Katy Independent School District
Effective Date: 01-01-2021
Aetna Open Access® Aetna Select℠
Memorial Hermann ACO Plan

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

PLAN FEATURES	IN-NETWORK DESIGNATED PROVIDERS
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)	$1,750 Individual $3,500 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 will not apply towards the Deductible. Once Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the year. There is no Individual Deductible to satisfy within the Family Deductible. Copays do not apply to deductible.	
Member Coinsurance	20%
Applies to all expenses unless otherwise stated.	
Payment Limit (per calendar year)	$4,500 Individual $9,000 Family
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
Certification Requirements - Certification for certain types of Out-of-Network care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is $400 per occurrence.	
Referral Requirement	None
Network Designations- In order to be covered at the preferred in-network benefit level you must use a designated provider for care. If you receive care from a non-designated provider your care may be paid at the out-of-network benefit level or may not be covered at all.	
PREVENTIVE CARE	**IN-NETWORK DESIGNATED PROVIDERS**
Routine Adult Physical Exams/ Immunizations	Covered 100%; deductible waived
1 exam per calendar year	
Routine Well Child Exams	Covered 100%; deductible waived
7 exams first 12 months, 3 exams 13th - 24th months, 3 exams 25th - 36th months, 1 exam per calendar year thereafter.	
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
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.	

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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.	
Prostate-specific Antigen Test	Covered 100%; deductible waived
Recommended: For covered males age 40 and over.	
Colorectal Cancer Screening	Covered 100%; deductible waived
Recommended: For all members age 45 and over.	
Preventative Eye Exams	Not Covered
Routine Hearing Screening	Covered 100%; deductible waived
PHYSICIAN SERVICES	**IN-NETWORK**
Office Visits to member's selected Primary Care Physician	20%; after deductible
Specialist Office Visits	25%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician if the physician is not the member's selected PCP.	
Diagnostic Hearing Exams	20%; after deductible
Pre-Natal Maternity	Covered 100%; deductible waived
Allergy Testing	20%; after deductible
Allergy Injections	20%; after deductible
DIAGNOSTIC PROCEDURES	**IN-NETWORK**
Diagnostic X-ray	20%; after deductible
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	20%; after deductible
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
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.	
EMERGENCY MEDICAL CARE	**IN-NETWORK DESIGNATED PROVIDERS**
Walk-in Clinics	20%; after deductible
Urgent Care Provider	20%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered
Emergency Room	50% after $250 copay; after deductible; waived if admitted
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 DESIGNATED PROVIDERS**
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.	

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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.	
MENTAL HEALTH SERVICES	**IN-NETWORK DESIGNATED PROVIDERS**
Inpatient	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Mental Health Office Visits	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
Other Mental Health Services	20%; after deductible
SUBSTANCE ABUSE	**IN-NETWORK DESIGNATED PROVIDERS**
Inpatient	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Residential Treatment Facility	20%; deductible waived
Substance Abuse Office Visits	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
Other Substance Abuse Services	20%; after deductible
OTHER SERVICES	**IN-NETWORK DESIGNATED PROVIDERS**
Skilled Nursing Facility	20%; after deductible
Limited to 60 days per year Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Home Health Care	20%; after deductible
Limited to 100 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.	
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.	
Outpatient Short-Term Rehabilitation	20%; after deductible
Limited to 60 visits per year Includes Speech, Physical, and Occupational Therapy	
Spinal Manipulation Therapy	20%; after deductible
Limited to 20 visits per year	
Habilitative Physical Therapy	20%; after deductible
Habilitative Occupational Therapy	20%; after deductible
Habilitative Speech Therapy	20%; after deductible
Autism Behavioral Therapy	Refer to MBH Outpatient Mental Health
Combined with outpatient mental health visits	
Autism Applied Behavior Analysis	Refer to MBH Outpatient Mental Health All Other
Covered same as any other Outpatient Mental Health All Other benefit	
Autism Physical Therapy	20%; after deductible
Autism Occupational Therapy	20%; after deductible
Autism Speech Therapy	20%; after deductible
Durable Medical Equipment	20%; after deductible
Orthotics	20%; after deductible Excludes foot orthotics, orthopedic shoes and supportive devices of the feet.

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Diabetic Supplies -- (if not covered under Pharmacy benefit)	Diabetic supplies covered by EXPRESS SCRIPTS and not covered under AETNA Medical Plan. Except monitors (Glucometers), Insulin Pumps and supplies related to the pump covered. Supplies related to the monitor not eligible.
Affordable Care Act Mandated Women's Contraceptives	Covered 100%; deductible waived
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived
Infusion Therapy Administered in the home or physician's office	20%; after deductible
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	20%; after deductible
Transplants	20%; after deductible Preferred coverage is provided at an IOE contracted facility only.
Bariatric Surgery- Institutes of Quality Required	20%; after deductible
*Covered up to $15,000 Lifetime Maximum Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
FAMILY PLANNING	**IN-NETWORK DESIGNATED PROVIDERS**
Infertility Treatment Diagnosis and treatment of the underlying medical condition only.	20%; after deductible
Comprehensive Infertility Services Artificial insemination and ovulation induction- Maximum of 6 sessions	20%; after deductible
Advanced Reproductive Technology (ART) In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery	Not Covered
Vasectomy	Your cost sharing is based on the type of service and where it is performed
Tubal Ligation	Covered 100%; deductible waived
GENERAL PROVISIONS	
Dependents Eligibility - Spouse, children from birth to age 26 regardless of student status. (Any Dependent child born while you are insured will become insured on the date of his/her birth if you elect Dependent Insurance no later than 31 days after his/her birth). Eligible dependent grandchildren under the age of 25 may be covered if you provide required documentation. Please check with your employer for required documents.	

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.

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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
• 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.

Aetna may receive rebates from certain drug manufacturers. Generally, such rebates do not directly reduce the amount a member pays the pharmacy for covered prescriptions.

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.

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