aetna®

Pasadena ISD
Draft- Effective Date: 01/01/2024
Kelsey Care
Aetna Kelsey Care ACO (Accountable Care Organization)

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	IN-NETWORK
Deductible (per calendar year)	$3,000 Individual $6,000 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, Pharmacy 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	**Required- assigned to Kelsey Provider ID#**
Referral Requirement	None internally to Kelsey, referrals required by Kelsey for external specialists
Network Designations- In order 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 be paid at the out-of-network benefit level or may not be covered at all.	
PREVENTIVE CARE	**IN-NETWORK**
Routine Adult Physical Exams/ Immunizations	Covered 100%; deductible waived
1 exam every 12 months for members age 18 to age 65; 1 exam per calendar year 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 18. 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.	

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Prostate-specific Antigen Test Recommended: For covered males age 40 and over.	Covered 100%; deductible waived
Colorectal Cancer Screening 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 age 45 and over.	Covered 100%; deductible waived
Routine Eye Exams 1 routine exam per calendar year.	$70 copay; deductible waive
Newborn Hearing Screening 1 in the first 30 days of life and follow-up diagnostic care until the age of 24 months	Covered 100%; deductible waived
Routine Hearing Exams 1 routine exam per 24 months	Covered as either PCP or specialist office visit
PHYSICIAN SERVICES	**IN-NETWORK**
Office Visits to Non-Specialist Includes services of an internist, general physician, family practitioner or pediatrician.	$35 copay; deductible waived
Specialist Office Visits	$70 copay; deductible waived
Office Based Surgery	Your cost sharing is based on the type of service and where it is performed
Hearing Exams 1 routine exam per 24 months.	$70 copay; deductible waived
Pre-Natal Maternity	Covered 100%; deductible waived
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
Walk-In Clinics (Kelsey)	***These are the Kelsey clinics only- all other walk-in clinics are excluded***
DIAGNOSTIC PROCEDURES	**IN-NETWORK**
Diagnostic X-ray (other than Complex Imaging Services) 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.	Covered 100%; deductible waived
Diagnostic Laboratory 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.	Covered 100%; deductible waived
Complex Imaging (examples: MRI/ CAT/ PET scans)	$150 copay: deductible waived
EMERGENCY MEDICAL CARE	**IN-NETWORK**
Urgent Care Provider	$70 copay; deductible waived
Non-Urgent Use of Urgent Care Provider	Not Covered
Emergency Room	20% after deductible; after $500 per confinement copay
Non-Emergency Care in an Emergency Room	Not Covered
Emergency Use of Ambulance	20%; after deductible
Non-Emergency Use of Ambulance	Not Covered
HOSPITAL CARE	**IN-NETWORK**
Inpatient Coverage Your cost sharing applies to all covered benefits incurred during your inpatient stay.	20% after deductible;

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Inpatient Maternity Coverage (includes delivery and postpartum care) Your cost sharing applies to all covered benefits incurred during your inpatient stay.	20% after deductible;
Outpatient Hospital Expenses Your cost sharing applies to all covered benefits incurred during your outpatient visit.	20%; after deductible
Outpatient Surgery - Hospital Your cost sharing applies to all covered benefits incurred during your outpatient visit.	20%; after deductible
Outpatient Surgery - Freestanding Facility Your cost sharing applies to all covered benefits incurred during your outpatient visit.	$150 copay; deductible waived
MENTAL HEALTH SERVICES	**IN-NETWORK**
Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	20% after deductible;
Crisis Stabilization Units/ Residential Treatment Centers (for children and adolescents)	20% after deductible;
Mental Health Office Visits Your cost sharing applies to all covered benefits incurred during your outpatient visit.	$35 copay; deductible waived
Other Mental Health Services	20%; after deductible
SUBSTANCE ABUSE	**IN-NETWORK**
Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	20% after deductible;
Residential Treatment Facility	20% after deductible;
Substance Abuse Office Visits Your cost sharing applies to all covered benefits incurred during your outpatient visit.	$35 copay; deductible waived
Other Substance Abuse Services	20%; after deductible
OTHER SERVICES	**IN-NETWORK**
Skilled Nursing Facility Limited to 60 days per calendar year. Your cost sharing applies to all covered benefits incurred during your inpatient stay.	20% after deductible;
Home Health Care 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.	20%; after deductible
Hospice Care - Inpatient Your cost sharing applies to all covered benefits incurred during your inpatient stay.	20% after deductible;
Hospice Care - Outpatient Your cost sharing applies to all covered benefits incurred during your outpatient visit.	$70 copay; deductible waived
Private Duty Nursing - Outpatient	Not Covered
Outpatient Short-Term Rehabilitation Includes Speech, Physical, and Occupational Therapy, limited to 60 visits per calendar year.	$70 copay; deductible waived
Spinal Manipulation Therapy Limited to 24 visits per calendar year.	$70 copay, deductible waived
Autism Behavioral Therapy Covered same as any other Outpatient Mental Health benefit	$35 copay, deductible waived
Autism Applied Behavior Analysis Covered same as any other Outpatient Mental Health Other Services benefit	$35 copay, deductible waived

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Autism Physical Therapy	$35 copay, deductible waived
Autism Occupational Therapy	$35 copay, deductible waived
Autism Speech Therapy	$35 copay, deductible waived
Habilitative (PT/OT/ST)	$35 copay; deductible waived
Durable Medical Equipment	20%; after deductible
Prosthetics	20%; after deductible
Orthotics	20%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered 100%for supplies only
Affordable Care Act mandated Women's Contraceptives	Covered 100%; deductible waived
Women's Contraceptive devices not obtainable at a pharmacy	Covered 100%; deductible waived
Hearing Aids	20%; after deductible (limits apply)
Infusion Therapy Administered in the home or physician's office	Your cost sharing is based on the type of service and where it is performed
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	Your cost sharing is based on the type of service and where it is performed
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	Your cost sharing is based on the type of service and where it is performed
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	Your cost sharing is based on the type of service and where it is performed
Tubal Ligation	Covered 100%; deductible waived
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.

•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;
• Hearing aids;
• 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.
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 traduccion 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.**