



PLAN DESIGN

Customer Name: Katy Independent School District

Proposed Effective Date: 01-01-2027

Organization Name: Aetna



Katy Independent School District
Effective Date: 01-01-2027
HMO-KelseyCare
Aetna KelseyCare

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

PLAN FEATURES	IN-NETWORK DESIGNATED PROVIDERS
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Benefit limitations - Some service or supplies have limits on them per year. There might be a maximum number of visits or days, or a dollar limit per year. In such cases, the benefit year begins on January 1 (unless otherwise noted). Refer to your plan documents to learn more.

Deductible (per calendar year)	\$1,950 per Individual \$3,775 per Family
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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.

Prescription drug costs do not count toward the deductible. Refer to your plan documents for details.

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.
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Out-of-pocket limit (per calendar year)	\$4,700 per Individual \$9,200 per Family
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Certain member cost sharing elements may not apply toward the Payment Limit.

Pharmacy expenses do not count toward the out-of-pocket 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. 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.
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Primary care physician selection	Optional
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Referral requirement	None internally to Kelsey; referrals required by Kelsey for external specialists
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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 not be covered.

PREVENTIVE CARE	IN-NETWORK DESIGNATED PROVIDERS
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Routine adult physical exams/immunizations	Covered 100%; no deductible
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1 exam every 12 months

Routine well child exams	Covered 100%; no deductible
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- 7 exams in the first 12 months

- 3 exams from age 13 months to 24 months

- 3 exams from age 25 months to 36 months

- 1 exam every 12 months thereafter until age 22

Childhood immunizations	Covered 100%; no deductible
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Routine gynecological care exams	Covered 100%; no deductible
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1 exam and pap smear per year, including related fees

Breast cancer screening	Covered 100%; no deductible
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Recommended: One per year for members age 40 and over



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Women's health	Covered 100%; no deductible
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.	
Also includes: contraceptive methods (ACA mandated contraceptives, including contraceptives and devices you can't get at a pharmacy), sterilization procedures (including tubal ligation), patient education and counseling. Limits may apply.	
Pre-natal maternity	Covered 100%; no deductible
Routine digital rectal exams / Prostate specific antigen test	Covered 100%; no deductible
Recommended: For members age 40 and over	
Colorectal cancer screening	Covered 100%; no deductible
Recommended: For all members age 45 and over.	
Frequency schedule applies.	
Preventative eye exams	Not Covered
Routine hearing screening	Covered 100%; no deductible
1 routine exam per 24 months	
PHYSICIAN SERVICES	IN-NETWORK DESIGNATED PROVIDERS
Primary care physician visits	\$10 office visit copay
Includes services of an internist, general physician, family practitioner or pediatrician.	
Specialist office visits	\$50 office visit copay
Diagnostic Hearing Exams	20% after deductible
Walk-in clinics	20%; after deductible
Walk-in clinics are free-standing health care facilities. Sometimes they may be within a pharmacy, drug store, supermarket, or other retail store. They offer some limited medical care and services.	
Not walk-in clinics: Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices.	
Allergy testing	20% after deductible.
Allergy injections	20% after deductible.
DIAGNOSTIC PROCEDURES	IN-NETWORK DESIGNATED PROVIDERS
Diagnostic x-ray (Other than complex imaging services)	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 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 complex imaging	\$500 copay
When your physician performs and bills for this service at their office, you pay your office visit cost share amount.	
EMERGENCY MEDICAL CARE	IN-NETWORK DESIGNATED PROVIDERS
Urgent care provider	\$75 office visit copay
Adults and dependent children age 19 and over	
Dependent children to age 19	
Non-urgent use of urgent care provider	Not Covered
Emergency room	\$500 copay
Copay waived if admitted	



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Non-emergency care in an emergency room	Not Covered
Emergency use of ambulance	\$500 copay
Non-emergency use of ambulance	Not Covered
HOSPITAL CARE	IN-NETWORK DESIGNATED PROVIDERS
Inpatient coverage When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	20%; after deductible
Inpatient maternity coverage (includes delivery and postpartum care) When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	20%; after deductible
Outpatient surgery - Hospital The member cost sharing applies to all covered benefits incurred during a member's outpatient stay.	20%; after deductible
Outpatient surgery - Freestanding The member cost sharing applies to all covered benefits incurred during a member's outpatient stay.	20%; after deductible
MENTAL HEALTH SERVICES	IN-NETWORK DESIGNATED PROVIDERS
Inpatient When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	20%; after deductible
Mental health office visits	\$50 office visit copay
Other mental health services 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.	\$50 office visit copay
SUBSTANCE ABUSE	IN-NETWORK DESIGNATED PROVIDERS
Inpatient When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.	20%; after deductible
Residential treatment facility When admitted into a facility, cost sharing amount counts toward all covered benefits received.	20%; after deductible
Substance abuse office visits	\$50 office visit copay
Other substance abuse services 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.	\$50 office visit copay
THERAPY SERVICES	IN-NETWORK DESIGNATED PROVIDERS
Spinal manipulation therapy Limited to 20 visits per year	20%; after deductible



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Outpatient short-term rehabilitation Limited to 60 visits per year Includes speech, physical, occupational therapy	20%; after deductible
Habilitative physical therapy	\$50 office visit copay
Habilitative occupational therapy	\$50 office visit copay
Habilitative speech therapy	\$50 office visit copay
Autism related physical therapy	\$50 office visit copay
Autism related occupational therapy	\$50 office visit copay
Autism related speech therapy	\$50 office visit copay
Autism related behavioral therapy	\$50 office visit copay
These benefits are combined with outpatient mental health visits.	
Autism related applied behavior analysis	\$50 office visit copay
Your benefits for these services are the same as any other outpatient mental health other services benefit	
OTHER SERVICES	IN-NETWORK
Skilled nursing facility Limited to 60 days per year. When admitted into a facility, cost sharing amount counts toward all covered benefits received.	20%; after deductible
Home health care 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 hours or less.	20%; after deductible
Hospice care - inpatient When admitted into a facility, cost sharing amount counts toward all covered benefits received.	20%; after deductible
Hospice care - outpatient 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.	20%; after deductible
Durable medical equipment	20%; after deductible
Orthotics	20%; after deductible (excludes foot orthotics, orthopedic shores and supportive devices of the feet.
Diabetic supplies • If not covered under the Pharmacy benefit	Diabetic supplies are covered by HEB-Medimpact and not covered under Aetna Medical Plan. Except monitors (Glucometers), Insulin Pumps and supplies related to the pump covered. Supplies related to the monitor are not eligible.
Infusion therapy - home/office	20%; after deductible
Infusion therapy - outpatient hospital/freestanding facility	20%; after deductible
Hearing aids	20%; after deductible (limited to 2 devices per 36 months; coverage to age 18.
Transplants	20%; after deductible In-network coverage is only available at Institutes of Excellence (IOE) contracted facility.



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Bariatric surgery-Institutes of Quality Required 20%; after deductible

*Covered up to \$15,000 Lifetime Maximum.

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

FAMILY PLANNING

IN-NETWORK DESIGNATED PROVIDERS

Infertility Treatment 20%; after deductible

Diagnosis and treatment of the underlying medical condition only.

Advanced Reproductive Technology (ART) Not Covered

Comprehensive Infertility Services 20%; after deductible

Artificial insemination and ovulation induction – Maximum of 6 sessions

Vasectomy Your cost sharing depends on the type of service and where you receive it.

Tubal ligation Covered 100%; deductible waived

GENERAL PROVISIONS

Dependents who are eligible to be on your plan Spouse, children from birth to age 26. Student status of children does not matter.

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.
- Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.



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- 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 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.

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

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.

*****This plan document provides you with an overview of some of your benefits and your cost share obligations. This information is for illustrative purposes ONLY. This document is not an official document and may differ from your Certificate of Coverage (COC), which is your official document. Refer to your COC for your coverage and services and any obligations on your part.**