

Schedule of Benefits

Employer: Aldine Independent School District
ASA: 620264
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Schedule: 4A
Booklet Base: 4

For: Open Access Aetna Select- Low Option Plan

This is not an ERISA plan. Please contact your employer for more information.

Aetna Select Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Calendar Year Deductible*		
Individual Deductible*	\$4,000	Not applicable
Family Deductible*	\$8,000	Not applicable

*Unless otherwise indicated, any applicable **deductible** must be met before benefits are paid.

First Dollar Benefit

The Plan pays 100% of covered medical expenses up to the first dollar individual maximum shown. Refer to the Expense Provision section of this Schedule for eligible First Dollar Benefits

Individual Amount	\$225	Not Covered
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Plan Maximum Out of Pocket Limit includes plan **copayments**.

Individual Maximum Out of Pocket Limit:

- For **network** expenses: \$6,600

Family Maximum Out of Pocket Limit:

- For **network** expenses: \$13,200

<i>Lifetime Maximum Benefit per person</i>	Unlimited	Not applicable
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Payment Percentage listed in the Schedule below reflects the Plan Payment Percentage. This is the amount the Plan pays. You are responsible to pay any deductibles and the remaining payment percentage. You are responsible for full payment of any non-covered expenses you incur.

All Covered Expenses Are Subject To The Calendar Year Deductible Unless Otherwise Noted In The Schedule Below.

Maximums for specific covered expenses, including visit, day and dollar maximums are combined maximums between network and out-of-network, unless specifically stated otherwise.

PLAN FEATURES	NETWORK	OUT OF NETWORK
<i>Preventive Care Benefits</i>		
<i>Routine Physical Exams</i>		
<i>Office Visits -</i>	100% per visit. No copay or deductible applies.	Not Covered
<i>Covered Persons through age 21: Maximum Age & Visit Limits per Calendar Year</i>	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents. <i>For details, contact your physician or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card.</i>	Not Covered
<i>Covered Persons ages 22 but less than 65: Maximum Visits per Calendar Year</i>	1 visit	Not Covered
<i>Covered Persons age 65 and over: Maximum Visits per Calendar Year</i>	1 visit	Not Covered.

Preventive Care Immunizations

*Performed in a facility or **physician's** office*

100% per visit.

Not Covered

No **copay** or **deductible** applies.

Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

*For details, contact your **physician** or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card.*

Screening & Counseling Services

100% per visit.

Not Covered

Office Visits

Obesity and/or Healthy Diet

No **copay** or **deductible** applies.

Misuse of Alcohol and/or Drugs & Use of Tobacco Products

Sexually Transmitted Infections

Genetic Risk for Breast and Ovarian Cancer

Obesity and/or Healthy Diet Benefit Maximums

Maximum Visits per Calendar Year
(This maximum applies only to Covered Persons ages 22 & 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)**

Not Covered.

***Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.**

Misuse of Alcohol and/or Drugs Benefit Maximums

Maximum Visits per Calendar Year

5 visits*

Not Covered.

***Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.**

<i>Use of Tobacco Products Benefit</i>		
<i>Maximums</i>		
Maximum Visits per Calendar Year	8 visits*	Not Covered.
*Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.		
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<i>Sexually Transmitted Infections Benefit</i>		
<i>Maximums</i>		
Maximum Visits per Calendar Year	2 visits*	Not Covered
*Note: In figuring the Maximum Visits, each session of up to 30 minutes is equal to one visit.		
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<i>Well Woman Preventive Visits</i>		
<i>Office Visits</i>	100%	Not Covered
	No Calendar Year deductible applies	
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Maximum Visits per Calendar Year	1 visit	Not Covered
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<i>Routine Cancer Screening</i>		
<i>Outpatient</i>	100% per visit	Not Covered
	No Calendar Year deductible applies.	
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Routine Cancer Screening Maximums	Subject to any age; family history and frequency guidelines as set forth in the most current: <ul style="list-style-type: none"> 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. <p><i>For details, contact your physician or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card.</i></p>	Not Covered
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<i>Lung Cancer Screening Maximum</i>	One screening every 12 months*	Not Covered
*Important Note: Lung cancer screenings in excess of the maximum as shown above are covered under the Outpatient Diagnostic and Preoperative Testing section of your Schedule of Benefits.		

<i>Prenatal Care</i>		
<i>Office Visits</i>	100% per visit No copay or deductible applies.	Not Covered
Important Note: Refer to the Physician Services and Pregnancy Expenses sections of the Schedule of Benefits for more information on coverage levels for pregnancy expenses under this Plan, including other prenatal care, delivery and postnatal care office visits.		
<i>Comprehensive Lactation Support and Counseling Services</i>		
Lactation Counseling Services	100% per visit	Not Covered.
<i>Facility or Office Visits</i>	No copay or deductible applies.	
Lactation Counseling Services	6* visits per calendar year	Not Covered
Maximum Visits either in a group or individual setting		
*Important Note: Visits in excess of the Lactation Counseling Services Maximum as shown above, are covered under the <i>Physician Services</i> office visit section of the <i>Schedule of Benefits</i> .		
Breast Pumps & Supplies		
	100% per item. No copay or deductible applies.	Not Covered
<i>Family Planning - Other</i>		
Voluntary Termination of Pregnancy Outpatient	70% per visit after Calendar Year deductible.	Not Covered.
Voluntary Sterilization for Males Outpatient	70% per visit after Calendar Year deductible.	Not Covered.
<i>Family Planning Services</i>		
Female Contraceptive Counseling Services -Office Visits.	100% per visit after Calendar Year deductible	Not Covered.
Contraceptive Counseling Services - Maximum Visits either in a group or individual setting	2* visits per 12 months	Not Covered.
*Important Note: Visits in excess of the Contraceptive Counseling Services Maximum as shown above, are covered under the <i>Physician Services</i> office visit section of the <i>Schedule of Benefits</i> .		
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Female Contraceptive Generic Prescription Drugs and Devices provided, administered, or removed, by a Physician during an Office Visits.	100% per item No copay or deductible applies.	Not Covered.
<i>Family Planning - Female Voluntary Sterilization</i>		
<i>Inpatient</i>	100% per visit No copay or deductible applies.	Not Covered
<i>Outpatient</i>	100% per visit No copay or deductible applies.	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Family Planning Services - Female Contraceptives</i>		
Female Contraceptive Generic Prescription Drugs For each 30 day supply filled at a retail pharmacy	100% per prescription or refill. No deductible applies.	No coverage.
Female Contraceptive Devices For each 30 day supply filled at a retail pharmacy	100% per prescription or refill. No deductible applies.	No coverage.
FDA-Approved Female Generic Emergency Contraceptives For each 30 day supply filled at a retail pharmacy	100% per prescription or refill. No deductible applies.	No coverage.
FDA-Approved Female and Male Generic Over-the-Counter Contraceptives For each 30 day supply filled at a retail pharmacy	100% per prescription or refill. No deductible applies.	No coverage.
Important Note: Refer to the <i>Outpatient Prescription Drug Expenses</i> section of your <i>Schedule of Benefits</i> for more information on other prescription drug coverage under this Plan		

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Physician Services</i>		
<i>Office Visits to Primary Care Physician</i> Office visits (non-surgical) to non-specialist	70% per visit after Calendar Year deductible	Not Covered
<i>Specialist Office Visits</i>	70% per visit after Calendar Year deductible	Not Covered

Walk-In Clinic Visit (Non-Emergency)**Preventive Care Services***

Immunizations	100% per visit	Not Covered
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No **copay** or **deductible** applies.

For details, contact your **physician**, log onto the **Aetna** website www.aetna.com, or call the number on the back of your ID card.

Individual Screening and Counseling Services for Tobacco Use	100% per visit	Not Covered
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No **copay** or **deductible** applies.

Maximum Benefit per visit - Individual Screening and Counseling Services for Tobacco Use	Refer to the <i>Preventive Care Benefit</i> section earlier in this Schedule of Benefits for maximums that may apply to these types of services	Not Applicable
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Individual Screening and Counseling Services for Obesity	100% per visit	Not Covered
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No **copay** or **deductible** applies.

Maximum Benefit per visit - Individual Screening and Counseling Services for Obesity	Refer to the <i>Preventive Care Benefit</i> section earlier in this Schedule of Benefits for maximums that may apply to these types of services	Not Applicable
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***Important Note:**

Not all preventive care services are available at all **Walk-In Clinics**. The types of services offered will vary by the provider and location of the clinic. These services may also be obtained from your **physician**.

All Other Services	70% per visit after Calendar Year deductible	Not Covered
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Physician Office Visits-Surgery	70% per visit after Calendar Year deductible	Not Covered
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Physician Services for Inpatient Facility and Hospital Visits	70% per visit after Calendar Year deductible	Not Covered
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Administration of Anesthesia	70% after Calendar Year deductible	Not Covered
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Emergency Medical Services		
Hospital Emergency Facility and Physician	70% per visit after Calendar Year deductible	Paid same as Network benefits <i>*See Important note below</i>
<p>*Important Note: Please note that as these providers are not Network Providers and do not have a contract with Aetna, the provider may not accept payment of your cost share 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 Emergency Room Facility or physician bills you for an amount above your cost share, you are not responsible for paying that amount. Please send Aetna the bill at the address listed on the back of your member ID card and Aetna will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.</p>		
Non-Emergency Care in a Hospital Emergency Room	50% after Calendar Year deductible	Not Covered
Urgent Care Services		
Urgent Medical Care <i>(at a non-hospital free standing facility)</i>	70% per visit after Calendar Year deductible	Not Applicable
Urgent Medical Care <i>(from other than a non-hospital free standing facility)</i>	Refer to <i>Emergency Medical Services</i> and <i>Physician Services</i> above.	Refer to <i>Emergency Medical Services</i> and <i>Physician Services</i> above.
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Diagnostic and Preoperative Testing		
Complex Imaging Services		
Complex Imaging	70% per test after Calendar Year deductible	Not Covered
Diagnostic Laboratory Testing		
	70% per procedure after Calendar Year deductible	Not Covered
Diagnostic X-Rays		
Diagnostic X-Rays (except Complex Imaging Services)	70% per procedure after Calendar Year deductible	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Outpatient Surgery</i>		
<i>Outpatient Surgery</i>	70% per visit/surgical procedure after Calendar Year deductible	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Inpatient Facility Expenses</i>		
<i>Birthing Center</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered

<i>Hospital Facility Expenses</i> Room and Board (including maternity)	70% per admission after Calendar Year deductible	Not Covered
Other than Room and Board	70% per admission after Calendar Year deductible	Not Covered

<i>Skilled Nursing Inpatient Facility</i>	70% per admission after Calendar Year deductible	Not Covered
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Maximum Days per Calendar Year	60 days	Not Covered
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Specialty Benefits</i>		
<i>Home Health Care(Outpatient)</i>	70% per visit after the Calendar Year deductible	Not Covered

Maximum Visits per Calendar Year	100 visits	Not Covered
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<i>Skilled Nursing Care (Outpatient)</i>	70% per visit after the Calendar Year deductible	Not Covered
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<i>Hospice Benefits</i>		
<i>Hospice Care –Facility Expenses</i> (Room & Board)	70% per admission after Calendar Year deductible	Not Covered
<i>Hospice Care – Other Expenses during a stay</i>	70% per admission after Calendar Year deductible	Not Covered

Maximum Benefit per lifetime	Unlimited days	Not Covered
<i>Hospice Outpatient Visits</i>	70% per visit after Calendar Year deductible	Not Covered
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Infertility Treatment</i>		
<i>Basic Infertility Expenses</i> Coverage is for the diagnosis and treatment of the underlying medical condition causing the infertility only.	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Inpatient Treatment of Mental Disorders</i>		
<i>Mental Disorder</i>	Calendar Year deductible then the plan pays 70%	Not Covered
Maximum Benefit per Calendar Year	45 days	Not Covered
<i>Outpatient Treatment Of Mental Disorders</i>		
<i>Mental Disorder</i>	Calendar Year deductible then the plan pays 70%	Not Covered
Maximum Visits per Calendar Year	60 visits	Not Covered
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Inpatient Treatment of Alcoholism and Substance Abuse</i>		
<i>Inpatient Treatment</i>	Calendar Year deductible then the plan pays 70%	Not Covered
Maximum Days per Calendar Year	45 days	Not Covered
<i>Outpatient Treatment of Alcoholism and Substance Abuse</i>		
<i>Outpatient Treatment</i>	Calendar Year deductible then the plan pays 70%	Not Covered

Maximum Visits per Calendar Year	60 visits	Not Covered
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PLAN FEATURES	NETWORK (IOQ Facility Only)	OUT-OF-NETWORK (Network non-IOQ Facility or Out-of-Network Facility)
<i>Obesity Treatment Non Surgical</i>		
<i>Outpatient Obesity Treatment (non surgical)</i>	70% per visit after the Calendar Year deductible	Not Covered

PLAN FEATURES	NETWORK (IOQ Facility Only)	OUT-OF-NETWORK (Network non-IOQ Facility or Out- of-Network Facility)
<i>Obesity Treatment Surgical</i>		
<i>Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services)</i>	70% per admission after the Calendar Year deductible	Not Covered

<i>Outpatient Morbid Obesity Surgery</i>	70% per service after Calendar Year deductible	Not Covered
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Maximum Benefit Morbid Obesity Surgery (Inpatient and Outpatient)	\$12,000 per lifetime	Not Covered
This maximum includes benefits provided or administered by Aetna or any affiliated company of Aetna		

PLAN FEATURES	NETWORK (IOE Facility)	NETWORK (Non-IOE Facility)	OUT-OF-NETWORK
<i>Transplant Services Facility and Non-Facility Expenses</i>			
<i>Transplant Facility Expenses</i>	70% per admission after Calendar Year deductible	Not Covered	Not Covered
<i>Transplant Physician Services</i> (including office visits)	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Other Covered Health Expenses</i>		
<i>Acupuncture in lieu of anesthesia</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
<i>Ground, Air or Water Ambulance</i>	70% after Calendar Year deductible	Not Covered
<i>Diabetic Equipment and Education - includes glucometers, insulin pumps and pump supplies</i>	70% per item after the Calendar Year deductible .	Not Covered
<i>Durable Medical and Surgical Equipment</i>	70% per item after the Calendar Year deductible	Not Covered
<i>Clinical Trial Therapies</i> (Experimental or Investigational Treatment)	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered.
<i>Routine Patient Costs</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered.
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
<i>Prosthetic Devices</i>	70% after Calendar Year deductible	Not Covered
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Outpatient Therapies</i>		
<i>Chemotherapy</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
<i>Infusion Therapy</i>	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered

Radiation Therapy	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Short Term Outpatient Rehabilitation Therapies		
Outpatient Physical, Occupational, and Speech Therapy combined	Calendar Year deductible then the plan pays 70%	Not Covered
Combined Physical, Occupational and Speech Therapy Maximum visits per Calendar Year including all hospital rehabilitation facilities or office settings (combined with Autism Spectrum Disorder visits)	60 visits	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Autism Spectrum Disorder		
Applied Behavioral Analysis	70% per visit after Calendar Year deductible	Not Covered
Behavioral Therapy	70% per visit after Calendar Year deductible	Not Covered
Occupational Therapy, Physical Therapy and Speech Therapy*	70% per visit after Calendar Year deductible	Not Covered
*Autism Spectrum Disorder Occupational Therapy, Physical Therapy and Speech Therapy are combined with the Short Term Rehabilitation visit maximum.		

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Spinal Manipulation		
	Calendar Year deductible then the plan pays 70%	Not Covered
Spinal Manipulation Maximum visits per Calendar Year	20 visits	Not Covered

Expense Provisions

The following provisions apply to your health expense plan.

This section describes cost sharing features, benefit maximums and other important provisions that apply to your Plan. The specific cost sharing features and the applicable dollar amounts or benefit percentages are contained in the attached health expense sections of this *Schedule of Benefits*.

This *Schedule of Benefits* replaces any *Schedule of Benefits* previously in effect under your plan of health benefits.

KEEP THIS SCHEDULE OF BENEFITS WITH YOUR BOOKLET.

Deductible Provisions

All **covered expenses** accumulate toward the **network provider deductible** except for those **covered expenses** identified later in this *Schedule of Benefits*.

You and each of your covered dependents have separate Calendar Year **deductibles**. Each of you must meet your **deductible** separately and they cannot be combined. This Plan has individual and family Calendar Year **deductibles**.

Network Provider Calendar Year Deductible

Individual

This is the amount of **covered expenses** that you and each of your covered dependents incur each Calendar Year from a **network provider** for which no benefits will be paid. This individual Calendar Year **deductible** applies separately to you and each of your covered dependents. After **covered expenses** reach this individual Calendar Year **deductible**; this Plan will begin to pay benefits for **covered expenses** that you incur from a **network provider** for the rest of the Calendar Year.

Family Deductible Limit

When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **deductibles**, these expenses will also count toward a family **deductible** limit.

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

The combined **covered expenses** 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.

First Dollar Benefit Description

The First Dollar Benefit provides 100% coverage and **deductibles, copayments** and **coinsurance** are waived for covered expenses under this Booklet up to the First Dollar Amount per Calendar Year.

You will be eligible under the First Dollar Benefit for coverage of First Dollar Benefits up to the First Dollar Benefit amount shown on the *Schedule of Benefits*. After the First Dollar Benefit is exhausted, covered expenses are subject to any applicable **deductible, copayment, or payment percentage** cost sharing shown on the *Schedule of Benefits*. The First Dollar Benefit is not a cash account and has no cash value. The First Dollar Benefit does not duplicate other coverage provided by this Booklet.

The First Dollar Benefit amount is the amount of coverage provided each Calendar Year for coverage of covered expenses which are eligible for First Dollar Benefit coverage.

The First Dollar Benefit applies to all **covered expenses** except routine services.

Copayments and Benefit Deductible Provisions

Copayment, Copay

This is a specified dollar amount or percentage, shown in the *Schedule of Benefits*, you are required to pay for **covered expenses**.

Payment Provisions

Payment Percentage

This is the percentage of your **covered expenses** that the plan pays and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as the “Plan Payment Percentage”. Once any applicable **deductibles** have been met, your plan will pay a percentage of the **covered expenses**, and you will be responsible for the rest of the costs. The payment percentage may vary by the type of expense. Refer to your *Schedule of Benefits* for payment percentage amounts for each covered benefit.

Maximum Out-of-Pocket Limit

The **Maximum Out-of-Pocket Limit** is the maximum amount you are responsible to pay for **covered expenses** during the Calendar Year. This Plan has an individual **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 and they cannot be combined and applied towards one limit.

Certain **covered expenses** do not apply toward the **Maximum Out-of-Pocket Limit**. See list below.

Network Provider Maximum Out-of-Pocket Limit

Individual

Once the amount of eligible **network provider** expenses you or your covered dependents have paid during the Calendar Year meets the individual **Maximum Out-of-Pocket Limit**, this Plan will pay 100% of such **covered expenses** that apply toward the limit for the remainder of the Calendar Year for that person.

Family Maximum Out-of-Pocket Limit

When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **network provider Maximum Out-of-Pocket Limit**, these expenses will also count toward a family **network provider Maximum Out-of-Pocket Limit**.

To satisfy this family **network provider 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 **network provider 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 **network provider Maximum Out-of-Pocket Limit** amount in a Calendar Year.

You may still be responsible for any applicable copayments even if you have met your **Maximum Out-of-Pocket**.

Covered expenses that are subject to the **Maximum Out-of-Pocket Limit** include **prescription drug** expenses provided under the Medical or **Prescription drug** Plans, as applicable.

Expenses That Do Not Apply to Your Out-of-Pocket Limit

Certain covered expenses do not apply toward your plan **out-of-pocket** limit. These include:

- Non-covered expenses;
- Any **covered expenses** which are payable by **Aetna** at 50%; and
- Expenses incurred for bariatric surgery.

General

This Schedule of Benefits replaces any similar Schedule of Benefits previously in effect under your plan of benefits. Requests for coverage other than that to which you are entitled in accordance with this Schedule of Benefits cannot be accepted. This Schedule is part of your Booklet and should be kept with your Booklet.