Davis School District #737435
Effective Date: 01-01-2022
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Copay Plan

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

PLAN FEATURES	IN-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)	$2,500 Individual $5,000 Family
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. **Contact Navitus for information about pharmacy benefits.** 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%
Applies to all expenses unless otherwise stated.	
Payment Limit (per calendar year)	$3,500 Individual $7,000 Family
Certain member cost sharing elements may not apply toward the Payment Limit. Pharmacy expenses apply towards the Payment Limit**. Contact Navitus for information about pharmacy benefits.** 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.	
Primary Care Physician Selection	Optional
Referral Requirement	None
PREVENTIVE CARE	**IN-NETWORK**
Routine Adult Physical Exams/ Immunizations	Covered 100%; deductible waived
1 exam per calendar year up to age 65, 1 exam per calendar year age 65 and older	
Routine Well Child Exams	Covered 100%; deductible waived
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 calendar year thereafter to age 22.	
Routine Gynecological Care Exams	Covered 100%; deductible waived
1 exam and pap smear per calendar year, includes related fees.	
Routine Mammograms	Covered 100%; deductible waived
One baseline mammogram for females age 35 - 39; and one annual mammogram for females age 40 and over per calendar year.	
Women's Health	Covered 100%; deductible waived
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
Recommended: For covered males age 40 and over; one exam per calendar year.	
Prostate-specific Antigen Test	Covered 100%; deductible waived
Recommended: For covered males age 40 and over; one exam per calendar year.	
Colorectal Cancer Screening	Covered 100%; deductible waived
For all members age 45 and over.	

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Routine Eye Exams 1 routine exam per 12 months.	Covered 100%; deductible waived
Routine Hearing Screening (part of routine annual exam)	Covered 100%; deductible waived
PHYSICIAN SERVICES	**IN-NETWORK**
Primary Care Physician Visits	$40 copay; deductible waived
Specialist Office Visits	$50 copay; deductible waived
Hearing Exams	Not Covered
Pre-Natal Maternity	Covered 100%; deductible waived
Walk-in Clinics	$40 copay; deductible waived
Walk-in Clinics are free-standing health care facilities that (a) may be located in or with a pharmacy, drug store, supermarket or other retail store; and (b) provide limited medical care and services on a scheduled or unscheduled basis. Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices are not considered to be Walk-in Clinics. 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	Your cost sharing is based on the type of service and where it is performed
Allergy Injections	Your cost sharing is based on the type of service and where it is performed
DIAGNOSTIC PROCEDURES	**IN-NETWORK**
Diagnostic X-ray	Covered 100%; deductible waived
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%; deductible waived
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
EMERGENCY MEDICAL CARE	**IN-NETWORK**
Urgent Care Provider	$50 copay; deductible waived
Non-Urgent Use of Urgent Care Provider	Not Covered
Emergency Room Copay waived if admitted	$300 copay; deductible waived
Non-Emergency Care in an Emergency Room	Not Covered
Emergency Use of Ambulance	20%; after deductible
Non-Emergency Use of Ambulance	Not Covered
HOSPITAL CARE	**IN-NETWORK**
Inpatient Coverage	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Inpatient Maternity Coverage (includes delivery and postpartum care)	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Outpatient Hospital	20%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient stay.	
Outpatient Surgery - Hospital	20%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient stay.	
Outpatient Surgery - Freestanding Facility	20%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient stay.	

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MENTAL HEALTH SERVICES	IN-NETWORK
Inpatient	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Outpatient	$40 copay; deductible waived
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
Other Mental Health Services	Covered 100%; deductible waived
SUBSTANCE ABUSE	**IN-NETWORK**
Inpatient	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Residential Treatment Facility	20%; after deductible
Substance Abuse Office Visits	$40 copay; deductible waived
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
Other Substance Abuse Services	Covered 100%; deductible waived
OTHER SERVICES	**IN-NETWORK**
Skilled Nursing Facility	20%; after deductible
Limited to 60 days per calendar year.	
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Home Health Care	20% after $50 copay; after deductible
Limited to 60 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
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Hospice Care - Outpatient	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
Private Duty Nursing	20%; after deductible
Includes Private Duty Nursing limited to 60, eight-hour shifts per calendar year	
Outpatient Short-Term Rehabilitation	$50 copay; deductible waived
Includes speech, physical, occupational therapy; limited to 20 visits per calendar year	
Spinal Manipulation Therapy	$50 copay; deductible waived
Limited to 20 visits per calendar year.	
Autism Behavioral Therapy	Refer to Outpatient Mental Health
Covered same as any other 'Outpatient Mental Health' benefit	
Autism Applied Behavior Analysis	Refer to Outpatient Mental Health
Covered same as any other 'Outpatient Mental Health Other' benefit	
Autism Physical Therapy	$50 copay; deductible waived
Autism Occupational Therapy	$50 copay; deductible waived
Autism Speech Therapy	$50 copay; deductible waived
Habilitative Services	$50 copay; deductible waived
Covered the same as any other 'Outpatient Mental Health Other Service.' Includes Physical Therapy, Occupational Therapy and Speech Therapy	
Durable Medical Equipment	20%; deductible waived
Prosthetics	20%; deductible waived
Orthotics	20%; deductible waived
Diabetic Supplies -- (if not covered under Pharmacy benefit)	20%; deductible waived
Affordable Care Act mandated Women's Contraceptives	Covered 100%; deductible waived

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Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived
Infusion Therapy	Your cost sharing is based on the type of service and where it is performed
Administered in the home or physician's office	
Infusion Therapy	Your cost sharing is based on the type of service and where it is performed
Administered in an outpatient hospital department or freestanding facility	
Transplants	20%; after deductible Preferred coverage is provided at an IOE contracted facility only.
Gene-based, Cellular and Other Innovative therapies (GCIT)	20%; after deductible Preferred coverage is provided at a GCIT-designated provider/facility only.
Bariatric Surgery	Not Covered
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
FAMILY PLANNING	**IN-NETWORK**
Infertility Treatment	Applicable cost sharing based on the type of service performed and place of service where rendered
Diagnosis and treatment of the underlying medical condition only.	
Comprehensive Infertility Services	Not Covered
Artificial insemination and ovulation induction	
Advanced Reproductive Technology (ART)	Not Covered
In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery	
Vasectomy	20%; after deductible
Tubal Ligation	Covered 100%; deductible waived

NAVITUS – PHARMACY	**IN-NETWORK**
Pharmacy Coverage	Navitus Information about **prescription drug coverage** is available at 1-844-268-9789 or www.navitus.com
Pharmacy Deductible (per calendar year)	$100 Per Individual No Family Maximum
Generic Drugs – *Deductible waived*	
Retail	$15 copay
Mail Order	$30 copay
Preferred Brand-Name Drugs	
Retail	$30 copay
Mail Order	$60 copay
Non-Preferred Brand-Name Drugs	
Retail	$50 copay
Mail Order	$100 copay
Retail Out-of-Network Coverage	Not Covered
Standard Specialty Drugs	
Preferred Brand Specialty	$100 copay
Non-Preferred Brand Specialty	$100 copay
Pharmacy Day Supply and Requirements	
Retail	Up to a 30 day supply from Navitus Network providers
Mail Order	A 31-90 day supply from Navitus Network providers
Specialty	Up to a 30 day supply Navitus Specialty pharmacy

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GENERAL PROVISIONS

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

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.

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.

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.

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

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• 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.