Schedule of Benefits

Employer:	**Alief Independent School District**
ASA:	100085
Issue Date:	September 20, 2016
Effective Date:	September 1, 2016
Schedule:	4A
Booklet Base:	4

For: Aexcel Plus Aetna Select

This is not an ERISA plan. Please contact your Employer for additional information.

Aetna Select Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Calendar Year Deductible*		
Individual Deductible*	$750	Not applicable
Family Deductible*	$2,250	Not applicable
Per Admission Copayment/Deductible	$300 per admission	Not applicable

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

Plan Maximum Out of Pocket Limit includes plan **deductible and copayments**.

Individual Maximum Out of Pocket Limit:

- For **network** expenses: $3,000

Family Maximum Out of Pocket Limit:

- For **network** expenses: $6,000

Lifetime Maximum Benefit per person	Unlimited	Not applicable

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, co payments, 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
Preventive Care Benefits		
Routine Physical Exams		
Office Visits -	100% per visit. No copay or **deductible** applies.	Not Covered
Covered Persons through age 21: Maximum Age & Visit Limits per 12 consecutive months	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. *For details, contact your* ***physician*** *log onto the Aetna website www.aetna.com, or call the number on the back of your ID card.*	Not Covered
Covered Persons ages 22 but less than 65: Maximum Visits per Calendar Year	1 visit	Not Covered
Covered Persons age 65 and over: Maximum Visits per Calendar Year	1 visit	Not Covered.
Well Child Exams Includes coverage for immunizations	100% No Calendar Year **deductible** applies.	Not Covered
Maximum exams Under age 3		
first 12 months of life	7 exams	Not Covered
13th-24th months of life	3 exams	Not Covered
25th-36th months of life	3 exams	Not Covered
Maximum exams per 12 consecutive months		
For age 3 to 18	1 exam	Not Covered

Screening & Counseling Services ***Office Visits*** ***Obesity and/or Healthy Diet*** ***Misuse of Alcohol and/or Drugs & Use of Tobacco Products*** ***Sexually Transmitted Infections*** ***Genetic Risk for Breast and Ovarian Cancer***	100% per visit. No **copay** or **deductible** applies.	Not Covered
Misuse of Alcohol and/or Drugs Maximum Visits per 12 consecutive months	5 visits*****	Not Covered.
Note:** ***In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.		
Use of Tobacco Products Maximum Visits per 12 consecutive months	8 visits*****	Not Covered.
Note:** ***In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.		
Routine Gynecological Exam	100% No Calendar Year **deductible** applies	Not Covered
Maximum exams per Calendar Year	1 exam	Not Covered
Hearing Exam	$40 exam **copay** then the plan pays 100% No Calendar Year **deductible** applies.	Not Covered
Maximum exams per 24 month period	1 exam	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Routine Cancer Screening		
Routine Mammography For covered females age 35 and over	100% No Calendar Year **deductible** applies.	Not Covered
Maximum tests per Calendar Year	1 test	Not Covered
Prostate Specific Antigen Test For covered males age 40 and over	100% per test No Calendar Year **deductible** applies.	Not Covered
Maximum tests per Calendar Year	1 test	Not Covered
Routine Digital Rectal Exam For covered males age 40 and over	100% per test No Calendar Year **deductible** applies.	Not Covered
Maximum tests per Calendar Year	1 test	Not Covered
Routine Pap Smears	100% No Calendar Year **deductible** applies.	Not Covered
Maximum tests per Calendar Year	1 test	Not Covered
Fecal Occult Blood Test	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Maximum tests per Calendar Year	1 test	Not Covered
Sigmoidoscopy Age 50 and over	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered

Maximum tests per 5 consecutive year period	1 test	Not Covered
Double Contrast Barium Enema (DCBE) Age 50 and over	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Maximum tests per 5 consecutive year period	1 test	Not Covered
Colonoscopy age 50 and over	100% No Calendar Year **deductible** applies.	Not Covered
Maximum tests per 10 consecutive year period	1 test	Not Covered
Prenatal Care ***Office Visits***	100% per visit after Calendar Year **deductible.**	Not Covered
more information on coverage levels for pregnancy expenses under this Plan, including other prenatal care, delivery and postnatal care office visits.		
Voluntary Sterilization for Males		
Outpatient	80% per visit after Calendar Year **deductible.**	Not Covered.
Family Planning Services Female Contraceptive Counseling Services -Office Visits.	$30 PCP or $40 Specialist visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	Not Covered.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Physician Services		
Office Visits to Primary Care Physician Office visits (non-surgical) to non-**specialist**	$30 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	Not Covered
Specialist Office Visits	$40 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	Not Covered
Aexcel Designated Network Specialist	$40 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	Not Covered
Non-Designated Network Specialist	$60 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	Not Covered
Walk-In Clinics Non-Emergency Visit	$30 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	Not Covered
Physician Office Visits-Surgery	$30 PCP or $40 Specialist visit **copay** after Calendar Year **deductible** then the plan pays 100%	Not Covered
Aexcel Designated Network Specialist	$30 PCP or $40 Specialist visit **copay** after Calendar Year **deductible** then the plan pays 100%	Not Covered
Non-Designated Network Specialist	$30 PCP or $60 Specialist visit **copay** after Calendar Year **deductible** then the plan pays 100%	Not Covered

Physician Services for Inpatient Facility and Hospital Visits	80% per visit after Calendar Year **deductible**	Not Covered
Aexcel Designated Network Specialist	80% per visit after Calendar Year **deductible**	Not Covered
Non-Designated Network Specialist	80% per visit after Calendar Year **deductible**	Not Covered
Administration of Anesthesia	80% after Calendar Year **deductible**	Not Covered
Prenatal Visits	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Emergency Medical Services		
Hospital Emergency Facility and Physician	$350 **copay** per visit then the plan pays 100% No Calendar Year **deductible** applies.	Paid the same as the Network level of benefits. **See Important note below*

***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.

Non-Emergency Care in a Hospital Emergency Room	Not Covered	Not Covered

Important Notice:
A separate **hospital** emergency room **deductible** or **copay** applies for each visit to an emergency room for emergency care. If you are admitted to a **hospital** as an inpatient immediately following a visit to an emergency room, your **deductible** or **copay** is waived.

Urgent Care Services		
Urgent Medical Care *(at a non-hospital free standing facility)*	$40 **copay** per visit then the plan pays 100% No Calendar Year **deductible** applies	Not Applicable

Urgent Medical Care *(from other than a non-hospital free standing facility)*	Refer to *Emergency Medical Services* and *Physician Services* above.	Refer to *Emergency Medical Services* and *Physician Services* above.

Non-Urgent Use of Urgent Care Provider *(at an Emergency Room or a non-hospital free standing facility)*	Not Covered	Not Covered

Important Notice:
A separate **urgent care copay** or **deductible** applies for each visit to an **urgent care provider** for **urgent care**.

Covered expenses that are applied to the **urgent care copay** or **deductible** cannot be applied to any other **copay** or **deductible** under your plan. Likewise, covered expenses that are applied to your plan's other **copays** or **deductibles** cannot be applied to the **urgent care copay** or **deductible**.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Diagnostic and Preoperative Testing		
Complex Imaging Services		
Complex Imaging	$40 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies	Not Covered
Diagnostic Laboratory Testing		
	$40 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies	Not Covered
Diagnostic X-Rays		
Diagnostic X-Rays (except Complex Imaging Services)	$40 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Surgery		
Outpatient Surgery	80% per visit/surgical procedure after Calendar Year **deductible**	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Facility Expenses		
Birthing Center	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Hospital Facility Expenses Room and Board (including maternity)	$350 per admission **copay** after Calendar Year **deductible** then the plan pays 80%	Not Covered
Other than Room and Board	80% per admission after Calendar Year **deductible**	Not Covered
Skilled Nursing Inpatient Facility	$300 per admission **copay** after Calendar Year **deductible** then the plan pays 80%	Not Covered
Maximum Days per Calendar Year	100 days	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Specialty Benefits		
Home Health Care(Outpatient)	100% per visit No Calendar Year **deductible** applies.	Not Covered
Skilled Nursing Care (Outpatient)	100% per visit No Calendar Year **deductible** applies	Not Covered
Private Duty Nursing (Outpatient)	100% per visit No Calendar Year **deductible** applies	Not Covered
Maximum Visit Limit per Calendar Year	70 Private Duty Nursing Shifts. Up to 8 hours will be deemed to be one private duty nursing shift.	Not Covered

Hospice Benefits		
Hospice Care –Facility Expenses (Room & Board)	$300 per admission **copay** after Calendar Year deductible then the plan pays 80%	Not Covered
Hospice Care – Other Expenses during a stay	80% per admission after Calendar Year **deductible**	Not Covered
Maximum Benefit per lifetime	Unlimited days	Not Covered
Hospice Outpatient Visits	$40 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Infertility Treatment		
Basic Infertility Expenses 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
Inpatient Treatment of Mental Disorders		
Mental Disorder	$300 per admission **copay** after Calendar Year **deductible** then the plan pays 80%	Not Covered
Maximum Benefit per Calendar Year	45 days	Not Covered
Outpatient Treatment Of Mental Disorders		
Mental Disorder	$40 per visit **copay** after Calendar Year **deductible** then the plan pays 100%	Not Covered
Maximum Visits per Calendar Year	30 visits	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Treatment of Alcoholism and Substance Abuse		
Inpatient Treatment	$300 per admission **copay** after Calendar Year **deductible** then the plan pays 80%	Not Covered
Maximum Days per Calendar Year	45 days	Not Covered
Outpatient Treatment of Alcoholism and Substance Abuse		
Outpatient Treatment	$40 per visit **copay** after Calendar Year **deductible** then the plan pays 100%	Not Covered
Maximum Visits per Calendar Year	30 visits	Not Covered

PLAN FEATURES	NETWORK (IOE Facility)	NETWORK (Non-IOE Facility)	OUT-OF-NETWORK
Transplant Services Facility and Non-Facility Expenses			
Transplant Facility Expenses	$300 per admission **copay** after Calendar Year **deductible,** then the plan pays 80%	Not Covered	Not Covered
Transplant Physician Services (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
Other Covered Health Expenses		
Acupuncture in lieu of anesthesia	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Ground, Air or Water Ambulance	100% after Calendar Year **deductible**	Not Covered
Diabetic Equipment, Supplies and Education	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered

Durable Medical and Surgical Equipment	80% per item after the Calendar Year **deductible**	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Prosthetic Devices	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Therapies		
Chemotherapy	80% per visit after Calendar Year deductible	Not Covered
Infusion Therapy	80% per visit after Calendar Year deductible	Not Covered
Radiation Therapy	80% per visit after Calendar Year deductible	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Short Term Outpatient Rehabilitation Therapies		
Outpatient Physical and Occupational Therapy only	$40 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Short Term Outpatient Rehabilitation Therapies		
Speech Therapy only	$40 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Autism Spectrum Disorder		
Autism – Physical therapy, Occupational Therapy, Speech Therapy	100% after a $40.00 **copay** No **deductible** applies	Not Covered
Autism - behavioral therapy	100% after a $40.00 **copay** No **deductible** applies	Not Covered
Autism - Applied Behavior Analysis	100% after a $40.00 **copay** No **deductible** applies	Not Covered
Combined Autism Physical, Occupational and Speech Therapy Maximum visits per calendar year	60 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.

Copayments and Benefit Deductible Provisions

Copayment, Copay

This is a specified dollar amount or percentage of the **negotiated charge** required to be paid by you at the time you receive a covered service from a **network provider**. It represents a portion of the applicable expense.

Per Admission Copayment

A Per Admission **Copayment** is an amount you are required to pay when you or a covered dependent have a **stay** in an inpatient facility. A **copayment** is a specified dollar amount or percentage of the **negotiated charge** required to be paid by you at the time you receive a covered service from a **network provider**. It represents a portion of the applicable expense.

Separate **copayments** may apply per facility. These **copayments** are in addition to any other **copayments** applicable under this plan. They may apply to each **stay** or they may apply on a per day basis up to a per admission maximum amount.

Covered expenses applied to the per admission **copayment** cannot be applied to any other **copayment** required in your plan. Likewise, **covered expenses** applied to your plan's other **copayments** cannot be applied to meet the per admission **copayment**.

For the stay of a well newborn baby (starting at birth), the per admission **copayment** amount will not exceed the hospital's actual **room and board charge** on the first day of the stay.

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 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.

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;
- Expenses for non-emergency use of the emergency room;
- Expenses incurred for non-urgent use of an **urgent care provider**; and
- Expenses that are not paid, or **precertification** benefit reductions because a required **precertification** for the service(s) or supply was not obtained from **Aetna**.

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.