



North Kansas City School District No. 74  
 Proposed Effective Date: 07-01-2020  
 A3 - Aetna Health Network Only<sup>SM</sup> - Missouri  
 A3 Primary Care 100 (\$\$)

**PLAN DESIGN & BENEFITS  
 PROVIDED BY AETNA HEALTH INC. - FULL RISK**

<b>PLAN FEATURES</b>	<b>IN-NETWORK</b>
<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)	None Individual None Family
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>Out-of-Pocket Maximum</b> (per calendar year)	\$1,350 Individual \$2,700 Family
In-network expenses include coinsurance/copays and deductibles. Pharmacy expenses apply towards the Out-of-Pocket-Maximum. The family Out-of-Pocket Maximum is a cumulative Out-of-Pocket Maximum for all family members. The family Out-of-Pocket Maximum can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Out-of-Pocket Maximum amount.	
<b>Lifetime Maximum</b>	Unlimited except where otherwise indicated.
<b>Primary Care Physician Selection</b>	Optional
<b>Referral Requirement</b>	None
<b>PREVENTIVE CARE</b>	<b>IN-NETWORK</b>
<b>Routine Adult Physical Exams/ Immunizations</b>	Covered 100%
1 exam per 12 months for members age 22 and older.	
<b>Routine Well Child Exams</b> (Age and frequency schedules apply)	Covered 100%
<b>Childhood Immunizations</b>	Covered 100% from birth to age 5
<b>Routine Gynecological Care Exams</b>	Covered 100%
1 exam per 12 months Includes routine tests and related lab fees.	
<b>Routine Mammograms</b>	Covered 100%
Recommended: One baseline mammogram for females age 35 - 39; and one annual mammogram for females age 40 and over.	
<b>Women's Health</b>	Covered 100%
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.	
<b>Routine Digital Rectal Exams / Prostate Specific Antigen Test</b>	Covered 100%
Recommended for males age 40 and over.	
<b>Colorectal Cancer Screening</b>	Covered 100%
Frequency schedule applies.	



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<b>Routine Eye Exams</b> 1 routine exam per 12 months.	Covered 100%
<b>Routine Hearing Screening</b>	Covered 100%
<b>PHYSICIAN SERVICES</b>	<b>IN-NETWORK</b>
<b>Office Visits to member's selected Primary Care Physician</b>	Covered 100%
<b>Specialist Office Visits</b> Includes services of an internist, general physician, family practitioner or pediatrician if the physician is not the member's selected PCP.	20%
<b>Pre-Natal Maternity</b>	Covered 100%
<b>Walk-in Clinics</b> 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.	20%
<b>Allergy Testing</b>	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. Covered 100% when an office visit charge is not applicable.
<b>Hearing Exams</b>	Your cost sharing is based on the type of service and where it is performed
<b>DIAGNOSTIC PROCEDURES</b>	<b>IN-NETWORK</b>
<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.	20%
<b>Diagnostic X-ray</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.	20%
<b>Diagnostic X-ray for Complex Imaging Services</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.	20%
<b>EMERGENCY MEDICAL CARE</b>	<b>IN-NETWORK</b>
<b>Urgent Care Provider</b>	20%
<b>Non-Urgent Use of Urgent Care Provider</b>	Not Covered
<b>Emergency Room</b>	20%
<b>Non-Emergency Care in an Emergency Room</b>	Not Covered
<b>Emergency Use of Ambulance</b>	20%
<b>Non-Emergency Use of Ambulance</b>	Not Covered
<b>HOSPITAL CARE</b>	<b>IN-NETWORK</b>
<b>Inpatient Coverage</b> Your cost sharing applies to all covered benefits incurred during your inpatient stay.	20%
<b>Inpatient Maternity Coverage</b> (includes delivery and postpartum care) Your cost sharing applies to all covered benefits incurred during your inpatient stay.	20% for Physician maternity services; Covered 20% for Facility services



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<b>Outpatient Hospital</b>	20%
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
<b>MENTAL HEALTH SERVICES</b>	<b>IN-NETWORK</b>
<b>Inpatient</b>	20%
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
<b>Mental Health Office Visits</b>	20%
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
<b>Other Mental Health Services</b>	Covered 100%
<b>SUBSTANCE ABUSE</b>	<b>IN-NETWORK</b>
<b>Inpatient</b>	20%
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
<b>Residential Treatment Facility</b>	20%
<b>Substance Abuse Office Visits</b>	20%
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
<b>Other Substance Abuse Services</b>	Covered 100%
<b>OTHER SERVICES</b>	<b>IN-NETWORK</b>
<b>Skilled Nursing Facility</b>	20%
Limited to 30 days per year Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
<b>Home Health Care</b>	20%
Limited to 60 visits per year 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>	20%
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
<b>Hospice Care - Outpatient</b>	20%
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
<b>Outpatient Rehabilitative Speech Therapy</b>	Covered 100%
<b>Outpatient Physical and Occupational Therapy</b>	Covered 100%
Limited to 60 visits; per year	
<b>Early Intervention Services</b>	Your cost sharing is based on the type of service and where it is performed
Children from birth to age 3; Includes short-term rehabilitation services, up to \$3,000 per year and \$9,000 maximum per child	



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<b>Spinal Manipulation Therapy</b>	20%
<b>Habilitative Services (Physical Therapy/Occupational Therapy/Speech Therapy)</b>	Covered 100%
<b>Autism Behavioral Therapy</b>	Refer to MBH Outpatient Mental Health Covered same as any other Outpatient Mental Health benefit
<b>Autism Applied Behavior Analysis</b>	Refer to MBH Outpatient Mental Health Other Services Covered same as any other Outpatient Mental Health Other Services benefit
<b>Autism Physical Therapy</b>	Covered 100%
<b>Autism Occupational Therapy</b>	Covered 100%
<b>Autism Speech Therapy</b>	Covered 100%
<b>Durable Medical Equipment</b>	20%
<b>Prosthetics</b>	20%
<b>Diabetic Supplies</b>	Pharmacy cost sharing applies if Pharmacy coverage is included; otherwise PCP office visit cost sharing applies.
<b>Women's Contraceptive drugs and devices not obtainable at a pharmacy. Also includes male condoms.</b>	Covered 100%
<b>Affordable Care Act Mandated Women's Contraceptives. Also includes male condoms.</b>	Covered 100%
<b>Hearing Aids</b>	20%
Child to age 1, 1 hearing aid covered for each impaired ear.	
<b>Infusion Therapy</b> Administered in the home or physician's office	Your cost sharing is based on the type of service and where it is performed
<b>Infusion Therapy</b> Administered in an outpatient hospital department or freestanding facility	Your cost sharing is based on the type of service and where it is performed
<b>Transplants</b>	20% Preferred coverage is provided at an IOE contracted facility only.
<b>Bariatric Surgery</b> Your cost sharing applies to all covered benefits incurred during your inpatient stay.	20%
<b>FAMILY PLANNING IN-NETWORK</b>	
<b>Infertility Treatment</b> Diagnosis and treatment of the underlying medical condition only.	Your cost sharing is based on the type of service and where it is performed
<b>Comprehensive Infertility Services</b> Artificial insemination and ovulation induction	Not Covered



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<b>Advanced Reproductive Technology (ART)</b>	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>	Covered 100%
<b>Female Sterilization</b>	Covered 100%
<b>Voluntary Abortion</b>	Not Covered
<b>PRESCRIPTION DRUG BENEFITS IN-NETWORK</b>	
<b>Pharmacy Plan Type</b>	Advanced Control Plan
<b>Preferred Generic Drugs</b>	
	<b>Retail</b> \$5 copay
	<b>Mail Order</b> \$15 copay
<b>Preferred Brand-Name Drugs</b>	
	<b>Retail</b> \$50 copay
	<b>Mail Order</b> \$150 copay
<b>Non-Preferred Generic and Brand-Name Drugs</b>	
	<b>Retail</b> \$55 copay
	<b>Mail Order</b> \$165 copay
<b>Pharmacy Day Supply and Requirements</b>	
	<b>Retail</b> Up to a 34 day supply 1 x copay, 35-68 day supply 2 x copay, 69-101 day supply 3 x copay from Aetna National Network
	<b>Mail Order</b> Up to a 101 day supply from CVS Caremark® Mail Service Pharmacy
	<b>Specialty</b> Up to a 30 day supply Advanced Control Formulary Aetna Insured List
<b>Choose Generics with Dispense as Written (DAW) override</b> - The member pays the applicable copay. If the physician requires brand-name, member would pay brand-name copay. If the member requests brand-name when a generic is available, the member pays the applicable copay plus the difference between the generic price and the brand-name price.	
<b>Plan Includes:</b> Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy. A limited list of over-the-counter medications are covered when filled with a prescription. Oral chemotherapy drugs covered 100% Precertification and quantity limits included Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network. Also includes male condoms.	
<b>GENERAL PROVISIONS</b>	
<b>Dependents Eligibility</b>	Spouse, children from birth to age 26 regardless of student status.

**Exclusions and Limitations**

**Health benefits and health insurance plans are offered and/or underwritten by Aetna Health Inc. Each insurer has sole financial responsibility for its own products.**

This material is for information only. Health benefits 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.



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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.

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.
- 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, or its affiliate(s), receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates may reduce the amount a member pays the pharmacy for covered prescriptions. CVS Caremark ® Mail Service Pharmacy refers to CVS Caremark ® Mail Service Pharmacy, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with CVS Caremark ® Mail Service Pharmacy 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.



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

**If you require language assistance, please call the Member Services number located on your ID card, and you will be connected with the language line if needed; or you may dial direct at 1-888-982-3862 (140 languages are available. You must ask for an interpreter). TDD 1-800-628-3323 (hearing impaired only).**

**Si requiere la asistencia de un representante que hable su idioma, por favor llame al número de Servicios al Miembro que aparece en su tarjeta de identificación y se le comunicará con la línea de idiomas si es necesario; de lo contrario, puede llamar directamente al 1-888-982-3862 (140 idiomas disponibles. Debe pedir un intérprete). TDD-1-800-628-3323 (sólo para las personas con impedimentos auditivos).**

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). While this material is believed to be accurate as of the production date, it is subject to change.

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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