Harris County
Effective Date: 01-01-2027
HMO- Kelsey Care
Aetna Kelsey Care ACO (Accountable Care Organization)

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA HEALTH INC. - SELF-FUNDED

PLAN FEATURES	IN-NETWORK DESIGNATED PROVIDERS
Benefit limitations - For any service or supply that is subject to a maximum visit, day, or dollar limitation on a per year basis, the benefit year begins on January 1st unless otherwise mandated. Refer to your plan documents for more information.	
Deductible (per calendar year) 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.	$0 Individual $0 Family
Out-of-Pocket Maximum (per calendar year) In-Network expenses include coinsurance/copays and deductibles. Pharmacy expenses apply towards the Out-of-Pocket-Maximum. The family Out-of-Pocket Maximum is a cumulative Out-of-Pocket Maximum for all family members. The family Out-of-Pocket Maximum can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Out-of-Pocket Maximum amount.	$6,350 Individual $12,700 Family
Member Coinsurance Applies to all expenses unless otherwise stated.	10%
Lifetime maximum	Unlimited except where otherwise indicated.
Primary care physician selection	**Required**
Referral requirement	None internally to Kelsey, referrals required by Kelsey for external specialists
Telehealth consultations - You can access covered services for telehealth visits from providers in your plan. Log on to Aetna.com to see a list of telehealth providers. You will also find more about your options, including cost share amounts.	
Network Designations- To be covered at the preferred in-network benefit level you must use a designated provider for care. If you receive care from a non-designated provider your care may not be covered.	
PREVENTIVE CARE	**IN-NETWORK DESIGNATED PROVIDERS**
Routine adult physical exams/ immunizations 1 exam per calendar year for all ages	Covered 100%

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Routine well child exams (Age and frequency schedules apply) 7 exams in the first 12 months, 3 exams from age 13 through 24 months, 3 exams from age 25 through 36 months, 1 exam per year thereafter to age 22.	Covered 100%
Childhood immunizations The following immunizations will be covered at 100%: diphtheria; haemophiles 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.	Covered 100%
Routine gynecological care exams 1 exam per calendar year Includes routine tests and related lab fees.	Covered 100%
Routine mammogram Recommended: One per year mammogram for females age 35 and over.	Covered 100%
Women's health 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.	Covered 100%; no deductible
Routine digital rectal exams / Prostate specific antigen test Recommended for males age 40 and over.	Covered 100%
Colorectal cancer screening Recommended: For all members age 40 and over, covers preventative & diagnostic services Frequency schedule applies.	Covered 100%
Routine eye exams	Not Covered
Routine hearing screening	**Covered 100% (in provider office)**

PHYSICIAN SERVICES	**IN-NETWORK DESIGNATED PROVIDERS**
Office Visits to Primary Care Includes services of an internist, general physician, family practitioner or pediatrician.	$15 office visit copay
Telehealth consultation with non-specialist	$15 office visit copay
Specialist office visits	$30 office visit copay
Telehealth consultation with specialist	$30 office visit copay
Pre-Natal Maternity	Covered 100%
Walk-in clinics (includes designated CVS walk-in clinics)	$25 copay| Designated CVS Minute Clinic covered 100%

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Walk-in Clinics are free-standing health care facilities that (a) may be located in or with a pharmacy, drug store, supermarket or other retail store; and (b) provide limited medical care and services on a scheduled or unscheduled basis. Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices are not considered to be Walk-in Clinics.

Harris County employee onsite Kelsey Clinic	$0 office visit copay by clinic
Allergy testing	Covered 100%
Allergy injections	Covered 100% (up to 150 doses per calendar year)
DIAGNOSTIC PROCEDURES	**IN-NETWORK DESIGNATED PROVIDERS**
Diagnostic laboratory	Covered 100%
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 X-ray	Covered 100%
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 complex imaging	Covered 100%
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.	
EMERGENCY MEDICAL CARE	**IN-NETWORK DESIGNATED PROVIDERS**
Urgent care provider *(Kelsey in-network)*	$50 office visit copay
Non-urgent use of urgent care provider	Not Covered
Emergency room	$300 copay
Copay waived if admitted	
Non-emergency care in an emergency room	Not Covered
Emergency use of ambulance	Covered 100%
Non-emergency use of ambulance	Not Covered
HOSPITAL CARE	**IN-NETWORK DESIGNATED PROVIDERS**
Inpatient hospital	$600 Copay
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Inpatient maternity coverage (includes delivery and postpartum care)	$600 Copay
Your cost sharing applies to all covered benefits incurred during your inpatient stay. If baby stays after discharge the baby has their own $600 copay.	
Outpatient hospital	Non-surgical services covered 100%
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
Outpatient Surgery- Free Standing Facility (Kelsey)	$400 copay
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
MENTAL HEALTH SERVICES	**IN-NETWORK DESIGNATED PROVIDERS**
Inpatient or Residential Treatment facility	$600 Copay
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Mental health office visits	$30 copay
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	

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Mental health telehealth consultations	$30 office visit copay
Outpatient mental health services	Covered 100%

When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit. (example: 23 hour BH observation, Psychological testing)

SUBSTANCE ABUSE	IN-NETWORK DESIGNATED PROVIDERS
Inpatient	$600 Copay

Your cost sharing applies to all covered benefits incurred during your inpatient stay.

Residential treatment facility	$600 Copay; no deductible
Substance abuse office visits	$30 copay

Your cost sharing applies to all covered benefits incurred during your outpatient visit.

Substance abuse telehealth consultations	$30 office visit copay

Your cost sharing applies to all covered benefits incurred during your outpatient visit.

Outpatient substance abuse	Covered 100%

When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit. (example: Treatment for withdrawal symptoms)

OTHER SERVICES	IN-NETWORK DESIGNATED PROVIDERS
Skilled nursing facility	Covered 100%

Limited to 100 days per year
Your cost sharing applies to all covered benefits incurred during your inpatient stay.

Home health care	Covered 100%

Limited to 100 visits per year
Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs. or less.

Hospice care - inpatient	10% after $250 Copay

Your cost sharing applies to all covered benefits incurred during your inpatient stay.

Hospice care - outpatient	10% after $250 Copay

Your cost sharing applies to all covered benefits incurred during your outpatient visit.

Outpatient Short-Term Rehabilitation	$20 copay

Limited to 60 visits per year
Includes speech, physical, occupational therapy, *Pulmonary & Cardiac Rehab*, Cognitive Therapy

Spinal Manipulation Therapy	Covered 100%

Limited to 10 visits per year

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Habilitative Physical Therapy	$20 Copay
Habilitative Occupational Therapy	$20 Copay
Habilitative Speech Therapy	$20 Copay
Autism Behavioral Therapy Combined with outpatient mental health visits	$20 Copay
Autism Applied Behavior Analysis Covered same as any other Outpatient Mental Health Other Services benefit	$20 Copay
Autism Physical Therapy	$20 Copay
Autism Occupational Therapy	$20 Copay
Autism Speech Therapy	$20 Copay
Durable medical equipment	Covered 100%
External Prosthetics & orthotics Orthopedic shoes & support devices	Covered 100%
Diabetic supplies	Not covered by medical-refer to pharmacy coverage
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%
Affordable Care Act mandated women's contraceptives	Covered 100%
Infusion therapy Administered in the home or physician's office	100% no deductible after $30 copay.
Infusion therapy Administered in an outpatient hospital department or freestanding facility	Covered 100%
Gene-based, Cellular, and other Innovative Therapies (GCIT™)	Your cost sharing amount depends on the type of service and where you receive it. $50 Copay; no deductible for gene therapy drugs, if applicable In-network coverage is provided at GCIT™ designated facilities only.
Hearing aids	20%; no deductible Limited to 2 devices every 36 months, includes testing & fitting of devices
Transplants	Covered 100% Institutes of Excellence (IOE) contracted facility. $600 Copay; no deductible for all other in-network facilities.
Bariatric surgery (no force to IOQ)	$600 per admission copay
Acupuncture Limited to 10 visits per year	Covered 100%
FAMILY PLANNING	**IN-NETWORK DESIGNATED PROVIDERS**
Infertility treatment You have coverage for the diagnosis and treatment of the underlying medical condition only.	Your cost sharing amount depends on the type of service and where you receive it.
Comprehensive infertility services Artificial insemination and ovulation induction, **fertility drugs excluded**.	Covered 100%

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Advanced Reproductive Technology (ART)	**Not Covered**
Vasectomy	Covered 100%
Tubal ligation	Covered 100%
PRESCRIPTION DRUG BENEFITS	**IN-NETWORK**
Pharmacy plan type	Aetna Standard Open Formulary
Generic drugs	
Retail	25% Minimum $5 Maximum $50
Mail order	25% Minimum $10 Maximum $100
Preferred brand-name drugs	
Retail	30% Minimum $25 Maximum $150
Mail order	30% Minimum $50 Maximum $300
Non-preferred brand-name drugs	
Retail	35% Minimum $50 Maximum $250
Mail order	35% Minimum $100 Maximum $500
Specialty drugs	30% Minimum $75 Maximum $350
Pharmacy day supply and requirements	
Retail	You can get up to a 90-day supply from retail pharmacies in the Extended Day Supply Network. Percentage copays will not be doubled
Mail order	You can get a 31–90-day supply from CVS Caremark® Mail Service Pharmacy
Specialty	You can get up to a 30-day supply of specialty drugs. You must fill all specialty drugs through our preferred specialty pharmacy network. Aetna Specialty Performance Network Drug List

Choose Generics with Dispense as Written (DAW) override - Sometimes your physician may say you need a brand-name prescription drug even if a generic is available. If so, you will pay the brand-name copay. If you ask for a brand-name prescription drug when a generic is available, you will pay the applicable brand-name copay plus the difference between the generic price and the brand-name price.

Plan Includes: Diabetic supplies, blood glucose monitors, prescription and contraceptive drugs and devices obtainable from a pharmacy.
Erectile Dysfunction for 8 scripts.
Standard Pre-certification for Specialty Drugs included
Seasonal Vaccinations covered 100% in-network
Preventive Vaccinations covered 100% in-network
Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.
Custom network- certain pharmacies are excluded
Weight loss drugs are not covered.

GENERAL PROVISIONS	
Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status.

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Exclusions and Limitations

Health benefits and health insurance plans are offered and/or underwritten by Aetna Health Inc. Each insurer has sole financial responsibility for its own products.

This material is for information only. Health benefits 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.

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.
• Cosmetic surgery, including breast reduction.
• Custodial care.
• Dental care and dental x-rays.
• Donor egg retrieval.
• Durable medical equipment.
• Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
• Hearing aids.
• Home births.
• Immunizations for travel or work except where medically necessary or indicated.
• Implantable drugs and certain injectable drugs including 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.
• Orthotics except diabetic orthotics.
• 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 or inadequacies including therapy, supplies or counseling or prescription drugs.
• Special duty nursing.
• Therapy or rehabilitation other than those listed as covered.
• Treatment of behavioral disorders.
• Weight control services including 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.

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

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If you require language assistance, please call the member services number located on your ID card, and you will be connected with the language line if needed; or you may dial direct at 1-888-982-3862 (140 languages are available. You must ask for an interpreter). TDD 1-800-628-3323 (hearing impaired only).

Si requiere la asistencia de un representante que hable su idioma, por favor llame al número de Servicios al Miembro que aparece en su tarjeta de identificación y se le comunicará con la línea de idiomas si es necesario; de lo contrario, puede llamar directamente al 1-888-982-3862 (140 idiomas disponibles. Debe pedir un intérprete). TDD-1-800-628-3323 (sólo para las personas con impedimentos auditivos).

Plan features and availability may vary by location and group size.

For more information about Aetna plans, refer to **www.aetna.com.** While this material is believed to be accurate as of the production date, it is subject to change.

Aetna and MinuteClinic, LLC (which either operates or provides certain management support services to MinuteClinic-branded walk-in clinics) are both within the CVS Health family.

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