered according to standard claim practice.
Walk-in Clinics	$20 copay	Not Covered
Walk-in Clinics are network, free-standing health care facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor the outpatient department of a hospital, shall be considered a Walk-in Clinic.		
Allergy Testing	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Allergy Injections	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray	20%	30%; 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	20%	30%; after deductible

PLAN DESIGN & BENEFITS
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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	20%	30%; after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	$40 copay	30%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room Copay waived if admitted	20% after $100 copay	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	20%	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	20% after $400 copay	30%; after deductible
Inpatient Maternity Coverage (includes delivery and postpartum care) The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	20% after $400 copay	30%; after deductible
Outpatient Hospital Expenses The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	20%	30%; after deductible
Outpatient Surgery - Hospital The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	20% after $100 copay	30%; after deductible
Outpatient Surgery - Freestanding Facility The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	20% after $100 copay	30%; after deductible
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	20% after $400 copay	30%; after deductible
Outpatient The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	$20 copay	30%; after deductible
ALCOHOL/DRUG ABUSE SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	20% after $400 copay	30%; after deductible
Residential Treatment Facility	20% after $400 copay	30%; after deductible
Outpatient	$20 copay	30%; after deductible

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

The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.

OTHER SERVICES	IN-NETWORK	OUT-OF-NETWORK
Convalescent Facility Limited to 100 days per calendar year. The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	20%	30%; after deductible
Home Health Care Limited to 90 visits per calendar year. Each visit by a nurse or therapist is one visit. Each visit up to 4 hours by a home health care aide is one visit.	20%	30%; after deductible
Hospice Care - Inpatient The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	Covered 100%	30%; after deductible
Hospice Care - Outpatient The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	Covered 100%	30%; after deductible
Private Duty Nursing	Not Covered	Not Covered
Outpatient Speech Therapy Limited to 30 visits per calendar year.	$40 copay	30%; after deductible
Outpatient Physical and Occupational Therapy Limited to 30 visits per calendar year combined.	$40 copay	30%; after deductible
Spinal Manipulation Therapy Limited to 30 visits per calendar year.	$40 copay	30%; after deductible
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	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Autism Physical Therapy Visits combined with Physical and Occupational Combined Therapies.	$40 copay	30%; after deductible
Autism Occupational Therapy Visits combined with Physical and Occupational Combined Therapies.	$40 copay	30%; after deductible
Autism Speech Therapy Visits combined with Speech Therapy.	$40 copay	30%; after deductible
Durable Medical Equipment	20%	30%; after deductible
Diabetic Supplies	Covered same as any other medical expense.	Covered same as any other medical expense.
Generic FDA-approved Women's Contraceptives	Covered 100%	30%; after deductible
Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%	Covered same as any other medical expense.
Transplants	20% after $400 copay Preferred coverage is provided at an IOE contracted facility only.	30%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered

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Early Intervention Services	Member cost sharing is based on the type of service performed and the place of service where it is rendered.	Member cost sharing is based on the type of service performed and the place of service where it is rendered.
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment Diagnosis and treatment of the underlying medical condition.	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Comprehensive Infertility Services	Not Covered	Not Covered
Advanced Reproductive Technology (ART)	Not Covered	Not Covered
Vasectomy	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Tubal Ligation	Covered 100%	Member cost sharing is based on the type of service performed and the place of service where it is rendered
PHARMACY	**IN-NETWORK**	**OUT-OF-NETWORK**
Pharmacy Plan Type	Aetna Value Open Formulary	
Retail (3x copay for 90 day supply of retail prescription drugs).	$10 copay for formulary generic drugs, $30 copay for formulary brand-name drugs, and $50 copay for non-formulary brand-name and generic drugs up to a 30 day supply at participating pharmacies.	Not Covered
Mail Order	$20 copay for formulary generic drugs, $60 copay for formulary brand-name drugs, and $100 copay for non-formulary brand-name and generic drugs. Up to a 31-90 day supply from Aetna Rx Home Delivery®.	Not Covered

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Aetna Value Specialty Drugs	$10 copay for formulary generic drugs, $30 copay for formulary brand-name drugs, and $50 copay for non-formulary brand-name and generic drugs up to a 30 day supply at participating pharmacies.	Not Covered

All prescription fills must be through our preferred Aetna Specialty Pharmacy network.
Value Specialty Drug List

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: Contraceptive drugs and devices obtainable from a pharmacy.
A limited list of over-the-counter medications are covered when filled with a prescription.
Performance Enhancing Drugs limited to 6 tablets per month.
Value Pre-certification included
Value Step Therapy included
One transition fill allowed within 90 days of member's effective date
Formulary Generic FDA-approved Women's Contraceptives and certain over-the-counter preventive medications covered 100% in network.

Prescription Drug Annual Out of Pocket Maximum	$3,350 Individual $6,700 Family	Not Covered

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.

PLAN DESIGN & BENEFITS
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• 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.
• Durable medical Equipment
• 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.
• Orthotics except diabetic orthotics.
• 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 or inadequacies, including therapy, supplies or counseling or prescription drugs.
• Special duty nursing.
• Therapy or rehabilitation other than those listed as covered.
• Treatment of behavioral disorders.
• 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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In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

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aetna®

CHARLOTTESVILLE CITY SCHOOLS – CCS 30
Effective Date: 07-01-2016
Aetna Choice® POS II -- ASC

PLAN DESIGN & BENEFITS
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PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	$1,000 Individual $2,000 Family	$1,500 Individual $3,000 Family
All covered expenses accumulate separately toward the preferred or non-preferred 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.	20%	40%
Payment Limit (per calendar year)	$3,500 Individual $7,000 Family	$5,500 Individual $11,000 Family
All covered expenses accumulate separately toward the preferred or non-preferred 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 Non-Preferred 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	Covered 100%; deductible waived	40%; after deductible
1 exam every 12 months for members age 22 to age 65; 1 exam every 12 months for adults age 65 and older.		
Routine Well Child Exams/Immunizations	Covered 100%; deductible waived	40%; after deductible
7 exams in the first 12 months of life, 3 exams in the second 12 months of life, 3 exams in the third 12 months of life, 1 exam per year thereafter to age 22.		
Routine Gynecological Care Exams	Covered 100%; deductible waived	40%; after deductible
Recommended: One exam per calendar year. Includes routine tests and related lab fees.		
Routine Mammograms	Covered 100%; deductible waived	40%; after deductible

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Women's Health	Covered 100%; deductible waived	40%; 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	40%; after deductible
Recommended: For covered males age 40 and over.		
Prostate-specific Antigen Test	Covered 100%; deductible waived	40%; after deductible
Recommended: For covered males age 40 and over.		
Colorectal Cancer Screening	Covered 100%; deductible waived	Covered under Routine Adult Exams
Recommended: For all members age 50 and over.		
Routine Eye Exams	Covered 100%; deductible waived	Not Covered
1 routine exam per 12 months.		
Routine Hearing Screening	Covered 100%; deductible waived	40%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to Non-Specialist	$30 copay; deductible waived	40%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Specialist Office Visits	$30 copay; deductible waived	40%; after deductible
Non-Routine OB/GYN Office Visits	$30 copay; deductible waived	40%; after deductible
Non-Routine Mammogram Office Visits	Covered 100%; deductible waived	40%; after deductible
Audiometric Hearing Exam	Not Covered	Not Covered
Pre-Natal Maternity	Covered 100%; deductible waived	Covered according to standard claim practice.
Walk-in Clinics	$30 copay; deductible waived	Not Covered
Walk-in Clinics are network, free-standing health care facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor the outpatient department of a hospital, shall be considered a Walk-in Clinic.		
Allergy Testing	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Allergy Injections	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray	20%; after deductible	40%; 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	20%; after deductible	40%; after deductible

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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	20%; after deductible	40%; after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	$30 copay; deductible waived	40%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	20%; after deductible	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	20%; after deductible	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage	20%; after deductible	40%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	20%; after deductible	40%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Hospital Expenses	20%; after deductible	40%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Outpatient Surgery - Hospital	20%; after deductible	40%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Outpatient Surgery - Freestanding Facility	20%; after deductible	40%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	20%; after deductible	40%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient	$20 copay; deductible waived	40%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
ALCOHOL/DRUG ABUSE SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	20%; after deductible	40%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Residential Treatment Facility	20%; after deductible	40%; after deductible
Outpatient	$20 copay; deductible waived	40%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		

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OTHER SERVICES	IN-NETWORK	OUT-OF-NETWORK
Convalescent Facility Limited to 100 days per calendar year. The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	20%; after deductible	40%; after deductible
Home Health Care Limited to 90 visits per calendar year. Each visit by a nurse or therapist is one visit. Each visit up to 4 hours by a home health care aide is one visit.	20%; after deductible	40%; after deductible
Hospice Care - Inpatient The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	20%; after deductible	40%; after deductible
Hospice Care - Outpatient The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	20%; after deductible	40%; after deductible
Private Duty Nursing	Not Covered	Not Covered
Outpatient Speech Therapy Limited to 30 days per calendar year.	20%; after deductible	40%; after deductible
Outpatient Physical and Occupational Therapy Limited to 30 visits per calendar year combined.	20%; after deductible	40%; after deductible
Spinal Manipulation Therapy Limited to 30 visits per calendar year.	20%; after deductible	40%; after deductible
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	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Autism Physical Therapy Visits combined with Physical and Occupational Combined Therapies.	$30 copay; deductible waived	40%; after deductible
Autism Occupational Therapy Visits combined with Physical and Occupational Combined Therapies.	$30 copay; deductible waived	40%; after deductible
Autism Speech Therapy Visits combined with Speech Therapy.	$30 copay; deductible waived	40%; after deductible
Durable Medical Equipment	20%; after deductible	40%; after deductible
Diabetic Supplies	Covered same as any other medical expense.	Covered same as any other medical expense.
Generic FDA-approved Women's Contraceptives	Covered 100%; deductible waived	40%; after deductible
Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered same as any other medical expense.
Vision Eyewear	Not Covered	Same as preferred care.
Transplants	20%; 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.

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Bariatric Surgery	Not Covered	Not Covered
Early Intervention Services	Member cost sharing is based on the type of service performed and the place of service where it is rendered.	Member cost sharing is based on the type of service performed and the place of service where it is rendered.
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment Diagnosis and treatment of the underlying medical condition.	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Comprehensive Infertility Services	Not Covered	Not Covered
Advanced Reproductive Technology (ART)	Not Covered	Not Covered
Vasectomy	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Tubal Ligation	Covered 100%; deductible waived	Member cost sharing is based on the type of service performed and the place of service where it is rendered
PHARMACY	**IN-NETWORK**	**OUT-OF-NETWORK**
Pharmacy Plan Type	Aetna Value Open Formulary	
Retail (3x copay for 90 day supply of retail prescription drugs).	$10 copay for formulary generic drugs, $30 copay for formulary brand-name drugs, and $50 copay for non-formulary brand-name and generic drugs up to a 30 day supply at participating pharmacies.	Not Covered
Mail Order	$20 copay for formulary generic drugs, $60 copay for formulary brand-name drugs, and $100 copay for non-formulary brand-name and generic drugs. Up to a 31-90 day supply from Aetna Rx Home Delivery®.	Not Covered

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Aetna Value Specialty Drugs	$10 copay for formulary generic drugs, $30 copay for formulary brand-name drugs, and $50 copay for non-formulary brand-name and generic drugs up to a 30 day supply at participating pharmacies.	Not Covered

All prescription fills must be through our preferred Aetna Specialty Pharmacy network.
Value Specialty Drug List

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: Contraceptive drugs and devices obtainable from a pharmacy.
A limited list of over-the-counter medications are covered when filled with a prescription.
Performance Enhancing Drugs limited to 6 tablets per month.
Value Pre-certification included
Value Step Therapy included
One transition fill allowed within 90 days of member's effective date
Formulary Generic FDA-approved Women's Contraceptives and certain over-the-counter preventive medications covered 100% in network.

Prescription Drug Annual Out of Pocket Maximum	$2,850 Individual $5,700 Family	Not Covered

GENERAL PROVISIONS

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

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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.

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