

Aetna Self Funded Health Care Plans

South San Antonio Independent School District

Board Approved 9-18-19 Carrier Provider Network	Aetna / Express Scripts			Aetna / Express Scripts		Aetna / Express Scripts	
	Option 1 – Aetna Whole Health ACO			Option 2 POS		Option 3 POS	
General	Baptist Providers (Tier 1)	All other Aetna network (Tier 2)	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Preventive Care Services	100%	100%	No Coverage	100%		100%	
Calendar Year Deductible							
Individual	\$5,000	\$5,000	No Coverage	\$6,000	\$10,000	\$3,000	\$5,000
Family (Embedded)	\$10,000	\$10,000	No Coverage	\$12,000	\$30,000	\$6,000	\$10,000
Hospital Admission Inpatient	85% after deductible	65% after deductible	No Coverage	80% after deductible	50% after deductible	80% after Deductible	50% after deductible
Coinsurance %	85%	65%	No Coverage	80%	50%	80%	50%
Out-of-Pocket Maximum:							
Individual	\$6,350	\$6,350	No Coverage	\$7,150	\$13,000	\$6,000	\$10,000
Family	\$12,700	\$12,700	No Coverage	\$14,300	\$39,000	\$12,000	\$20,000
Policy Maximum	Unlimited	Unlimited	No Coverage	NA	NA	NA	NA
Physician Services:							
Primary Care Physician: Office Co-pays	\$35 copay	\$35 copay	No Coverage	\$40 copay	50% after deductible	\$35 copay	50% after deductible
Specialist / Urgent Care: Office Co-pays	\$70 copay Spec; \$100 Urgent Care	\$70 copay Spec; \$100 Urgent Care	No Coverage	\$60 copay Spec; \$100 Urgent Care	50% after deductible	\$45 copay Spec; \$75 Urgent Care	50% after deductible
Hospital Visits – Emergency Room Service	\$250 copay; deductible waived	\$250 copay; deductible waived	\$250 copay; deductible waived	80% after deductible	50% after deductible	80% after Deductible	50% after deductible
Maternity Prenatal Care	Covered 100%, deductible waived	Covered 100%, deductible waived	No Coverage	Covered 100%, deductible waived	50% after deductible	Covered 100%, deductible waived	50% after deductible
Allergy Injections	\$35 PCP \$70 Specialist	\$35 PCP \$70 Specialist	No Coverage	\$40 PCP \$60 Specialist	50% after deductible	\$35 PCP \$45 Specialist	50% after deductible
In-Patient Psych.	85% after deductible	65% after deductible	No Coverage	80% after deductible	50% after deductible	80% after Deductible	50% after deductible
Out-Patient Psych.	\$70 copay	\$70 copay	No Coverage	\$40 copay	50% after deductible	\$35 Copay	50% after deductible
Hospital Services:							
Room & Board Inpatient Services	85% after deductible	65% after deductible	No Coverage	80% after deductible	50% after deductible	80% after Deductible	50% after \$250 per admission deductible
Surgery	85% after deductible	65% after deductible	No Coverage	80% after deductible	50% after deductible	80% after Deductible	50% after deductible
Hospital Services Out Patient:							
Surgery	85% after deductible	65% after deductible	No Coverage	80% after deductible	50% after deductible	80% after Deductible	50% after deductible
Emergency - Facility	\$250 co-pay; ded. waived	\$250 co-pay; ded. waived	\$250 co-pay; ded. waived	80% after \$250 co-pay; ded. waived	80% after \$250 co-pay; ded. waived	80% after \$200 co-pay; ded. waived	80% after \$200 co-pay; ded waived
Emergency - Physician	80% after deductible	80% after deductible	No Coverage	80% after deductible	50% after deductible	80% after Deductible	80% after Deductible
Other Services:							
Home Health Care	85% after deductible	65% after deductible	Not Covered	80% after deductible	50% after deductible	80% after Deductible	50% after deductible
Hospice Care	100% , ded. waived	100% ded. waived	No Coverage	100%, ded. waived	70% after deductible	100%, ded. waived	70% after deductible
Ambulance- Emergency Medical Transportation	85% after deductible	85% after deductible	No Coverage	80% after deductible	80% after deductible	80% after Deductible	80% after deductible
Diagnostic X-ray & Lab, PET,MRI	85% after deductible	65% after deductible	No Coverage	80% after deductible	70% after deductible	80% after Deductible	70% after deductible
Pharmacy (ESI)	In-Network		Out of network	In-Network	Out of network	In-Network	Out of network
Prescription Drug Coverage	\$15/\$35/\$70		No Coverage	\$20/\$50/\$80	No coverage	\$25/\$45/\$80	No Coverage
Mail Order Pharmacy	\$37.50/\$87.50/\$175		No Coverage	\$50/\$125/\$200	NA	\$62.50/\$112.50/\$200	NA
Monthly Rates:	District Contribution	EE Pays		District Contribution	EE Pays	District Contribution	EE Pays
Employee Only	\$386.49	\$0.00		\$401.80	\$36.97	\$401.80	\$192.68
Employee/Spouse	\$386.49	\$283.64		\$401.80	\$368.36	\$401.80	\$824.01
Employee/Child(ren)	\$386.49	\$212.43		\$401.80	\$271.74	\$401.80	\$714.96
Employee/Family	\$386.49	\$494.86		\$401.80	\$603.61	\$401.80	\$1,152.31

