



**YISD ISD –TENET ACO PLAN I**  
Effective Date: 01-01-2022  
**AWH Open Access ACO Tenet-- ASC**

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

<b>PLAN FEATURES</b>	<b>Tenet ACO</b>	<b>All Other Aetna</b>
<b>Deductible</b> (per calendar year)	\$300 Individual \$900 Family	\$600 Individual \$1,800 Family
All covered expenses accumulate toward the Deductible. 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.		
<b>Member Coinsurance</b>	20%	40%
Applies to all expenses unless otherwise stated.		
<b>Payment Limit</b> (per calendar year)	\$1,800 Individual \$5,400 Family	\$3,600 Individual \$10,800 Family
All covered expenses accumulate toward 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. Pharmacy expenses apply towards 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.		
<b>Lifetime Maximum</b>	Unlimited except where otherwise indicated.	
<b>Primary Care Physician Selection</b>	Optional	Optional
<b>Certification Requirements -</b>	Certification for certain types of Non-Preferred 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.	
<b>Referral Requirement</b>	None	None
<b>PREVENTIVE CARE</b>	<b>Tenet ACO</b>	<b>All Other Aetna</b>
<b>Routine Adult Physical Exams/ Immunizations</b>	Covered 100%; no deductible; copay waived	Covered 100%; no deductible; copay waived
1 exam every calendar year, includes hearing screening.		
<b>Routine Well Child Exams/Immunizations</b>	Covered 100%; no deductible; copay waived	Covered 100%; no deductible; copay 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 calendar year thereafter.		
<b>Routine Gynecological Care Exams</b>	Covered 100%; no deductible; copay waived	Covered 100%; no deductible; copay waived
Recommended: One routine GYN exam per year with one pap-smear & related lab fees.		
<b>Routine Mammograms</b>	Covered 100%; no deductible; copay waived	Covered 100%; no deductible; copay waived
No age or frequency limit. Members should follow American Cancer Society guidelines		



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<b>Women's Health</b>	Covered 100%; no deductible, copay waived	Covered 100%; no deductible, copay 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. Limitation: For first 2 visits per 12 months. Applicable PCP/Spec office visit cost share applies thereafter.		
<b>Routine Digital Rectal Exam</b>	Covered 100%; no deductible; copay waived	Covered 100%; no deductible; copay waived
Recommended: No age or frequency limit		
<b>Prostate-specific Antigen Test</b>	Covered 100%; no deductible; copay waived	Covered 100%; no deductible; copay waived
Recommended: No age or frequency limit.		
<b>Colorectal Cancer Screening</b>	Covered 100%; no deductible; copay waived	Covered 100%; no deductible; copay waived
Recommended: For all members age 45 and over.		
<b>Routine Eye Exams</b>	Not covered	Not covered
<b>PHYSICIAN SERVICES</b>	<b>Tenet ACO</b>	<b>All Other Aetna</b>
<b>Office Visits</b>	Covered 100% no copay	Covered 100% after \$20 copay
Includes services of an internist, general physician, family practitioner, OB/GYN or pediatrician.		
<b>Specialist Office Visits</b>	Covered 100% after \$25 copay	Covered 100% after \$25 copay
<b>Audiometric Hearing Exam</b>	Not Covered	Not Covered
<b>Pre-Natal Maternity</b>	Covered 100%; no deductible copay waived	Covered 100%; no deductible copay waived
<b>Walk-in Clinics</b>	N/A	Covered 100% after \$20 copay
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. No WICs in El Paso at this time.		
<b>Teladoc</b>	\$20 co-pay	
Teladoc gives you 24/7/365 access to doctors virtually via Teladoc website, phone, or app		
<b>Allergy Testing</b>	20% after deductible	40% after deductible
<b>Allergy Injections</b>	20% after deductible	40% after deductible
<b>DIAGNOSTIC PROCEDURES</b>	<b>Tenet ACO</b>	<b>All Other Aetna</b>
<b>Diagnostic X-ray and Laboratory</b>	20% after deductible;	40%; after deductible
100% no deductible and no copay for Quest and LabCorp. 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.		
<b>Diagnostic Complex Imaging</b>	20% after deductible	40%; after deductible



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<b>EMERGENCY MEDICAL CARE</b>	<b>Tenet ACO</b>	<b>All Other Aetna</b>
<b>Urgent Care Provider</b>	Covered 100%; after \$20 copay	40%; after deductible
<b>Non-Urgent Use of Urgent Care Provider</b>	Not Covered	Not Covered
<b>Emergency Room</b>	20% after deductible; after \$100 ER copay	20% after deductible; after \$100 ER copay
Copay waived if admitted		
<b>Non-Emergency Care in an Emergency Room</b>	Not Covered	Not Covered
<b>Emergency Use of Ambulance</b>	20% after deductible	20% after deductible
<b>Non-Emergency Use of Ambulance</b>	Not Covered	Not Covered
<b>HOSPITAL CARE</b>	<b>Tenet ACO</b>	<b>All Other Aetna</b>
<b>Inpatient Coverage</b>	20%; after deductible; after \$150 copay	40%; after deductible; after \$350 copay
Co-pay waived for subsequent confinements, regardless of cause which are separated by less than 10 days.		
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay; semi-private room rate.		
<b>Inpatient Maternity Coverage</b> (includes delivery and postpartum care)	20%; after deductible; after \$150 copay	40%; after deductible; after \$350 copay
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
<b>Outpatient Hospital Expenses</b>	20%; after deductible	40%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
<b>Outpatient Surgery - Hospital</b>	20%; after deductible	40%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
<b>Outpatient Surgery - Freestanding Facility</b>	20%; after deductible	40%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
<b>MENTAL HEALTH SERVICES</b>	<b>Tenet ACO</b>	<b>All Other Aetna</b>
<b>Inpatient</b>	20%; after deductible; after \$150 copay	40%; after deductible; after \$350 copay
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay; semi-private room rate		
<b>Outpatient</b>	Covered 100%; after \$25 copay	Covered 100%; after \$25 copay
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
<b>ALCOHOL/DRUG ABUSE SERVICES</b>	<b>Tenet ACO</b>	<b>All Other Aetna</b>
<b>Inpatient</b>	20%; after deductible; after \$150 copay	40%; after deductible; after \$350 copay
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
<b>Residential Treatment Facility</b>	20%; after deductible; after \$150 copay	40%; after deductible; after \$350 copay



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<b>Outpatient</b>	Covered 100% after \$25 copay	Covered 100% after \$25 copay
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
<b>OTHER SERVICES</b>	<b>Tenet ACO</b>	<b>All Other Aetna</b>
<b>Skilled Nursing Facility</b>	20%; after deductible	40%; after deductible
Limited to 60 days per calendar year. The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
<b>Home Health Care</b>	20%; after deductible	40%; after deductible
Limited to 60 visits per calendar year. Home health care services. 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.		
<b>Hospice Care - Inpatient</b>	20%; after deductible	40%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay; semi-private room rate.		
<b>Hospice Care - Outpatient</b>	20%; after deductible	40%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
<b>Speech Therapy</b>	20%; after deductible	40%; after deductible
<b>Physical and Occupational Therapy Rehabilitation</b>	20%; after deductible	40%; after deductible
<b>Spinal Manipulation Therapy</b>	Covered 100%; after \$25 specialist copay	Covered at 100%; after \$25 specialty copay
25 Max visits per year		
<b>Autism Behavioral Therapy</b>	Covered 100%; after \$25 copay; no deductible	Covered 100%; after \$25 copay; no deductible
<b>Autism Applied Behavior Analysis</b>	Covered 100%; after \$25 copay; no deductible	Covered 100%; after \$25 copay; no deductible
<b>Autism Physical Therapy</b>	20%; after deductible	40%; after deductible
Includes Physical Therapy, Occupational Therapy, and Speech Therapy for the treatment of autism.		
<b>Autism Occupational Therapy</b>	20%; after deductible	40%; after deductible
Includes Physical Therapy, Occupational Therapy, and Speech Therapy for the treatment of autism.		
<b>Autism Speech Therapy</b>	20%; after deductible	40%; after deductible
Includes Physical Therapy, Occupational Therapy, and Speech Therapy for the treatment of autism.		
<b>Durable Medical Equipment</b>	20%; after deductible	40%; after deductible
<b>Generic FDA-approved Women's Contraceptives</b>	Covered 100%; deductible waived	Covered 100%; deductible waived
<b>Contraceptive drugs and devices not obtainable at a pharmacy</b>	Covered 100%; deductible waived	Covered 100%; deductible waived
<b>Vision Eyewear</b>	Not Covered	Not Covered
<b>Transplants</b>	20%; after deductible; after \$150 copay	40%; after deductible; after \$350 copay

Preferred coverage is provided at an IOE contracted facility only. Non-Preferred coverage is provided at a Non-IOE facility.



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<b>Bariatric Surgery</b>	Covered same as Hospital Inpatient	Covered same as Hospital Inpatient
\$50,000 max per lifetime		
<b>FAMILY PLANNING</b>	<b>Tenet ACO</b>	<b>All Other Aetna</b>
<b>Infertility Treatment</b>	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Diagnosis and treatment of the underlying medical condition only.		
<b>Comprehensive Infertility Services</b>	Not Covered	Not Covered
Artificial insemination and ovulation induction		
<b>Advanced Reproductive Technology (ART)</b>	Not Covered	Not Covered
In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery		
<b>Vasectomy</b>	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered
<b>Tubal Ligation</b>	Covered 100%; deductible waived	Covered 100%; deductible waived
Includes associated ancillary services		
<b>PHARMACY</b>	<b>Tenet ACO</b>	<b>All Other Aetna</b>
<b>Pharmacy Plan Type</b>	AETNA STANDARD PLAN A - OPEN FORMULARY	
<b>Generic Drugs</b>		
<b>Retail 30-day supply</b>	\$10 copay	\$10 copay
<b>Mail Order</b>	\$20 copay	\$20 copay
<b>Preferred Brand-Name Drugs</b>		
<b>Retail 30-day supply</b>	\$35 copay	\$35 copay
<b>Mail Order</b>	\$70 copay	\$70 copay
<b>Non-Preferred Brand-Name Drugs</b>		
<b>Retail 30-day supply</b>	\$60 copay	\$60 copay
<b>Mail Order</b>	\$120 copay	\$120 copay
<b>Diabetic Supplies</b>	covers needles and syringes without purchase of insulin	
<b>Specialty Brand</b>	covered at Aetna Specialty Pharmacy	
<b>Choose Generic</b>	not applicable	
<b>GENERAL PROVISIONS</b>		
<b>Dependents Eligibility</b>	Spouse, children from birth to age 26 regardless of student status.	



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Plans are provided by Aetna Life Insurance Company. 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. 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.
- Acupuncture
- Blood and Blood Products
- Cosmetic surgery, including breast reduction.
- Custodial care.
- Dental care and dental X-rays.
- Donor egg retrieval
- Eye surgery performed mainly to correct refractive errors
- Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
- Foreign claims, excludes non-emergency, non-urgent care received outside the United States
- Blood and Blood Products
- 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.
- Reversal of sterilization.
- Services for the treatment of sexual dysfunction/enhancement, including therapy, supplies or counseling or prescription drugs.
- Private duty nursing.
- 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.



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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.

Translation of the material into another language may be available. Please call Member Services at **1-888-982-3862**.

Puede estar disponible la traducción 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](http://www.aetna.com)**.

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