Open Access Aetna Select Medical Plan

Schedule of Benefits

Prepared exclusively for:

Employer:	Pasadena Independent School District
Contract number:	MSA-838899
	Schedule of Benefits 2A
Plan effective date:	January 1, 2019
Plan issue date:	December 1, 2018

These benefits are not insured with Aetna but will be paid from the Employer's funds. Aetna will provide certain administrative services under the Aetna medical benefits plan.

Schedule of benefits

This schedule of benefits lists the **deductibles** and **copayments/payment percentage**, if any, that apply to the services you receive under this plan. You should review this schedule to become familiar with your **deductibles** and **copayments/payment percentage** and any limits that apply to the services.

How to read your schedule of benefits

- When we say:
  - "In-network coverage", we mean you get care from a **network provider**.
- The **deductibles** and **copayments/payment percentage** listed in the schedule of benefits below reflect the **deductibles** and **copayment/payment percentage** amounts under your plan.
- Any **payment percentage** listed in the schedule of benefits reflects the plan **payment percentage**. This is the amount the Plan pays. You are responsible to pay any **deductibles**, **copayments**, and the remaining **payment percentage**.
- You are responsible for full payment of any health care services you receive that are not a **covered benefit**.
- This plan has maximums for specific **covered benefits**. For example, these could be visit, day or dollar maximums.
- At the end of this schedule you will find detailed explanations about your:
  - **Deductible**
  - **Maximum out-of-pocket limits**

Important note:
All **covered benefits** are subject to the Calendar Year **deductible** and **copayment/payment percentage** unless otherwise noted in the schedule of benefits below.

We are here to answer any questions. Contact Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or at the toll-free number on your ID card.

This schedule of benefits replaces any schedule of benefits previously in effect under your plan of benefits. Keep this schedule of benefits with your booklet.

Plan features	Deductible/Maximums
	In-network coverage*
Deductible	
You have to meet your Calendar Year **deductible** before this plan pays for benefits.	
Individual	$3,500 per Calendar Year
Family	$7,000 per Calendar Year
Deductible waiver	
The Calendar Year in-network **deductible** is waived for all of the following **eligible health services:** • Preventive care and wellness • Family planning services - female contraceptives	
Maximum out-of-pocket limit	
Maximum out-of-pocket limit per Calendar Year.	
Individual	$7,900 per Calendar Year
Family	$15,800 per Calendar Year

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services	In-network coverage*
Preventive care and wellness	
Routine physical exams	
Performed at a **physician's**, **PCP** office	100% per visit No **deductible** applies
Covered persons through age 21:	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents. For details, contact your **physician** or Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on your ID card.
Preventive care immunizations	
Performed in a facility or at a **physician's** office	100% per visit No **deductible** applies
	Subject to any age and visit limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on your ID card.
Well woman preventive visits routine gynecological exams (including pap smears)	
Performed at a **physician's**, **PCP**, obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% per visit No **deductible** applies
Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
Preventive screening and counseling services	
Office visits • Obesity and/or healthy diet counseling • Misuse of alcohol and/or drugs	100% per visit No **deductible** applies

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

• Use of tobacco products • Sexually transmitted infection counseling • Genetic risk counseling for breast and ovarian cancer	
Obesity and/or healthy diet counseling maximums:	
Maximum visits per 12 months (This maximum applies only to covered persons age 22 and older.)	26 visits (however, of these, only 10 visits will be allowed under the plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.	
Misuse of alcohol and/or drugs maximums:	
Maximum visits per 12 months	5 visits*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.	
Use of tobacco products maximums:	
Maximum visits per 12 months	8 visits*
*Note: In figuring the maximum visits, each session of up to 60 minutes is equal to one visit.	
Sexually transmitted infection counseling maximums:	
Maximum visits per 12 months	2 visits*
*Note: In figuring the maximum visits, each session of up to 30 minutes is equal to one visit.	
Genetic risk counseling for breast and ovarian cancer maximums:	
Genetic risk counseling for breast and ovarian cancer	Not subject to any age or frequency limitations

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Routine cancer screenings (applies whether performed at a physician's, PCP, specialist office or facility)	
Routine cancer screenings	100% per visit No **deductible** applies
Maximums	Subject to any age, family history, and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your **physician** or Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on your ID card.
Lung cancer screening maximums	1 screening every 12 months*
Important note: Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the *Outpatient diagnostic testing* section.	
Prenatal care **Prenatal care services (provided by an obstetrician (OB), gynecologist (GYN), and/or OB/GYN)**	
Preventive care services only	100% per visit No **deductible** applies
Important note: You should review the *Maternity and related newborn care* sections. They will give you more information on coverage levels for maternity care under this plan.	
Comprehensive lactation support and counseling services	
Lactation counseling services – facility or office visits	100% per visit No **deductible** applies
Lactation counseling services maximum per 12 months either in a group or individual setting	6 visits*
***Important note:** Any visits that exceed the lactation counseling services maximum are covered under **Physician** services office visits.	

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Breast feeding durable medical equipment	
Breast pump supplies and accessories	100% per item No **deductible** applies
Important note: See the *Breast feeding durable medical equipment* section of the booklet for limitations on breast pump and supplies.	
Family planning services – female contraceptives	
Counseling services	
Female contraceptive counseling services office visit	100% per visit No **deductible** applies
Contraceptive counseling services maximum visits per 12 months either in a group or individual setting	2 visits*
***Important note:** Any visits that exceed the contraceptive counseling services maximum are covered under **Physician** services office visits.	
Devices	
Female contraceptive device provided, administered, or removed, by a **physician** during an office visit	100% per item No **deductible** applies
Female voluntary sterilization	
Inpatient	100% per admission No **deductible** applies
Outpatient	100% per visit No **deductible** applies

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services	In-network coverage*
Physicians and other health professionals	
Physicians and **specialists** office visits (non-surgical)	
Physician services	
Office hours visits (non-surgical) non preventive care	80% (of the **negotiated charge**) per visit
Complex imaging services, lab work and radiological services performed during a **physician's** office visit	80% (of the **negotiated charge**) per visit
Immunizations that are not considered preventive care	
Immunizations that are not considered preventive care	Covered according to the type of benefit and the place where the service is received.
Specialist	
Specialist office visits	
Office hours visits (non-surgical)	80% (of the **negotiated charge**) per visit
Complex imaging services, lab work and radiological services performed during a **specialist** office visit	80% (of the **negotiated charge**) per visit
Physician surgical services	
Physicians and **specialists** office visits	
Performed at a **physician's**, **PCP** office	80% (of the **negotiated charge**) per visit
Performed at a **specialist's** office	80% (of the **negotiated charge**) per visit

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Alternatives to physician office visits	
Walk-in clinic visits	
Preventive Care Services	
Immunizations	100% per visit No **deductible** applies
	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your **physician** or Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on your ID card.
All non preventive care services for which cost sharing is not shown above	
All other services	$35 then the plan pays 100% (of the balance of the **negotiated charge**) per visit thereafter No **deductible** applies

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services	**In-network coverage***
Hospital and other facility care	
Hospital care	
Inpatient **hospital**	80% (of the **negotiated charge**) per admission
Alternatives to hospital stays	
Outpatient surgery and physician surgical services	
	80% (of the **negotiated charge**) per visit
Home health care	
Outpatient	80% (of the **negotiated charge**) per visit
Maximum visits per Calendar Year	60
Hospice care	
Inpatient facility	80% (of the **negotiated charge**) per admission
Maximum days per lifetime	Unlimited
Hospice care	
Outpatient	80% (of the **negotiated charge**) per visit
Skilled nursing facility	
Inpatient facility	80% (of the **negotiated charge**) per admission
Maximum days per Calendar Year	60

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services	In-network coverage*	Out-of-network coverage*
Emergency services and urgent care		
Emergency services		
Hospital emergency room	$500 then the plan pays 80% (of the balance of the **negotiated charge**) per visit	Paid the same as in-network coverage
Non-emergency care in a **hospital** emergency room	Not covered	Not covered
Important Note: ▪ As **out-of-network providers** do not have a contract with us the **provider** may not accept payment of your cost share, (**deductible, copayment** and **payment percentage**), as payment in full. You may receive a bill for the difference between the amount billed by the **provider** and the amount paid by this plan. If the **provider** bills you for an amount above your cost share, you are not responsible for paying that amount. You should send the bill to the address listed on your ID card, and we will resolve any payment dispute with the **provider** over that amount. Make sure the member's ID number is on the bill. ▪ A separate hospital emergency room **copayment/payment percentage** will apply for each visit to an emergency room. If you are admitted to a hospital as an inpatient right after a visit to an emergency room, your emergency room **copayment/payment percentage** will be waived and your inpatient **copayment/payment percentage** will apply.		
Urgent care		
Urgent medical care (at a non-**hospital** free standing facility)	80% (of the **negotiated charge**) per visit No **deductible** applies	
Non-urgent use of **urgent care provider** (at a non-**hospital** free standing facility)	Not covered	Not covered

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services	In-network coverage*
Specific conditions	
Autism spectrum disorder	
Autism spectrum disorder treatment	Covered according to the type of benefit and the place where the service is received
Applied behavior analysis	Covered according to the type of benefit and the place where the service is received
All other coverage for diagnosis and treatment, including behavioral therapy, will continue to be provided the same as any other **illness** under this plan	
Birthing center	
Inpatient	80% (of the **negotiated charge**) per admission
Diabetic equipment, supplies and education	
Diabetic equipment, supplies and education	100% (of the **negotiated charge**) per item/visit No **deductible** applies
Family planning services - other	
Voluntary sterilization for males	
Outpatient	80% (of the **negotiated charge**) per visit
Maternity and related newborn care	
Inpatient	80% (of the **negotiated charge**) per admission
Delivery services and postpartum care services	
Performed in a facility or at a **physician's** office	80% (of the **negotiated charge**) per visit
Other prenatal care services	Covered according to the type of benefit and the place where the service is received.

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Mental health treatment - inpatient	
Inpatient mental health treatment Inpatient **residential treatment facility** Coverage is provided under the same terms, conditions as any other **illness**.	80% (of the **negotiated charge**) per admission
Mental health treatment - outpatient	
Outpatient mental health treatment office visits to a **physician** or **behavioral health provider** includes **telemedicine** consultation Coverage is provided under the same terms, conditions as any other **illness**.	80% (of the **negotiated charge**) per visit
Outpatient mental health treatment office visits to a **physician** or **behavioral health provider** includes **telemedicine** cognitive behavior therapy consultation	80% (of the **negotiated charge**) per visit

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Other outpatient mental health treatment (includes skilled behavioral health services in the home) **Partial hospitalization treatment** (at least 4 hours, but less than 24 hours per day of clinical treatment) **Intensive outpatient program** (at least 2 hours per day and at least 6 hours per week of clinical treatment)	80% (of the **negotiated charge**) per visit

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Substance related disorders treatment - inpatient	
Inpatient **substance abuse detoxification** during a **hospital** confinement Inpatient **substance abuse** rehabilitation during a **hospital** confinement Inpatient **residential treatment facility** during a **hospital** confinement Coverage is provided under the same terms, conditions as any other **illness**.	80% (of the **negotiated charge**) per admission

Substance related disorders treatment - outpatient: detoxification and rehabilitation	
Outpatient **substance abuse** office visits to a **physician** or **behavioral health provider** includes **telemedicine** consultation Coverage is provided under the same terms, conditions as any other **illness**.	80% (of the **negotiated charge**) per visit
Outpatient **substance abuse** office visits to a **physician** or **behavioral health provider** includes **telemedicine** cognitive behavioral therapy consultations Coverage is provided under the same terms, conditions as any other **illness**.	80% (of the **negotiated charge**) per visit
Other outpatient **substance abuse** services (includes skilled	80% (of the **negotiated charge**) per visit

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

behavioral health services in the home) **Partial hospitalization treatment** (at least 4 hours, but less than 24 hours per day of clinical treatment) **Intensive outpatient program** (at least 2 hours per day and at least 6 hours per week of clinical treatment)	

Oral and maxillofacial treatment (mouth, jaws and teeth)	
Oral and maxillofacial treatment (mouth, jaws and teeth)	80% (of the **negotiated charge**) per visit

Reconstructive breast surgery	
Reconstructive breast **surgery**	Covered according to the type of benefit and the place where the service is received

Reconstructive surgery and supplies	
Reconstructive **surgery**	Covered according to the type of benefit and the place where the service is received

Eligible health services	**Network (IOE facility)**	**Network (Non-IOE facility)**
Transplant services facility and non-facility		
Inpatient **hospital** transplant services	80% (of the **negotiated charge**) per transplant	Not covered
Physician services including office visits	Covered according to the type of benefit and the place where the service is received.	Not covered

Eligible health services	**In-network coverage***
Treatment of infertility	
Basic infertility	
Basic **infertility**	Covered according to the type of benefit and the place where the service is received

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services	In-network coverage*
Specific therapies and tests	
Outpatient diagnostic testing	
Diagnostic complex imaging services	
	80% (of the **negotiated** charge) per visit
Diagnostic lab work	
	100% (of the **negotiated** charge) per visit. No **deductible** applies.
Diagnostic radiological services	
	100% of the **negotiated charge** per visit. No **deductible** applies.
Chemotherapy	
	Covered according to the type of benefit and the place where the service is received.
Outpatient infusion therapy	
	Covered according to the type of benefit and the place where the service is received.
Outpatient radiation therapy	
	Covered according to the type of benefit and the place where the service is received.

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Short-term cardiac and pulmonary rehabilitation services	
Cardiac rehabilitation	
Cardiac rehabilitation	Covered according to the type of benefit and the place where the service is received
Pulmonary rehabilitation	
Pulmonary rehabilitation	Covered according to the type of benefit and the place where the service is received

Short-term rehabilitation services	
Short-term rehabilitation services (outpatient physical, occupational, speech therapies) combined with Habilitation therapy services (outpatient physical, occupational, speech therapies)	
	80% (of the **negotiated charge**) per visit
Maximum visits per Calendar Year	60 visits

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services	**In-network coverage***
Other services	
Acupuncture	
Acupuncture	Covered according to the type of benefit and the place where the service is received
Ambulance service	
Ground, air or water **ambulance**	80% (of the **negotiated charge**) per visit
Clinical trial therapies (experimental or investigational)	
Clinical trial therapies	Covered according to the type of benefit and the place where the service is received
Clinical trials (routine patient costs)	
Clinical trial (routine patient costs)	Covered according to the type of benefit and the place where the service is received
Durable medical equipment (DME)	
DME	80% (of the **negotiated charge**) per item
Hearing aids and exams	
Hearing aid exams	80% (of the **negotiated charge**) per visit thereafter
Hearing aids	80% (of the **negotiated charge**) per item
Maximum per 36 month period	$2,500
Non-preventive hearing exams	
For adults and children	80% (of the **negotiated charge**) per visit thereafter
Maximum	One exam in any 24 month consecutive period.
Newborn hearing screening and follow-up screening	80% (of the **negotiated charge**) per visit thereafter No **deductible** applies

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Prosthetic devices	
Prosthetic devices	Covered according to the type of benefit and the place where the service is received
Spinal manipulation	
Spinal manipulation	80% (of the **negotiated charge**) per visit
Maximum visits per Calendar Year	24
Vision care	
Routine vision care	
Routine vision exams (including refraction)	
Performed by a legally qualified ophthalmologist or optometrist	80% (of the **negotiated charge**) per visit No **deductible** applies
Maximum visits per Calendar Year	1 visit

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Eligible health services*	
Outpatient prescription drugs	
Family planning services - female contraceptives	
Female contraceptives that are **generic prescription drugs**: • Injectable drugs • Vaginal rings • Transdermal contraceptive patches	100% per **prescription** or refill No **deductible** applies
Female contraceptives that are **brand-name prescription drugs**: • Injectable drugs • Vaginal rings • Transdermal contraceptive patches	100% per **prescription** or refill No **deductible** applies
Female contraceptive generic devices and brand-name devices	100% per **prescription** or refill No **deductible** applies
Preventive care drugs and supplements	
Preventive care drugs and supplements filled at a **pharmacy**	100% per **prescription** or refill No **deductible** applies

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Risk reducing breast cancer prescription drugs	
Risk reducing breast cancer **prescription drugs** filled at a **pharmacy**	100% per **prescription** or refill No **deductible** applies
Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on your ID card.
Tobacco cessation prescription and over-the-counter drugs	
Tobacco cessation **prescription drugs** and OTC drugs filled at a **pharmacy** for each 90 day supply	$0 per **prescription** or refill No **deductible** applies
Maximums:	Coverage is permitted for two 90-day treatment regimens only. Any additional treatment regimens will be subject to the cost sharing in your schedule of benefits below. Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation **prescription drugs** and OTC drugs, contact Member Services by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on your ID card.

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

General coverage provisions

This section provides detailed explanations about the:

- **Deductible**
- **Maximum out-of-pocket limits**

that are listed in the first part of this schedule of benefits.

Deductible provisions

The **deductible** may not apply to certain **eligible health services**. You must pay any applicable **copayments/payment percentage** for **eligible health services** to which the **deductible** does not apply.

Individual

This is the amount you owe for in-network **eligible health services** each Calendar Year before the plan begins to pay for **eligible health services**. This Calendar Year **deductible** applies separately to you and each of your covered dependents. After the amount you pay for **eligible health services** reaches the Calendar Year **deductible**, this plan will begin to pay for **eligible health services** for the rest of the Calendar Year.

Family

This is the amount you and your covered dependents owe for in-network **eligible health services** each Calendar Year before the plan begins to pay for **eligible health services**. After the amount you and your covered dependents pay for **eligible health services** reach this family Calendar Year **deductible**, this plan will begin to pay for **eligible health services** that you and your covered dependents incur for the rest of the Calendar Year.

To satisfy this family **deductible** limit for the rest of the Calendar Year, the following must happen:

- The combined **eligible health services** that you and each of your covered dependents incur towards the individual Calendar Year **deductibles** must reach this family **deductible** limit in a Calendar Year.

When this occurs in a Calendar Year, the individual Calendar Year **deductibles** for you and your covered dependents will be considered to be met for the rest of the Calendar Year.

Deductible carryover

Any amounts that you paid for **eligible health services** in the last three months of a Calendar Year that apply toward that year's Calendar Year **deductibles** will also count toward the following year's Calendar Year **deductibles**.

Copayments

Copayment

As it applies to in-network coverage, this is a specified dollar amount or percentage that must be paid by you at the time you receive **eligible health services** from a **network provider**.

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits

Payment percentage

The specific percentage the plan pays for a health care service listed in the schedule of benefits.

Maximum out-of-pocket limits provisions

Eligible health services that are subject to the **maximum out-of-pocket limit** include **prescription drug eligible health services** provided under the medical plan outpatient **prescription drug** plan.

The **maximum out-of-pocket limit** is the maximum amount you are responsible to pay for **copayments/payment percentage** and **deductibles** for **eligible health services** during the Calendar Year. This plan has an individual and family **maximum out-of-pocket limit**. As to the individual **maximum out-of-pocket limit** each of you must meet your **maximum out-of-pocket limit** separately.

Individual

Once the amount of the **copayments/payment percentage** and **deductibles** you and your covered dependents have paid for **eligible health services** during the Calendar Year meets the individual **maximum out-of-pocket limit**, this plan will pay 100% of the **negotiated charge** for **covered benefits** that apply toward the limit for the rest of the Calendar Year for that person.

Family

Once the amount of the **copayments/payment percentage** and **deductibles** you and your covered dependents have paid for **eligible health services** during the Calendar Year meets this family **maximum out-of-pocket limit**, this plan will pay 100% of the **negotiated charge** for such **covered benefits** that apply toward the limit for the remainder of the Calendar Year for all covered family members.

To satisfy this family **maximum out-of-pocket limit** for the rest of the Calendar Year, the following must happen:

- The family **maximum out-of-pocket limit** is a cumulative **maximum out-of-pocket limit** for all family members. The family **maximum out-of-pocket limit** can be met by a combination of family members with no single individual within the family contributing more than the individual **maximum out-of-pocket limit** amount in a Calendar Year.

The **maximum out-of-pocket limit** may not apply to certain **eligible health services**. If the **maximum out-of-pocket limit** does not apply to a covered benefit, your **copayment/payment percentage** for that covered benefit will not count toward satisfying the **maximum out-of-pocket limit** amount.

Certain costs that you incur do not apply toward the **maximum out-of-pocket limit**. These include:

- All costs for non-covered services
- All costs for non-emergency use of the emergency room
- All costs incurred for non-urgent use of an **urgent care provider**

Calculations; determination of benefits provisions

Your financial responsibility for the costs of services will be calculated on the basis of when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment or portions of stays that occur in more than one Calendar Year. Determinations regarding when benefits are covered are subject to the terms and conditions of the booklet.

*See *How to read your schedule of benefits* at the beginning of this schedule of benefits