South San Antonio Independent School District
Proposed Effective Date: 11-01-2019
Option 1- Aetna Open Access® Aetna Select℠

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

PLAN FEATURES	MAXIMUM SAVINGS	STANDARD SAVINGS
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)	$5,000 Individual $10,000 Family	$5,000 Individual $10,000 Family
All covered expenses accumulate simultaneously toward the 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	15%	35%
Applies to all expenses unless otherwise stated.		
Payment Limit (per calendar year)	$6,350 Individual $12,700 Family	$6,350 Individual $12,700 Family
All covered expenses accumulate simultaneously toward both the in-network or out-of-network Payment Limit. Certain member cost sharing elements may not apply toward the Payment Limit. Pharmacy expenses apply towards the Payment Limit. Only those out-of-pocket expenses resulting from the application of coinsurance percentage, copays, and deductibles (except any penalty amounts) may be used to satisfy the Payment Limit. The family Payment Limit is a cumulative Payment Limit for all family members. The family Payment Limit can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Payment Limit amount.		
Lifetime Maximum		
Unlimited except where otherwise indicated.		
Primary Care Physician Selection	Optional	Optional
Referral Requirement	None	None
PREVENTIVE CARE	**MAXIMUM SAVINGS**	**STANDARD SAVINGS**
Routine Adult Physical Exams/ Immunizations	Covered 100%; deductible waived	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	Covered 100%; deductible waived
7 exams first calendar year, 3 exams 13th - 24th months, 3 exams 25th - 36th months, 1 exam per calendar year thereafter to age 22.		
Routine Gynecological Care Exams	Covered 100%; deductible waived	Covered 100%; deductible waived
1 exam and pap smear per calendar year, includes related fees.		
Routine Mammograms	Covered 100%; deductible waived	Covered 100%; deductible waived
Women's Health	Covered 100%; deductible waived	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	Covered 100%; deductible waived
Recommended: For covered males age 40 and over.		
Prostate-specific Antigen Test	Covered 100%; deductible waived	Covered 100%; deductible waived
Recommended: For covered males age 40 and over.		

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Colorectal Cancer Screening Recommended: For all members age 45 and over.	Covered under Routine Adult Exams	Covered under Routine Adult Exams
Routine Eye Exams 1 routine exam per 24 months.	$70 copay; deductible waived	$70 copay; deductible waived
Routine Hearing Screening (1 per calendar year)	Covered 100%; deductible waived	Covered 100%; deductible waived
PHYSICIAN SERVICES	**MAXIMUM SAVINGS**	**STANDARD SAVINGS**
Office Visits to member's selected Primary Care Physician	$35 copay; deductible waived	$35 copay; deductible waived
Specialist Office Visits Includes services of an internist, general physician, family practitioner or pediatrician if the physician is not the member's selected PCP.	$70 copay; deductible waived	$70 copay; deductible waived
Hearing Exams (1 routine exam per 24 months)	$70 copay; deductible waived	$70 copay; deductible waived
Pre-Natal Maternity	Covered 100%; deductible waived	Covered 100%; deductible waived
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.	$35 copay; deductible waived	$35 copay; deductible waived
Allergy Testing	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Allergy Injections	Either the PCP copay $35 or Specialist copay $70 by place of service	Either the PCP copay $35 or Specialist copay $70 by place of service
DIAGNOSTIC PROCEDURES	**MAXIMUM SAVINGS**	**STANDARD SAVINGS**
Diagnostic X-ray 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.	15%; after deductible	35%; 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.	15%; after deductible	35%; after deductible
Diagnostic Complex Imaging 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.	15%; after deductible	35%; after deductible
EMERGENCY MEDICAL CARE	**MAXIMUM SAVINGS**	**STANDARD SAVINGS**
Urgent Care Provider	$100 copay; deductible waived	$100 copay; deductible waived
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room Copay waived if admitted	Hospital $250 copay; deductible waived / Physician 15% after deductible	Hospital $250 copay; deductible waived / Physician 15% after deductible
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	15%; after deductible	15%; after deductible
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**MAXIMUM SAVINGS**	**STANDARD SAVINGS**
Inpatient Coverage Your cost sharing applies to all covered benefits incurred during your inpatient stay.	15%; after deductible	35%; after deductible

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Inpatient Maternity Coverage (includes delivery and postpartum care)	15%; after deductible	35%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Outpatient Hospital	15%; after deductible	35%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient stay.		
Outpatient Surgery - Hospital	15%; after deductible	35%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient stay.		
Outpatient Surgery - Freestanding Facility	15%; after deductible	35%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient stay.		
MENTAL HEALTH SERVICES	**MAXIMUM SAVINGS**	**STANDARD SAVINGS**
Inpatient	15%; after deductible	35%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Mental Health Office Visits	$35 copay; deductible waived	$35 copay; deductible waived
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Mental Health Services	Covered 100%; deductible waived	Covered 100%; deductible waived
SUBSTANCE ABUSE	**MAXIMUM SAVINGS**	**STANDARD SAVINGS**
Inpatient	15%; after deductible	35%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Residential Treatment Facility	15%; after deductible	35%; after deductible
Substance Abuse Office Visits	$35 copay; deductible waived	$35 copay; deductible waived
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Other Substance Abuse Services	Covered 100%; deductible waived	Covered 100%; deductible waived
OTHER SERVICES	**MAXIMUM SAVINGS**	**STANDARD SAVINGS**
Skilled Nursing Facility Limited to 60 days per year	15%; after deductible	35%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Home Health Care	15%; after deductible	35%; after deductible
Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less.		
Hospice Care - Inpatient	Covered 100%; deductible waived	Covered 100%; deductible waived
Your cost sharing applies to all covered benefits incurred during your inpatient stay.		
Hospice Care - Outpatient	Covered 100%; deductible waived	Covered 100%; deductible waived
Your cost sharing applies to all covered benefits incurred during your outpatient visit.		
Outpatient Short-Term Rehabilitation	$70 copay; deductible waived	$70 copay; deductible waived
Includes speech, physical, occupational therapy limited to 35 visits per year		
Spinal Manipulation Therapy Limited to 20 visits per year	$70 copay; deductible waived	$70 copay; deductible waived
Habilitative Physical Therapy	$70 copay; deductible waived	$70 copay; deductible waived
Habilitative Occupational Therapy	$70 copay; deductible waived	$70 copay; deductible waived
Habilitative Speech Therapy	$70 copay; deductible waived	$70 copay; deductible waived
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	Covered 100%; deductible waived	Covered 100%; deductible waived
Covered same as any other Outpatient Mental Health All Other benefit		

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Autism Physical Therapy	$70 copay; deductible waived	$70 copay; deductible waived
Autism Occupational Therapy	$70 copay; deductible waived	$70 copay; deductible waived
Autism Speech Therapy	$70 copay; deductible waived	$70 copay; deductible waived
Durable Medical Equipment	15%; after deductible	35%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
Hearing Aids	15%; after deductible	35%; after deductible
Limited to 2 hearing aids every 36 months.		
Affordable Care Act Mandated Women's Contraceptives	Covered 100%; deductible waived	Covered 100%; deductible waived
Prosthetics	Not Covered	Not Covered
Orthotics	Not Covered	Not Covered
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered 100%; deductible waived
Infusion Therapy Administered in the home or physician's office	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Transplants	15%; after deductible Preferred coverage is provided at an IOE contracted facility only.	15%; after deductible Preferred coverage is provided at an IOE contracted facility only.
Bariatric Surgery	Not Covered	Not Covered
FAMILY PLANNING	**MAXIMUM SAVINGS**	**STANDARD SAVINGS**
Infertility Treatment	Applicable cost sharing based on the type of service performed and place of service where rendered	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 Artificial insemination and ovulation induction	Not Covered	Not Covered
Advanced Reproductive Technology (ART)	Not Covered	Not Covered
In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery		
Vasectomy	15%; after deductible	35%; after deductible
Tubal Ligation	Covered 100%; deductible waived	Covered 100%; deductible waived
GENERAL PROVISIONS		
Dependents Eligibility - Spouse, children from birth to age 26 regardless of student status.		

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.

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The following is a list of services and supplies that are generally *not covered*. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.
• All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
• Cosmetic surgery, including breast reduction.
• Custodial care.
• Dental care and dental X-rays.
• Donor egg retrieval
• Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
• Hearing aids
• Home births
• Immunizations for travel or work, except where medically necessary or indicated.
• Implantable drugs and certain injectable drugs including injectable infertility drugs.
• Infertility services, including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents.
• Long-term rehabilitation therapy.
• Non-medically necessary services or supplies.
• Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies.
• Radial keratotomy or related procedures.
• Reversal of sterilization.
• Services for the treatment of sexual dysfunction/enhancement, including therapy, supplies or counseling or prescription drugs.
• Special duty nursing.
• Therapy or rehabilitation other than those listed as covered.
• Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

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.**
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