City of Staunton & Staunton City Schools
Proposed Effective Date: 01-01-2018
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)	$1,000 Individual $2,000 Family	$1,000 Individual $2,000 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)	$3,000 Individual $6,000 Family	$3,000 Individual $6,000 Family
All covered expenses accumulate simultaneously toward both the preferred and 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. Please see your Pharmacy plan design for further details. 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 and Hospice Care 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
One (1) Routine Exam per calendar year, including one (1) Pap Smear and related fees for females age 18 and over.		
Routine Mammograms	Covered 100%; deductible waived	40%; after deductible
One baseline mammogram for females age 35 - 39; and one annual mammogram for females age 40 and over.		
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.		

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Prostate-specific Antigen Test Recommended: For covered males age 40 and over.	Covered 100%; deductible waived	40%; after deductible
Colorectal Cancer Screening – Routine and Diagnostic Recommended: For all members age 50 and over.	Covered 100%; deductible waived	40%; after deductible
Routine Eye Exams 1 routine exam per 12 months.	Covered 100%; deductible waived	Not Covered
Routine Hearing Screening	Not Covered	Not Covered
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to Non-Specialist Includes services of an internist, general physician, family practitioner or pediatrician.	$25 copay; deductible waived	40%; after deductible
Specialist Office Visits	$50 copay; deductible waived	40%; after deductible
Non-Routine OB/GYN Office Visits	$25 copay; deductible waived	40%; after deductible
Pre-Natal Maternity	Covered 100%; deductible waived	Covered according to standard claim practice.
Walk-in Clinics 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.	$25 copay; deductible waived	Not Covered
Allergy Testing	$5 copay; deductible waived	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Allergy Injections	$5 copay; deductible waived	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 (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.	20%; after deductible	40%; after deductible
Diagnostic Laboratory 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. Quest Diagnostics is the preferred Aetna provider.	Covered 100%; deductible waived	40%; after deductible
Diagnostic Complex Imaging	20%; after deductible	40%; after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	$75 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	$100 copay; deductible waived	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 deductible	40%; after deductible
Inpatient Maternity Coverage (includes delivery and postpartum care)	20%; after deductible	40%; after deductible

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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	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	$25 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	$25 copay; deductible waived	40%; 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%; after deductible	40%; 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%; after deductible	40%; 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	20%; after deductible	40%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Hospice Care - Outpatient	20%; after deductible	40%; 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 Short-Term Rehabilitation	$50 copay; after deductible	40%; after deductible
Includes Speech, Physical, and Occupational Therapy, limited to 30 visits combined per calendar year.		
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.
Spinal Manipulation Therapy	$50 copay; after deductible	40%; after deductible
Limited to 12 days per calendar year.		
Autism Behavioral Therapy	$25 copay; deductible waived	40%; after deductible
Covered same as any other Outpatient Mental Health benefit		
Autism Applied Behavior Analysis & Spectrum Disorder	$25 copay; deductible waived	40%; after deductible
Covered same as any other Outpatient Mental Health benefit		
Autism Physical Therapy	$50 copay; after deductible	40%; after deductible
Visits combined with Short Term Rehabilitation.		
Autism Occupational Therapy	$50 copay; after deductible	40%; after deductible
Visits combined with Short Term Rehabilitation.		
Autism Speech Therapy	$50 copay; after deductible	40%; after deductible
Visits combined with Short Term Rehabilitation.		
Durable Medical Equipment	20%; after deductible	40%; after deductible

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Diabetic Supplies Includes coverage of medically necessary foot orthotics	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.
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.
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
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.

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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.
• 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.
• 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.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.
Translation of the material into another language may be available. Please call Member Services at **1-888-982-3862.**
Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862.**
Plan features and availability may vary by location and group size.
For more information about Aetna plans, refer to **www.aetna.com.**