



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

| PLAN FEATURES | IN-NETWORK | OUT-OF-NETWORK |
|--|---|---|
| Deductible (per calendar year) | \$750 Individual \$1,250 Family | \$1,000 Individual \$2,000 Family |
| <p>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.</p> | | |
| Member Coinsurance | 20% | 50% |
| <p>Applies to all expenses unless otherwise stated.</p> | | |
| Payment Limit (per calendar year) | \$5,000 Individual \$10,000 Family | \$7,500 Individual \$15,000 Family |
| <p>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.</p> | | |
| Lifetime Maximum | Unlimited except where otherwise indicated. | |
| Primary Care Physician Selection | Optional | Not Applicable |
| <p>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.</p> | | |
| Referral Requirement | None | None |
| <p>PREVENTIVE CARE</p> | | |
| Routine Adult Physical Exams/ Immunizations | Covered 100%; deductible waived | 50%; after deductible |
| <p>1 exam every calendar year for members age 22 to age 65; 1 exam every calendar year months for adults age 65 and older.</p> | | |
| Routine Well Child Exams/Immunizations | Covered 100%; deductible waived | 50%; after deductible. Immunization Covered 100%, deductible waived |
| <p>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.</p> | | |
| Routine Gynecological Care Exams | Covered 100%; deductible waived | 50%; after deductible |
| <p>Recommended: One exam per calendar year. Includes routine tests and related lab fees.</p> | | |
| Routine Mammograms | Covered 100%; deductible waived | 50%; after deductible |
| <p>Recommended: One per calendar year for covered females age 35 and over.</p> | | |



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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 | \$35 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 | \$35 copay; deductible waived | 50%; after deductible |
| Includes services of an internist, general physician, family practitioner or pediatrician. | | |
| Specialist Office Visits | \$45 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 | \$35 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 | \$35 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) 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 | 50%; after deductible |
| 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 | 50%; after deductible |
| Diagnostic Complex Imaging | 20%; after deductible | 50%; after deductible |
| EMERGENCY MEDICAL CARE | IN-NETWORK | OUT-OF-NETWORK |
| Urgent Care Provider | \$35 copay; deductible waived | 50%; after deductible |
| Non-Urgent Use of Urgent Care Provider | Not Covered | Not Covered |
| Emergency Room Copay waived if admitted | 20% after \$250 copay; deductible waived | Same as in-network care |
| Non-Emergency Care in an Emergency Room | Not Covered | Not Covered |
| Emergency Use of Ambulance | 20%; 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 The member cost sharing applies to all covered benefits incurred during a member's inpatient stay. | 20%; after deductible | 50%; after \$350 copay; after deductible |
| Inpatient Maternity Coverage (includes delivery and postpartum care) The member cost sharing applies to all covered benefits incurred during a member's inpatient stay. | 20%; after deductible | 50%; after \$350 copay; after deductible |
| Outpatient Hospital Expenses The member cost sharing applies to all covered benefits incurred during a member's outpatient visit. | 20%; after deductible | 50%; after deductible |
| Outpatient Surgery - Hospital The member cost sharing applies to all covered benefits incurred during a member's outpatient visit. | 20%; after deductible | 50%; after deductible |
| Outpatient Surgery - Freestanding Facility The member cost sharing applies to all covered benefits incurred during a member's outpatient visit. | 20%; after deductible | 50%; after deductible |



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| MENTAL HEALTH SERVICES | IN-NETWORK | OUT-OF-NETWORK |
|--|---------------------------------------|--|
| Inpatient | 20%; 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 | \$45 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 | 20%; 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 | 20%; after deductible | 50%; after \$350 copay; after deductible |
| Outpatient | \$45 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 | 20%; after deductible | 50%; after deductible |
| Limited to 30 visits per calendar year. | | |
| Physical and Occupational Therapy Rehabilitation | 20%; after deductible | 50%; after deductible |
| Limited to 60 visits per calendar year. | | |
| Spinal Manipulation Therapy | 20%; after deductible | 50%; after deductible |
| Limited to 20 visits per calendar year. | | |
| 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 | 20%; after deductible | 50%; after deductible |
| Autism Physical Therapy Visits combined with Short Term Rehabilitation. | 20%; after deductible | 50%; after deductible |
| Autism Occupational Therapy Visits combined with Short Term Rehabilitation. | 20%; after deductible | 50%; after deductible |
| Autism Speech Therapy Visits combined with Short Term Rehabilitation. | 20%; after deductible | 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 | 20%; 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 Diagnosis and treatment of the underlying medical condition only. | Member cost sharing is based on the type of service performed and the place of service where it is rendered |
| Comprehensive Infertility Services Artificial insemination and ovulation induction | Not Covered | Not Covered |
| Advanced Reproductive Technology (ART) In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery | Not Covered | Not Covered |
| 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.



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

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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 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**.

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