County of Hidalgo – Basic Plan
Effective Date: 01-01-2017
Aetna Choice® POS II -- ASC

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

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	$1,250 Individual $2,500 Family	$2,000 Individual $4,000 Family
All covered expenses accumulate separately toward the preferred or non-preferred 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. Three-month Deductible carry over applies.		
Member Coinsurance	30%	50%
Applies to all expenses unless otherwise stated.		
Payment Limit (per calendar year)	$7,150 Individual $14,300 Family	$10,000 Individual $20,000 Family
All covered expenses accumulate separately toward the preferred or non-preferred 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.		
Lifetime Maximum		
Unlimited except where otherwise indicated.		
Primary Care Physician Selection	Optional	Not Applicable
Certification Requirements -		
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 - excluded amount applied separately to each type of expense is $250 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations	Covered 100%; deductible waived	50%; after deductible
1 exam every calendar year for members age 22 to age 65; 1 exam every calendar year months for adults age 65 and older.		
Routine Well Child Exams/Immunizations	Covered 100%; deductible waived	50%; after deductible. Immunization 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 calendar year thereafter to age 22.		
Routine Gynecological Care Exams	Covered 100%; deductible waived	50%; after deductible
Recommended: One exam per calendar year. Includes routine tests and related lab fees.		
Routine Mammograms	Covered 100%; deductible waived	50%; after deductible
Recommended: One per calendar year for covered females age 35 and over.		

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Women's Health	Covered 100%; deductible waived	50%; after 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. Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.		
Routine Digital Rectal Exam	Covered 100%; deductible waived	50%; after deductible
Recommended: For covered males age 40 and over.		
Prostate-specific Antigen Test	Covered 100%; deductible waived	50%; after deductible
Recommended: For covered males age 40 and over.		
Colorectal Cancer Screening	Covered 100%; deductible waived	Covered under Routine Adult Exams
Recommended: For all members age 50 and over.		
Routine Eye Exams	$40 copay; deductible waived	20%; after deductible
1 routine exam per calendar year.		
Routine Hearing Screening	Covered 100%; deductible waived	20%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to Non-Specialist	$40 copay; deductible waived	50%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
Specialist Office Visits	$50 copay; deductible waived	50%; after deductible
Audiometric Hearing Exam	Not Covered	Not Covered
Pre-Natal Maternity	Covered 100%; deductible waived	Covered according to standard claim practice.
Walk-in Clinics	$40 copay; deductible waived	50%; after deductible
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.		
Teladoc	$40 copay; deductible waived	Not Covered
Teladoc give you 24/7/365 access to doctors by telephone.		
Allergy Testing	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
Allergy Injections	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

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DIAGNOSTIC PROCEDURES	IN-NETWORK	OUT-OF-NETWORK
Diagnostic X-ray (other than Complex Imaging Services)	Covered 100%; deductible waived	50%; after deductible
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%; deductible waived	50%; after deductible
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	30%; after deductible	50%; after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	$40 copay; deductible waived	50%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room Copay waived if admitted	30% after $350 copay; deductible waived	Same as in-network care
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	30%; after deductible	Same as in-network care
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage	30%; after $350 copay; after deductible	50%; after $350 copay; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	30%; after $350 copay; after deductible	50%; after $350 copay; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Hospital Expenses	30%; after deductible	50%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Outpatient Surgery - Hospital	30%; after deductible	50%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Outpatient Surgery - Freestanding Facility	30%; after deductible	50%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		

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MENTAL HEALTH SERVICES	IN-NETWORK	OUT-OF-NETWORK
Inpatient	30%; after $350 copay; after deductible	50%; after $350 copay; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient	$50 copay; deductible waived	50%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
ALCOHOL/DRUG ABUSE SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	30%; after $350 copay; after deductible	50%; after $350 copay; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Residential Treatment Facility	30%; after $350 copay; after deductible	50%; after $350 copay; after deductible
Outpatient	$50 copay; deductible waived	50%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Convalescent Facility	Covered 100%; deductible waived	50%; after deductible
Limited to 25 days per calendar year. The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Home Health Care	Covered 100%; deductible waived	50%; after deductible
Limited to 120 visits per calendar year. Home health care services include private duty nursing 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.		
Hospice Care - Inpatient	Covered 100%; deductible waived	50%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Hospice Care - Outpatient	Covered 100%; deductible waived	50%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Speech Therapy Limited to 30 visits per calendar year.	$50 copay; deductible waived	50%; after deductible
Physical and Occupational Therapy Rehabilitation Limited to 60 visits per calendar year.	$50 copay; deductible waived	50%; after deductible
Spinal Manipulation Therapy Limited to 20 visits per calendar year.	$50 copay; deductible waived	50%; after deductible
Autism Behavioral Therapy	Refer to MBH Outpatient Mental Health	Refer to MBH Outpatient Mental Health
Combined with outpatient mental health visits		

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Autism Applied Behavior Analysis	$50 copay: deductible waived	50%; after deductible
Autism Physical Therapy Visits combined with Short Term Rehabilitation.	$50 copay; deductible waived	50%; after deductible
Autism Occupational Therapy Visits combined with Short Term Rehabilitation.	$50 copay; deductible waived	50%; after deductible
Autism Speech Therapy Visits combined with Short Term Rehabilitation.	$50 copay; deductible waived	50%; after deductible
Durable Medical Equipment (Hearing Aids limited to 1 new aid per ear per 36 months)	30%; after deductible	50%; after deductible
Diabetic Supplies	Covered same as any other medical expense.	Covered same as any other medical expense.
Generic FDA-approved Women's Contraceptives	Covered 100%; deductible waived	Covered same as any other expense.
Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered same as any other medical expense.
Vision Eyewear	Not Covered	Same as preferred care.
Transplants	30%; after $350 copay; after deductible Preferred coverage is provided at an IOE contracted facility only.	50%; after $350 copay; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment	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.		
Comprehensive Infertility Services Artificial insemination and ovulation induction	Not Covered	Not Covered
Advanced Reproductive Technology (ART)	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		
Vasectomy	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
Tubal Ligation	Covered 100%; deductible waived	Member cost sharing is based on the type of service performed and the place of service where it is rendered

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PHARMACY	IN-NETWORK	OUT-OF-NETWORK
Pharmacy Plan Type	Aetna Premier Plus Open Formulary	
Generic Drugs		
Retail	$10 copay	Not Covered
Mail Order	$20 copay	Not Applicable
Preferred Brand-Name Drugs		
Retail	$20 copay	Not Covered
Mail Order	$40 copay	Not Applicable
Non-Preferred Brand-Name Drugs		
Retail	$35 copay	Not Covered
Mail Order	$70 copay	Not Applicable
Premier Plus Specialty Drugs		
Preferred Specialty	$20 copay	Not Applicable
Non-Preferred Specialty	$35 copay	Not Applicable
Pharmacy Day Supply and Requirements		
Retail	Up to a 31-90 day supply	
Mail Order	Up to a 31-90 day supply from Aetna Rx Home Delivery®.	
Premier Plus Specialty	Up to a 30 day supply from Aetna Specialty Pharmacy Network. First prescription fill at any retail or specialty pharmacy. Subsequent fills must be through our preferred Aetna Specialty Pharmacy network.	
Bulk chemicals are excluded under compounding.		
Choose Generics - If the member requests brand when generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.		
Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy. Oral fertility drugs included. Premier Plus Pre-certification & Step Therapy with 90 day TOC. Formulary Generic FDA-approved Women's Contraceptives and certain over-the-counter preventive medications covered 100% in network.		

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

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.

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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.
• 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/enhancement, including therapy, supplies or counseling or prescription drugs.
• Special 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.

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.

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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.**