Pasadena **Independent School District**
Effective Date: 01-01-2024
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PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	IN-NETWORK
Deductible (per calendar year)	$3,500 Individual $7,000 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 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	20%
Applies to all expenses unless otherwise stated.	
Payment Limit (per calendar year)	$7,900 Individual $15,800 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
Referral Requirement	None
PREVENTIVE CARE	**IN-NETWORK**
Routine Adult Physical Exams/ Immunizations	Covered 100%; deductible waived
1 exam every 12 months for members age 22 to age 65; 1 exam every 12 months for adults age 65 and older.	
Routine Well Child Exams/Immunizations	Covered 100%; deductible waived
7 exams in the first 12 months of life, 3 exams in the second 12 months of life, 3 exams in the third 12 months of life, 1 exam per year thereafter to age 22. The following immunizations will be covered at 100%: diphtheria; haemophilus influenza type b, hepatitis B; measles; mumps; pertussis; polio; rubella; tetanus and varicella and any other immunization that is required by law for the child.	
Routine Gynecological Care Exams	Covered 100%; deductible waived
Recommended: One exam per calendar year. Includes routine tests and related lab fees.	
Routine Mammograms	Covered 100%; deductible waived
Recommended: One mammogram per calendar year for covered females age 35 and over.	
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. Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.	
Routine Digital Rectal Exam	Covered 100%; deductible waived
No age or frequency applies.	
Prostate-specific Antigen Test	Covered 100%; deductible waived
Recommended: For covered males age 40 and over.	

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Colorectal Cancer Screening	Covered 100%; deductible waived
Coverage includes the following: Annual fecal occult blood test, Digital rectal exam and a flexible sigmoidoscopy every 5 years, Digital rectal exam and a double contrast barium enema every 5 years, and Digital rectal exam and a colonoscopy every 10 years.	
Routine Eye Exams 1 routine exam per calendar year.	20%; deductible waived
Newborn Hearing Screening	20%; deductible waived
1 in the first 30 days of life and follow-up diagnostic care until the age of 24 months	
Routine Hearing Screening	Covered 100%; deductible waived
PHYSICIAN SERVICES	**IN-NETWORK**
Office Visits to Non-Specialist	20%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.	
Specialist Office Visits	20%; after deductible
Office Based Surgery	20%; after deductible
Audiometric Hearing Exam 1 exam per 2 calendar years	20%; after deductible
Pre-Natal Maternity	Covered 100%; deductible waived
Walk-in Clinics	$35 copay; deductible waived
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.	
Allergy Testing	Your cost sharing is based on the type of service and where it is performed
Allergy Injections	Your cost sharing is based on the type of service and where it is performed
DIAGNOSTIC PROCEDURES	**IN-NETWORK**
Diagnostic X-ray (other than Complex Imaging Services)	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 Outpatient Complex Imaging	20%; after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**
Urgent Care Provider	20%; deductible waived
Non-Urgent Use of Urgent Care Provider	Not Covered
Emergency Room Copay waived if admitted	20% after $500 copay; after deductible
Non-Emergency Care in an Emergency Room	Not Covered
Emergency Use of Ambulance	20%; after deductible
Non-Emergency Use of Ambulance	Not Covered

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HOSPITAL CARE	IN-NETWORK
Inpatient Coverage	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay. Deductible waived for newborn inpatient hospital expenses	
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 Expenses	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
Outpatient Surgery - Hospital	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
Outpatient Surgery - Freestanding Facility	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
MENTAL HEALTH SERVICES	**IN-NETWORK**
Inpatient	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Crisis Stabilization Units/ Residential Treatment Centers (for children and adolescents)	20%; after deductible
Partial Hospitalization (for day/night care and treatment)	20%; after deductible
Outpatient	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
SUBSTANCE ABUSE	**IN-NETWORK**
Inpatient	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Residential Treatment Facility	20%; after deductible
Outpatient	20%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
OTHER SERVICES	**IN-NETWORK**
Skilled Nursing Facility	20%, after deductible
Limited to 60 days per calendar year. Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Home Health Care	20%, after deductible
Limited to 60 visits per calendar year. Each visit by a nurse or therapist is one visit. Each visit up to 4 hours by a home health care aide is one visit.	
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.	
Private Duty Nursing - Outpatient	Not covered
Outpatient Short-Term Rehabilitation	20%; after deductible
Speech, Physical, and Occupational Therapy, limited to 60 visits per calendar year combined.	
Spinal Manipulation Therapy	20%; after deductible
Limited to 24 visits per calendar year.	
Autism Behavioral Therapy	20%; after deductible
Covered same as any other Outpatient Mental Health benefit	

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Autism Applied Behavior Analysis	Refer to MBH Outpatient Mental Health
Covered same as any other Outpatient Mental Health benefit with no age or visit limitations.	
Autism Physical Therapy	20%; after deductible
Autism Occupational Therapy	20%; after deductible
Autism Speech Therapy	20%; after deductible
Durable Medical Equipment	20%; after deductible
Prosthetics	20%; after deductible
Orthotics	20%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.
Generic FDA-approved Women's Contraceptives	Covered 100%; deductible waived
Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived
Hearing Aids	20%; after deductible 1 benefit maximum per 3 years for hearing aids and $2500 max; pay as billed
Infusion Therapy	20%; after deductible
Vision Eyewear	Not Covered
Transplants	20%; after deductible Preferred coverage is provided at an IOE contracted facility only.
Bariatric Surgery	Not Covered
Out of Area Dependents	No coverage for non-emergency care received outside the service area.
FAMILY PLANNING	**IN-NETWORK**
Infertility Treatment	20%; after deductible
Diagnosis and treatment of the underlying medical condition only.	
Comprehensive Infertility Services	Not Covered
Artificial insemination and ovulation induction	
Advanced Reproductive Technology (ART)	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	20%; after deductible
PHARMACY	**Not covered by Aetna**
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. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. 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.

Translation of the material into another language may be available. Please call Member Services at **1-888-982-3862.**
Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862**

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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 or 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;
- Home births;
- Immunizations for travel or work except where medically necessary or indicated;
- Implantable drugs and certain 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 procedure, 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 receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

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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