AETNA MEDICAL PLANS

**This is a Summary of Benefits only. Plan Document available on the Alief ISD website.*

BENEFIT FEATURES	**Kelsey Care** IN-NETWORK ONLY *Grp # 100085-15-00201*	**Memorial Hermann** IN-NETWORK ONLY *Grp # 100085-13-00001*	**EPO (TX Medical Neighborhood)** OA Select (in-network only) Grp # 100085-15-00101
Annual Deductible Individual Family **Out of Pocket Maximum** Individual Family **Coinsurance** **Lifetime Maximum**	..... $750 $2,250 ..... $3,000 $6,000 20% Unlimited	..... $750 $2,250 ..... $3,000 $6,000 20% Unlimited	..... $1,000 $3,000 ..... $4,000 $8,000 20% Unlimited
Preventive Services Immunizations, Routine Physicals, Well Child, Pap Smears, PSA Tests, plan lay Mammograms	100% Covered	100% Covered	100% Covered
Primary Care Physician Selection **Referrals to Specialist** **Physician Office Visit** Primary Care Specialist **Maternity OB Visits**	**Required** Not Required $30 Copay $40 Copay $40 Copay Initial Visit Only/Then 100%	Optional Not Required $30 Copay $40 Copay $40 Copay Initial Visit Only/Then 100%	**Required** Not Required $30 Copay $40/$60 Copays $40/$60 Copay Initial Visit Only/Then 100%
Urgent Care **Emergency Room** **Ambulance** (Non-emergency use not covered)	$40 Copay 20% after deductible 20% after deductible	$40 Copay 20% after deductible 20% after deductible	$40 Copay 20% after deductible 20% after deductible
Hospital Care Inpatient Inpatient Maternity Outpatient	$300 Copay + 20% after deductible Same as Inpatient Cost 20% after deductible	$300 Copay + 20% after deductible Same as Inpatient Cost 20% after deductible	$500 Copay + 20% after deductible Same as Inpatient Cost 20% after deductible
Diagnostic Services Laboratory & X-Ray– copay Complex Imaging	$40 Copay $150 Copay	$40 Copay $150 Copay	$40 Copay 20% after deductible
Skilled Nursing **Home Health Care** **Hospice Care**—Inpatient —Outpatient	$300 Copay + 20% after deductible 20% after deductible $300 Copay + 20% after deductible $40 Copay	$300 Copay + 20% after deductible 20% after deductible $300 Copay + 20% after deductible $40 copay	$500 copay + 20% after deductible 20% after deductible $500 copay + 20% after deductible $40 Copay
Mental Health Inpatient Outpatient	$300 Copay + 20% after deductible $40 Copay	$300 Copay + 20% after deductible $40 copay	$500 copay + 20% after deductible $40 Copay
Pharmacy Benefits by *EXPRESS SCRIPTS Retail Mail Order (3 month)	**Generic/Formulary/ Non-Formulary** $10/$30/$50 Copay $20/$60/$100 Copay	**Generic/Formulary/ Non-Formulary** $10/$30/$50 Copay $20/$60/$100 Copay	**Generic/Formulary/ Non-Formulary** $10/$30/$50 Copay $20/$60/$100 Copay