Hidalgo County Commissioner's Court
Life and Health Renewal 2018

Gary Looney
Alamo Insurance Group
October 17, 2017

ALAMO INSURANCE GROUP

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Memorandum

Date : October 2017
TO : Hidalgo County Commissioner's Court
From : Gary Looney REBC
RE : Group Medical and Life Insurance Plans 2018

We have received, reviewed, and negotiated with the Aetna Life Insurance company for the second year of their three year contract. The County's medical plan has two cost factors. The claim cost projection was prepared by the actuarial firm of Lewis & Ellis. The administration fees and stop loss insurance premiums have been negotiated with Aetna Life Insurance Company.

The result of the Lewis and Ellis evaluation was to recommend an increase in funding for the 2018 plan year. The report recommended a basic plan rate change of an 8% rate increase for those employees who insure their dependents on the basic plan and an 8% increase for all rates for the Buy Up option. The County would continue to provide the basic medical plan to all full time active employees at no cost to the employee. Based on Commissioner's Court decision the rate increase for employee and dependents was offset by increased County contributions. The result was no increase for the employee contributions for plan year 2018.

The following recommendations and plan change options do not impact the final budget requests that have been approved.

The Aetna is in the second year of a three year contract. The rate for the claims administration was fixed by contract and will reduce from $19.68 per EE/Month to $17.07 per EE/Month for plan year 2018.

The contract for stop loss insurance has an increase of 29%. The increase is due to the change from an immature contract to a mature contract. The change was anticipated at the initiation of the contract with Aetna and was factored into the long term cost of the stop loss insurance. The 2017 rate of $28.41ee/month will increase to $36.65 ee/month. The rate is significantly lower than all rate proposals received for the 2017 plan year.

The stop loss deductible is currently $250,000. The deductible has not changed for three years. As a result the annual trend of 8% has not been used to adjust the specific stop loss level. To stay in concert with trend increases the stop loss deductible limit needs to be increased. The increase recommended is a moderate change from $250,000 to $275,000. The stop loss premium rate would be reduced to $33.93 ee/month. The rate differential reduces the annual premium by approximately $125,000.

In addition to the rate increase there are two outstanding large claims which require an additional deductible. The two claimants will have an additional claim liability of $200,000 for the plan year 2018. The additional liability will only be applied, if in fact, the claimants exceed the stop loss limit.

In an effort to manage the health care costs for 2018 consider the following changes in your medical plans.

1. Bariatric Surgical benefits. The change would include very specific guidelines for employees to be eligible for the procedure. The addition of the benefits would not impact the budget or require additional funding for the medical plan. Please see backup material provided.

2. Prescription Benefit Plan Changes:
    a. In order to provide a period of time for the evaluation of the current Aetna prescription drug plan, the most liberal prescription management plan was selected for plan year 2017. The Aetna was instructed to evaluate the utilization of the current prescription plan. In an effort to track prescription drug expenses and provide an analysis of the current plan with potential cost saving options. The summary of potential savings and drug interruption is attached. The projected prescription plan savings is estimated to be over $650,000 per year.
    b. The recommended change is from the Aetna Premier Plus plan to the Aetna Value plan. The change would impact 81 medications moving from a lower tier to the highest tier copay. From a $10 or $20 copay to a $35 copay. There are 347 individuals impacted by the change.
    c. There are 40 medications that would require a current member to select a therapeutic equivalent for their current medication. The member impacted will be notified of the change and directed to an alternate therapeutic medication.

3. Home Health Care benefits were designed to provide a step down in cost from an inpatient hospital stay, to a rehabilitation facility, and finally to a home setting. The purpose of the benefit was to reduce the cost while a patient was recovering from a serious illness or injury. The current home health care benefits cover a claimant after waiver of the deductible for 100% up to 120 visits per year. This coverage is consistent with the Low Plan and the Buy Up Plan. There is no requirement for the claimant to have been hospitalized prior to being eligible for the home health care benefit. It is recommended that a hospital stay be required prior to being eligible for the home health care benefits and that the standard office visit copayment of High Plan $35 and the Low Plan $40.

4. Speech Therapy, Physical Therapy, Occupational Therapy, Spinal Manipulation Therapy, Autism (Physical. Occupational, Speech Therapies)
    a. The current plan design for the buy up plan requires a 20% copayment after the plan deductible has been satisfied with a limit of 30 visits for Speech Therapy, 60 visits for Physical and Occupational Therapy and 20 visits per year for Spinal Manipulation.
    b. The current plan design for the Low Plan is a $50 copay per visit with the deductible waived with the same day limits as the Buy Up Plan.

c. The plan designs should be consistent with both plans having the same basic benefit structure. The plans should waive the deductible for the various therapies, retain the day limits for each, and be subject to a standard office visit copay of $35 for the Buy Up Plan and a $40 copay for the low plan. The summary of the Aetna Plan Design & Benefits indicating the changes is attached.

5. The benefit plan claim payments provided by the medical plan comprise the majority of the cost of the health care plan. Personalized Prevention a wellness plan provider and administrator has been engaged to create a wellness plan for all County Employees. The program has been initialized and will be presented to County employees as soon as possible.

The Basic Life and Accidental Death and Dismemberment policy with Dearborn National is in the second year of a three year rate guarantee. There are no changes necessary for the group term life program.

Thank you for your confidence in our services.

Gary Looney
Sr VP Alamo Insurance Group

INSURERORʼS RENEWAL DOCUMENTS

Stop Loss Renewal

County of Hidalgo
January 1, 2018 through December 31, 2018

Aetna Life Insurance Company
Customer Number - 285608

- **This exhibit outlines your FIRM renewal rates effective January 1, 2018.**
- In an environment where healthcare costs are increasing, maintaining the same deductible shifts more of the claim cost to the stop loss provider.
- To help reduce the effect of leveraging, it is recommended that a plan sponsor consider increasing their Stop Loss deductible to keep pace with medical trend.
- **Quote assumes two claimants lasered at $450,000 each, separate structure suffix/account required for each employee.**
- **Please refer to the Stop Loss policy for detailed Stop Loss information.**

Stop Loss Coverage Specifications	1/1/2017	1/1/2018	Option 1	Option 2
Policy Period Length (months):	12	12	12	12
Number of Employees Covered Under Stop Loss:	3,809	3,809	3,809	3,809
Number of Single Covered Under Stop Loss:	2,410	2,410	2,410	2,410
Number of Family Covered Under Stop Loss:	1,399	1,399	1,399	1,399
Aetna Choice POS II:	3,809	3,809	3,809	3,809
Producer Compensation:	0%	0%	0%	0%
Terminal Liability Option:	TLO-3	TLO-3	TLO-3	TLO-3
Claims Paid Basis for Medical Coverages:	Issued	Issued	Issued	Issued
Claims Paid Basis for APM Rx coverage is on an issued basis				
Individual Stop Loss Coverage Specifications				
Individual Stop Loss Level:	$250,000	$250,000	$275,000	$300,000
Contract Type:	12/12	Paid	Paid	Paid
Coinsurance %:	100%	100%	100%	100%
M/N Claims Apply to ISL (Aetna Administered only):	Yes	Yes	Yes	Yes
Rx Claims Applied to ISL (Aetna Administered only):	Yes	Yes	Yes	Yes
Individual Specific Stop Loss Limits (Lasering):	No	**Lasering**	**Lasering**	**Lasering**
Individual Lifetime Stop Loss Payment Amount:	Unlimited	Unlimited	Unlimited	Unlimited
Reimbursement Method:	Immediate	Immediate	Immediate	Immediate
Financial Information				
Stop Loss Premium:	$1,298,564	$1,675,198	$1,550,872	$1,414,206
Premium (PEPM) Composite Rate:	**$28.41**	**$36.65**	**$33.93**	**$30.94**
Percentage Increase:		29.0%	19.4%	8.9%
If Terminal Liability Option is elected at termination				
Additional 2 months premium due				
Composite Rate:	$32.20	$36.65	$33.93	$30.94

aetna

Brian Donohue
Aetna
151 Farmington Ave,
RE11
Hartford, CT 06156
860-273-6820

October 12, 2016

County of Hidalgo
100 East Cano
Edinburg, TX 78539

Re: County of Hidalgo - Confirmation of Services and Administrative Services Only Fees

Dear County of Hidalgo:

Thank you for selecting Aetna and we look forward to beginning our business relationship with County of Hidalgo. Based on our original proposal and subsequent discussions, we have outlined the products and services County of Hidalgo has purchased for the plan effective January 1, 2017. Please review and confirm this information accurately reflects County of Hidalgo's understanding. If you have any questions, you may contact Louie Heerwagen to discuss any necessary changes.

The contract period begins on the effective date of January 1, 2017. Our contracts provide for automatic renewal upon the completion of each contract period unless either party invokes the termination provision, which requires 31 days advance written notice of termination to the other party. This provision may be invoked at any time during the continuance of the contract and is not limited to termination occurring on the renewal date, subject to the terms of the contract(s).

Coverages and Financial Arrangements

The following illustrates the funding arrangements by line of coverage:

Coverage	Funding Arrangement
Choice POS II	Self-Funded
Aetna Pharmacy Management	Self-Funded

Administrative Service Fees

Based on the package of services selected and enrollment awarded to Aetna, the per employee per month administrative services fees by plan for each of the three contract periods, as revised and quoted on August 26, 2016, are:

Plan	Projected Enrollment	01/01/2017	01/01/2018	01/01/2019
Choice POS II	3,779	$41.06	$40.40	$41.61
Pharmacy Rebate Offset		($21.38)	($23.33)	($25.02)
Total Per Employee Per Month		$19.68	$17.07	$16.59

Self Funded Fees include:

Included Services / Programs in Above Administrative Fees
Implementation & Communications
$10,000 Implementation Allowance (Year 1 Only)
$65,000 Wellness Allowance (Year 1 Only)
$45,000 Wellness Allowance (Year 2 Only)
$5,000 Wellness Allowance (Year 3 Only)
Designated Implementation Manager
Open Enrollment Marketing Material (noncustomized)
Onsite Open Enrollment Meeting Preparation
Standard ID Cards
General Administration
Experienced Account Management Team
Designated billing, eligibility, plan set up, underwriting and drafting services
Review or draft plan documents
Summary of Benefits and Coverage (SBCs)
Aetna Full Claim Fiduciary - Option 1
Aetna provides External Review
Alternate Stockpiling (1x Month) ACH Drawdown
Member and Claim Services
Claim Administration
Member Services
Aetna Voice Advantage
Designated Service Center
Plan Sponsor Liaison
Special Investigations / Zero Tolerance Fraud Unit
Network
National AdvantageTM Program
Standard Facility Charge Review
Network Access / Full National Reciprocity
Institutes of ExcellenceTM (Transplants)
Custom Network
Care Management
Utilization Management Inpatient Precertification
Utilization Management Outpatient Precertification
Utilization Management Concurrent Review

Utilization Management Discharge Planning
Utilization Management Retrospective Review
Aetna Compassionate Care Program (ACCP)
Infertility Case Management
National Medical Excellence®
Institutes of Quality Program (IOQ) (same benefits)
Informed Health® Line - 24-hour Nurseline 1-800 #
Simple Steps To A Healthier Life ®- Health Assessment
Behavioral Health
Managed Behavioral Health
Aetna Behavioral Health Basic Conditions Management Program
AbilTo network – subject to member cost share
Applied Behavioral Analysis (ABA)
Web Tools
DocFind® (online provider directory)
Aetna Navigator® - Member Self Service Web
Web-Chat Technology - Virtual Assistant Ann
Online Programs
Health Decision Support - Basic
Reporting
10 Hours of Ad Hoc Reports, Annual Restoration
Aetna Health Information Advantage
e.Plan Sponsor Monitor – Level B Reporting (Standaard Quarterly Utilization Reports)
Monthly Financial Claim Detail Reports
Monthly Banking Reports
Aetna Discount Program
at home products, books, fitness, hearing, national products and services, oral health care, vision and weight management

Services included through the claim wire:

Claim Wire Billing Programs	***Charged through the claim wire. Not included in the PEPM fees above.***
Subrogation	30% of recovered amount will be retained
Coordination of Benefits, Retro Terminations, Medical Bill and Hospital Bill Audits, Workers Compensation, DRG and Implant Audits	30% of recovered amount will be retained
Enhanced Clinical Review	$0.60 per member per month
Aetna Oncology Solutions℠	$125 per month of active treatment
Teladoc	$0.21 per member per month plus $3.00 for each Teladoc consultation and $40 per Teladoc consultation

- Broker/Consultant fees of $0.00 paid to Alamo.

Dearborn National®

January 5, 2017

HIDALGO COUNTY
ATTN: FLORA VAZQUEZ
2818 S BUSINESS HIGHWAY 281
EDINBURG TX 78539-6243

Subject: Renewal Analysis
Group Policy Number: F019016
Anniversary Date: January 1, 2017

Dear Policyholder:

Dearborn National would like to thank you for allowing us the opportunity to provide you and your employees with Group insurance products.

We have reviewed the current experience and demographics of your group insurance programs. As a result, it will be necessary to change the rates of your benefit program which will be effective on the anniversary date. Rates will be guaranteed until January 1, 2020.

Products	Current Rates	Renewal Rates
Life	$0.105 per $1,000	$0.125 per $1,000
AD&D	$0.02 per $1,000	$0.02 per $1,000

If you have any questions pertaining to your renewal, or would like more information including the availability of other products as well as a quote for additional benefit programs, please contact your local Dearborn National sales office or insurance broker.

We value our relationship with you and look forward to providing quality service to you in the future.

Sincerely,

Jon Potter
Strategic Account Executive
Dearborn National

701 East 22nd Street Lombard, IL 60148 ▲ Fax: 312.540.4706

PRESCRIPTION DRUG INFORMATION

Quality Health Plans and Benefits
Healthier Living
Financial Well-Being
Intelligent Solutions

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Pharmacy Drug Management Opportunities for

COUNTY OF HIDALGO

Data between 2017-05-01 and 2017-08-31

05.03.130.1 B (05/16)

Let's see how your claims would look in one of our pharmacy plans.

Your claims history: Data between 2017-05-01 and 2017-08-31
Your current formulary: Aetna Premier Plus

		Aetna Performance Only preferred generics, preferred brands and preferred specialty products.		Aetna Value	Aetna Value Plus 1-2 preferred brands per class. Most generics are preferred but some are non-preferred.		Aetna Premier	Aetna Premier Plus* More drug choices. All generics are preferred. More preferred brands per class.
Tier 1	Preferred generics	**80.4%**	Preferred generics	**76.3%**	**76.3%**	All generics	**79.3%**	**79.3%**
Tier 2	Preferred brands	**7.7%**	Preferred brands	**8.6%**	**8.6%**	Preferred brands	**11.1%**	**11.1%**
Tier 3	Not covered	**11.9%**	Non-preferred brands and generics	**15.1%**	**15.1%**	Non-preferred brands	**9.6%**	**9.6%**
		100.0%		**100.0%**	**100.0%**		**100.0%**	**100.0%**
Specialty		**0.5%**		**0.8%**	**0.8%**		**0.8%**	**0.8%**
Precertification*		**2.8%**		**3.7%**	**3.6%**		**1.3%**	**1.3%**
Step therapy*		**Not applicable**		**5.3%**	**4.6%**		**1.9%**	**1.9%**
Formulary Exclusions List*		**Not applicable**		**1.5%**	**1.5%**		**1.5%**	**1.5%**

This report is based on claims data and does **not** include any drug coverage reviews that your plan may have. See APPENDIX for more details.
*Specialty drug coverage reviews are included for all plans. Some non-specialty drug coverage reviews are optional for Premier Plus.

Aetna Value Formulary Summary

This shows the number of drugs and number of unique members impacted by tier and coverage changes or drug coverage reviews with this formulary. Some members will pay more for a drug, need to choose an alternative or need a drug coverage review. In many cases, lower cost options are available. And, some members may pay less for their drugs.

Tier Impact	Drugs Impacted	Unique Members Impacted
Higher member copays		
Tier 1 drugs moving to Tier 3	56	196
Tier 2 drugs moving to Tier 3	25	151
Lower member copays		
Tier 3 drugs moving to Tier 1	0	0
Tier 3 drugs moving to Tier 2	2	3

Drug Coverage Reviews	Drugs Impacted	Unique Members Impacted
Additional reviews		
Prior Authorization	11	42
Step Therapy	35	166
Formulary Exclusions*	40	97

*** Refer to Appendix**

Aetna Value Formulary: Tier Impact Detail

This report shows drugs that will change tier on the Value Formulary. For these impacted drugs, there are covered alternatives on Tier 1.

Higher member copays				Lower member copays			
Tier 1 drugs moving to Tier 3		Tier 2 drugs moving to Tier 3		Tier 3 drugs moving to Tier 1		Tier 3 drugs moving to Tier 2	
	Members Impacted		Members Impacted		Members Impacted		Members Impacted
CLOBETASOL PROPIONATE	21	BYSTOLIC	22			POLY-VI-FLOR	2
LIDOCAINE	18	TOUJEO SOLOSTAR	20			SOLIQUA 100/33	1
DESLORATADINE	14	LANTUS SOLOSTAR	19				
FLUOCINONIDE	12	PAZEO	17				
CELECOXIB	12	JARDIANCE	12				
AMLODIPINE/OLMESARTAN MED	10	KOMBIGLYZE XR	12				
CLINDAMYCIN PHOSPHATE	10	ADVAIR HFA	8				
METAXALONE	9	ADVAIR DISKUS	7				
OLMESARTAN MEDOXOMIL/AMLO	8	ONGLYZA	7				
FENOFIBRATE	7	GLYXAMBI	4				
CEFDINIR	6	SYNJARDY	4				
RISEDRONATE SODIUM	6	LANTUS	4				
DESVENLAFAXINE ER	5	FLOVENT HFA	3				
LEVALBUTEROL TARTRATE HFA	5	PYLERA	3				
CALCIPOTRIENE	5	LUMIGAN	3				
SODIUM SULFACETAMIDE/SULF	4	PATADAY	3				
KETOROLAC TROMETHAMINE	4	ALPHAGAN P	2				
ZOLPIDEM TARTRATE ER	4	RETIN-A MICRO PUMP	1				
ECONAZOLE NITRATE	4	SEROQUEL XR	1				
GUANFACINE ER	3	AZASITE	1				
CICLOPIROX	3	OMECLAMOX-PAK	1				
DESONIDE	3	SAVELLA TITRATION PACK	1				
TOLTERODINE TARTRATE ER	3	MULTAQ	1				
GLYCOPYRROLATE	2	TAZORAC	1				
BETAMETHASONE VALERATE	2	PRADAXA	1				
IBANDRONATE SODIUM	2						
METRONIDAZOLE	2						
REPAGLINIDE	2						
SALICYLIC ACID WART REMOV	2						
HALOBETASOL PROPIONATE	2						
METHYLPHENIDATE HCL	1						
ACYCLOVIR	1						
DESOXIMETASONE	1						
CARBINOXAMINE MALEATE	1						
MYORISAN	1						
DIHYDROERGOTAMINE MESYLAT	1						
RIVASTIGMINE TRANSDERMAL	1						
ALMOTRIPTAN MALATE	1						
TESTOSTERONE	1						

Higher member copays				Lower member copays			
Tier 1 drugs moving to Tier 3		Tier 2 drugs moving to Tier 3		Tier 3 drugs moving to Tier 1		Tier 3 drugs moving to Tier 2	
	Members Impacted		Members Impacted		Members Impacted		Members Impacted
MOMETASONE FUROATE	1						
PALIPERIDONE ER	1						
URSODIOL	1						
ALMOTRIPTAN	1						
SILDENAFIL^	1						
SULFACLEANSE 8/4	1						
CLONIDINE HCL	1						
HYDROCODONE BITARTRATE/AC	1						
QUETIAPINE FUMARATE ER	1						
BRIMONIDINE TARTRATE	1						
OLANZAPINE/FLUOXETINE	1						
ACETAMINOPHEN/CAFFEINE/DI	1						
NATEGLINIDE	1						
FLUVASTATIN SODIUM ER	1						
MATZIM LA	1						
SULFACETAMIDE SODIUM/SULF	1						
DOXEPIN HYDROCHLORIDE	1						

Aetna Value Formulary: Drug Coverage Review Detail

This report shows you the number of members impacted by **drug coverage reviews** for this formulary. Formulary Exclusions are included in this formulary (where allowed by state).

Prior Authorization	Members Impacted
BYSTOLIC	22
LANSOPRAZOLE	5
ONFI	3
LUMIGAN	3
FINASTERIDE	2
JUBLIA	2
SAVELLA TITRATION PACK	1
DESVENLAFAXINE ER	1
VIBERZI	1
SEROQUEL XR	1
KERYDIN	1

Step Therapy	Members Impacted
TOUJEO SOLOSTAR	20
LANTUS SOLOSTAR	19
CLOBETASOL PROPIONATE	18
KOMBIGLYZE XR	12
FLUOCINONIDE	12
ULORIC	10
CLINDAMYCIN PHOSPHATE	9
BYDUREON PEN	7
ONGLYZA	7
VESICARE	6
RISEDRONATE SODIUM	6
ACZONE	5
CALCIPOTRIENE	4
GLYXAMBI	4
MYRBETRIQ	4
LANTUS	4
ZOLPIDEM TARTRATE ER	4
DESONIDE	3
BENICAR HCT	3
IBANDRONATE SODIUM	2
VELTIN	2
QNASL	2
HALOBETASOL PROPIONATE	2
MOMETASONE FUROATE	1
NEXIUM	1
BETAMETHASONE VALERATE	1
SOOLANTRA	1
BYDUREON	1
LIPITOR	1
LATUDA	1
TROKENDI XR	1
BENICAR	1
PRADAXA	1
DESOXIMETASONE	1

Formulary Exclusions	Members Impacted
DEXILANT	16
DICLOFENAC SODIUM	14
BAYER CONTOUR BLOOD GLUCO	12
CLINDAMYCIN/BENZOYL PEROX	8
SOLODYN	5
ONEXTON	4
METFORMIN HCL ER	3
TREXIMET	3
CARISOPRODOL	2
DOXYCYCLINE MONOHYDRATE	2
BAYER CONTOUR NEXT BLOOD	2
ZIPSOR	2
DUEXIS	2
ACCU-CHEK AVIVA PLUS	2
ZENZEDI	1
AMLODIPINE BESYLATE/ATORV	1
ANDRODERM	1
ACCU-CHEK SMARTVIEW STRIP	1
NAPROXEN SODIUM ER	1
PHARMACIST CHOICE NO CODI	1
VIMOVO	1
TRUE METRIX SELF MONITORI	1
SILENOR	1
NASCOBAL	1
DOXYCYCLINE	1
ACANYA	1
NAFTIFINE HYDROCHLORIDE	1
PENNSAID	1
DOXYCYCLINE HYCLATE DR	1
ZYCLARA	1
EUCRISA	1
TRUE METRIX BLOOD GLUCOSE	1
ABSORICA	1
FLECTOR	1

Prior Authorization		Step Therapy		Formulary Exclusions	
	Members Impacted		Members Impacted		Members Impacted
		FABIOR	1	AXIRON	1
				PRODIGY NO CODING BLOOD G	1
				DYMISTA	1
				NAFTIN	1
				SUMAVEL DOSEPRO	1
				CAPEX	1

Covered and non-covered drugs

Drugs not covered — and their covered alternatives for the Value and Value Plus pharmacy plans

2018 Formulary Exclusions Drug List

aetna®

aetna.com

05.03.924.1 (9/17)

Additional exclusions may apply to certain Small Group plans.

Key	
UPPERCASE	Brand-name medicine
lowercase italics	Generic medicine

Category	Not covered	Covered alternatives
Analgesics	*acetaminophen/caffeine/dihydrocodeine tab* 325-30-16 mg	*acetaminophen/caffeine/dihydrocodeine cap* 320.5-30-16mg (generic TREZIX)
	CAMBIA *(diclofenac)*	*diclofenac potassium* (generic CATAFLAM), *sumatriptan* (generic IMITREX), *naratriptan* (generic AMERGE), *rizatriptan* (generic MAXALT)
	CONZIP* *(tramadol ER capsules)*	*tramadol* immediate-release or extended-release tablets (generic ULTRAM, ULTRAM ER)
	DUEXIS *(ibuprofen/famotidine)*	*ibuprofen* (generic MOTRIN) plus *famotidine* (generic PEPCID)
	FLECTOR PATCH *(diclofenac epolamine)*	Generic oral nonsteroidal anti-inflammatory drug
	NAPRELAN* *(naproxen sodium)*	Generic oral nonsteroidal anti-inflammatory drug
	PENNSAID* *(diclofenac sodium topical solution)*	Generic oral nonsteroidal anti-inflammatory drug
	RYBIX ODT *(tramadol)*	*tramadol* immediate-release or extended-release tablets (generic ULTRAM, ULTRAM ER)
	SOLARAZE* *(diclofenac sodium 3% gel)*	*imiquimod* (generic ALDARA), *fluorouracil* cream (generic CARAC)
	SPRIX *(ketorolac trometh nasal spray)*	Generic oral nonsteroidal anti-inflammatory drug
	TIVORBEX *(indomethacin)* VIVLODEX *(meloxicam)* ZORVOLEX *(diclofenac)*	Generic oral nonsteroidal anti-inflammatory drug
	VANATOL LQ *(acetaminophen/butalbital/caffeine)*	*acetaminophen/butalbital/caffeine* tablet (generic FIORICET)
	VIMOVO *(naproxen/esomeprazole)*	*esomeprazole magnesium* (generic NEXIUM) plus *naproxen* (generic NAPROSYN)
	ZIPSOR	Generic oral nonsteroidal anti-inflammatory drug
Antibiotics	ACTICLATE* *(doxycycline)* ADOXA* *(doxycycline)* AVIDOXY* *(doxycycline)* DORYX* *(doxycycline)* *doxycycline hyclate* 75 mg, 100 mg delayed-release tablets *doxycycline monohydrate* 75 mg capsules MONODOX 75 mg* *(doxycycline)* MONDOXYNE NL 75 mg capsules ORACEA* *(doxycycline)* TARGADOX *(doxycycline)*	*doxycycline monohydrate* 50 mg, 100 mg capsules (generic MONODOX) *doxycycline hyclate* 100 mg capsules (generic VIBRAMYCIN) DOXY-D 100 mg capsules MORGIDOX 50 mg, 100 mg capsules

*Generic product is available and is also excluded from coverage.

Category	Not covered	Covered alternatives
Antibiotics	DYNACIN* tablets *(minocycline)* SOLODYN *(minocycline)*	*minocycline* capsules (generic MINOCIN)
Antidotes	EVZIO *(naloxone HCl injection)*	NARCAN nasal spray
Antihyperlipidemic	FENOGLIDE* *(fenofibrate)*	Other generic *fenofibrates*
Antivirals	SITAVIG *(acyclovir)*	*acyclovir* capsules, tablets, ointment (generic ZOVIRAX)
Cardiovascular	AUVI-Q (epinephrine)	*epinephrine injection*, Epi-Pen
	CARDIZEM CD** *(diltiazem)*	*diltiazem ER*
	CADUET* *(amlodipine/atorvastatin)*	*amlodipine* (generic NORVASC) plus *atorvastatin* (generic LIPITOR)
	DIAMOX SEQUEL* *(acetazolamide ER)*	*acetazolamide* (generic DIAMOX)
	DUTOPROL *(metoprolol succinate/ hydrochlorothiazide extended-release tablets)*	*metoprolol ER* (generic TOPROL XL) plus *hydrocholorothiazide, metoprolol/ hydrochlorothiazide IR* (generic LOPRESS HCR)
	INDERAL LA** *(propranolol ER)*	*propranolol ER*
	metoprolol succinate/hydrochlorothiazide extended-release tablets	*metoprolol/hydrochlorothiazide tablets* (generic LOPRESSOR HCT)
	VASOTEC** *(enalapril maleate)*	*enalapril maleate*
Central nervous system (CNS) — antidepressants/ other	APLENZIN *(bupropion HBr)* FORFIVO XL *(bupropion HCl extended release)* WELLBUTRIN XL** *(bupropion extended release)*	*bupropion* immediate or extended release (generic WELLBUTRIN, WELLBUTRIN SR, WELLBUTRIN XL)
	PEXEVA *(paroxetine)*	*paroxetine* immediate or extended release (generic PAXIL, PAXIL CR)
	ATIVAN** *(lorazepam)*	*lorazepam*
	TRANSDERM SCOP**	*scopolamine transdermal patch*
	XANAX** *(alprazolam)*	*alprazolam*
	XANAX** XR *(alprazolam ER)*	*alprazolam ER*
	ZELAPAR *(selegiline)*	*selegiline* (generic ELDERPRYL)
CNS — antiseizure	STAVZOR *(valproic acid)*	*valproic acid* (generic DEPAKENE)
CNS — sedative/ hypnotics	EDLUAR *(sublingual zolpidem)* INTERMEZZO* *(sublingual zolpidem)* ZOLPIMIST oral spray *(zolpidem)*	*zolpidem* tablets (generic AMBIEN)
	SILENOR (doxepin)	*doxepin* (generic SINEQUAN)
CNS — attention deficit hyperactivity disorder (ADHD)	ZENZEDI 2.5 mg, 7.5 mg, 15 mg, 20 mg, 30 mg *(dextroamphetamine sulfate)*	*dextroamphetamine sulfate* (generic DEXEDRINE)

*Generic product is available and is also excluded from coverage.
**Generic product is available and is covered as an alternative to the brand-name product.

Category	Not covered	Covered alternatives
Dermatological	ABSORICA *(isotretinoin)*	AMNESTEEM, CLARAVIS, MYORISAN
	ACANYA gel pump *(benzoyl peroxide/clindamycin)* BENZACLIN* *(benzoyl peroxide/clindamycin)* DUAC* *(benzoyl peroxide/clindamycin)* NEUAC* *(benzoyl peroxide/clindamycin)* ONEXTON *(benzoyl peroxide/clindamycin)*	*Topical benzoyl peroxide* plus *clindamycin*
	ATRALIN** *(tretinoin)*	*Topical tretinoin* (generic RETIN-A, ATRALIN)
	calcipotriene-betamethasone dipropionate oint	*calcipotriene CR*, oint (generic DOVONEX); *betamethasone CR*, oint (generic VALISONE, DIPROSONE)
	CAPEX *(fluocinolone)*	*fluocinolone* (generic SYNALAR)
	CARAC* *(fluorouracil)*	*Topical fluorouracil* (generic EFUDEX)
	ECOZA *(econazole)*	*econazole* cream (generic SPECTAZOLE)
	EFUDEX CREAM 5%** *(fluorouracil)*	*Topical fluorouracil* (generic EFUDEX)
	ERTACZO *(sertaconzole)*	*ketoconazole* cream (generic NIZORAL)
	EUCRISA *(crisaborole)*	Topical corticosteroids
	EXELDERM *(sulconazole)*	*ketoconazole* cream (generic NIZORAL)
	EXTINA *(ketoconazole)*	*ketoconazole* cream (generic NIZORAL)
	FLUOROPLEX CREAM 1% *(fluorouracil)*	Topical *fluorouracil* (generic EFUDEX)
	fluorouracil cream 0.5%	Topical *fluorouracil* (generic EFUDEX)
	ketoconazole AER 2%	*ketoconazole* cream (generic NIZORAL)
	KETODAN *(ketoconazole)*	*ketoconazole* cream (generic NIZORAL)
	LUZU *(ketoconazole)*	*ketoconazole* cream (generic NIZORAL)
	MIRVASO *(brimonidine)*	*topical metronidazole* (generic METROGEL)
	naftifine cream 2%	*naftifine* 1% cream (generic NAFTIN)
	NAFTIN *(naftifine)*	*naftifine* 1% cream (generic NAFTIN)
	NUCORT *(hydrocortisone)*	*hydrocortisone* lotion
	ONMEL *(itraconazole)*	*itraconazole* (generic SPORANOX)
	oxiconazole cream	*ketoconazole* cream (generic NIZORAL)
	OXISTAT *(oxiconazole)*	*ketoconazole* cream (generic NIZORAL)
	PROCTOCORT** CREAM 1% (*hydrocortisone* cream)	*hydrocortisone* rectal cream
	SELRX shampoo *(selenium sulfide)*	*selenium sulfide* shampoo (generic EXCEL)
	SORILUX	Topical corticosteroids
	TACLONEX OINT* *(calcipotriene-betamethasone dipropionate)*	*calcipotriene CR*, oint (generic DOVONEX); *betamethasone CR*, oint (generic)
	TOLAK *(fluorouracil)*	Topical *fluorouracil* (generic EFUDEX)
	TOPICORT spray *(desoximetasone)*	*desoximetasone* cream, gel, ointment
	VANOS** *(fluocinonide)*	*fluocinonide* cream (generic VANOS)
	VERDESO *(desonide)*	*desonide* (generic DESOWEN)
	XOLEGEL *(ketoconazole)*	*ketoconazole* cream (generic NIZORAL)
	ZOVIRAX OINT** *(acyclovir)*	*acyclovir* ointment
	ZYCLARA *(imiquimod)*	*imiquimod* (generic ALDARA)

*Generic product is available and is also excluded from coverage.
**Generic product is available and is covered as an alternative to the brand-name product.

Category	Not covered	Covered alternatives
Endocrine	All non LIFESCAN/ABBOTT brand test strips	LIFESCAN/ABBOTT brand test strips
	ADLYXIN (*lixisenatide*) BYDUREON (*exenatide*) BYETTA (*exenatide*) TANZEUM (*albiglutide*)	VICTOZA, TRULICITY
	ANDRODERM (*testosterone*) ANDROGEL 1% (*testosterone*) AXIRON (*testosterone*) FORTESTA** (*testosterone*) NATESTO (*testosterone*) STRIANT (*testosterone*) TESTIM (*testosterone*) VOGELXO (*testosterone*)	ANDROGEL 1.62% *testosterone* transdermal gel (generic FORTESTA, ANDROGEL 1%)
	APIDRA (*insulin glulisine*) NOVOLOG (*insulin aspart*), NOVOLOG MIX	HUMALOG, HUMALOG MIX
	BINOSTO (*alendronate*)	*alendronate* tablets (generic FOSAMAX)
	FARXIGA (*dapagliflozin*)	INVOKANA, JARDIANCE
	FORTAMET* (*metformin extended release*) GLUMETZA* (*metformin extended release*)	*metformin* immediate and extended release (generic GLUCOPHAGE, GLUCOPHAGE XR)
	KAZANO (*alogliptin/metformin*) KOMBIGLYZE XR (*saxagliptin/metformin*)	JANUMET/XR, JENTADUETO
	LANTUS (*insulin glargine*) TOUJEO (*insulin glargine*)	LEVEMIR, TRESIBA
	NESINA (*alogliptin*) ONGLYZA (*saxagliptin*)	JANUVIA, TRADJENTA
	NOVOLIN N (*insulin NPH isophane*) NOVOLIN R (*insulin regular*) NOVOLIN MIX	HUMULIN N, R, MIX
	OSENI (*alogliptin/pioglitazone*)	JANUVIA or TRADJENTA plus *pioglitazone* (generic ACTOS)
	RAYOS*** (*prednisone*)	*prednisone* immediate release
	XIGDUO XR (*dapagliflozin/metformin*)	INVOKAMET, SYNJARDY
	ZONACORT (*dexamethasone*)	*dexamethasone* (generic DECADRON)
Gastrointestinal (GI) — other	*chlordiazepoxide/clidinium* LIBRAX (*chlordiazepoxide/clidinium*)	*dicyclomine* (generic BENTYL), *omeprazole* (generic PRILOSEC), *famotidine* (generic PEPCID)
	CORTIFOAM AER (*hydrocortisone ac*)	*hydrocortisone enema* (generic CORTENEMA)
	PROCTOFOAM AER 1% (*hydrocortisone ac/pramoxine*)	*hydrocortisone ac/pramoxine rectal cream* (generic ANALPRAM HC)
	SYNDROS (*dronabinol sol*)	*dronabinol capsules* (generic MARINOL)
	ZUPLENZ (*ondansetron film*)	*ondansetron tablets* (generic ZOFRAN)

*Generic product is available and is also excluded from coverage.
**Generic product is available and is covered as an alternative to the brand-name product.
***Does not apply to Affordable Care Act-compliant formulary offerings.

Category	Not covered	Covered alternatives
GI — prescription ulcer medicine	*esomeprazole strontium*	*esomeprazole magnesium* (generic NEXIUM)
	DEXILANT*** *(dexlansoprazole)*	*esomeprazole magnesium* (generic NEXIUM), *pantoprazole* (generic PROTONIX), *rabeprazole* (generic ACIPHEX)
	PREVACID delayed-release capsules 30 mg*	PREVACID OTC,[1] *esomeprazole magnesium* (generic NEXIUM), *pantoprazole* (generic PROTONIX), *rabeprazole* (generic ACIPHEX)
	PRILOSEC powder packet *(omeprazole)*	PRILOSEC OTC,[1] *esomeprazole magnesium* (generic NEXIUM), *pantoprazole* (generic PROTONIX), *rabeprazole* (generic ACIPHEX)
	ZEGERID* *(omeprazole/sodium bicarbonate)*	ZEGERID OTC,[1] *esomeprazole magnesium* (generic NEXIUM), *pantoprazole* (generic PROTONIX), *rabeprazole* (generic ACIPHEX)
Migraine products	ALSUMA *(sumatriptan injection)* SUMAVEL *(sumatriptan needleless)*	*sumatriptan* injection (generic IMITREX)
	MIGRANAL* *(dihydroergotamine)*	*dihydroergotamine* nasal spray
	RELPAX** *(eletriptan)*	*eletriptan*
	TREXIMET *(sumatriptan/naproxen)*	*sumatriptan* (generic IMITREX) plus *naproxen* (generic NAPROSYN)
Miscellaneous	NASCOBAL *(cyanocobalamin nasal spray)*	*cyanocobalamin* injection
Multiple sclerosis	COPAXONE** *(glatiramer acetate)*	GLATOPA
Muscle relaxants	AMRIX *(cyclobenzaprine)*	*cyclobenzaprine* (generic FLEXERIL)
	LORZONE *(chlorzoxazone)*	*chlorzoxazone* (generic PARAFON FORTE)
	SOMA 250 mg* *(carisoprodol)*	*carisoprodol* 350 mg (generic SOMA 350 mg)
	ZANAFLEX* CAPSULES	*tizanidine* tablets (generic ZANAFLEX tablets)
Oncology	ALKERAN** *(melphalan)*	*melphalan*
	GLEEVEC** *(imatinib)*	*imatinib*
	TEMODAR** *(temozolomide)*	*temozolomide*
	XELODA** *(capecitabine)*	*capecitabine*
Ophthalmics	VIGAMOX** *(moxifloxacin)*	*moxifloxacin ophthalmic solution*
Respiratory nasal/ cough and cold	DYMISTA *(azelastine/fluticasone)*	*carbinoxamine*
	RYVENT *(carbinoxamine)*	*azelastine* (generic ASTELIN), *mometasone* (generic NASONEX), *flunisolide* (generic NASALIDE)
	ZONATUSS** *(benzonatate)*	*benzonatate* (generic ZONATUSS, TESSALON PERLES)

*Generic product is available and is also excluded from coverage.

**Generic product is available and is covered as an alternative to the brand-name product.

***Does not apply to Affordable Care Act-compliant formulary offerings.

[1]Coverage of over-the-counter (OTC) products may not be available under all plan designs.

Please remember that this is not a complete list of medications covered under your plan. Because there are thousands of medications included in your pharmacy benefit, we only list the most common ones. Certain drugs, such as those for smoking cessation or vitamins, may not be covered by your particular pharmacy plan. Diabetic supplies may be covered under your medical plan. If you have any questions about your pharmacy benefits, please visit **aetna.com** and log in to your secure member website. If you don't have access to our website, call the toll-free number on your member ID card.

To check coverage and copay information for a specific medicine, visit **aetna.com** and log in to your secure member website. For more details, please call the toll-free number on your member ID card.

This is not an inclusive list. Products that are not represented on this list may be subject to plan-specific copayment or coinsurance. Void where prohibited by law.

Specific prescription benefits plan design may not cover certain categories or may be subject to additional charges or restrictions, regardless of their appearance in this document.

Aetna may receive rebates, discounts and service fees from pharmaceutical manufacturers for certain listed products.

Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information. Information is believed to be accurate as of the production date; however, it is subject to change. For questions, please call the toll-free number on your member ID card.

Policy forms issued in Missouri include: AL HGrpPol 01R5, HI HGrpAg 01, HO HGrpPol 01.

Policy forms issued in Oklahoma include: HMO OK COC-5 09/07, HMO/OK GA-3 11/01, HMO OK POS RIDER 08/07, GR-23, GR-29/GR-29N.

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BASIC LOW AND BUY UP PLAN CHANGES

aetna®

County of Hidalgo – Basic Plan
Draft-Effective Date: 01-01-2018
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, includes hearing screening.		
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.		

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

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.		
Hearing Exam (audiological)	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

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

DIAGNOSTIC PROCEDURES	IN-NETWORK	OUT-OF-NETWORK
Diagnostic X-ray	Covered 100%; deductible waived	50%; after deductible
(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.		
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 per day copay (2 max); 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 per day copay (2 max); 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.		

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

MENTAL HEALTH SERVICES	IN-NETWORK	OUT-OF-NETWORK
Inpatient	30%; after $350 copay; after deductible	50%; after $350 per day copay (2 max); 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 per day copay (2 max); 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 (change to $40 copay)	50%; after deductible
Limited to 120 visits per calendar year. Prior hospital confinement required. 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 (change to $40 copay)	50%; after deductible
Physical and Occupational Therapy Rehabilitation Limited to 60 visits per calendar year.	$50 copay; deductible waived (change to $40 copay)	50%; after deductible
Spinal Manipulation Therapy Limited to 20 visits per calendar year.	$50 copay; deductible waived (change to $40 copay)	50%; after deductible

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

Autism Behavioral Therapy Combined with outpatient mental health visits	Refer to MBH Outpatient Mental Health change to $40 copay	Refer to MBH Outpatient Mental Health
Autism Applied Behavior Analysis	$50 copay: deductible waived change to $40 copay)	50%; after deductible
Autism Physical Therapy Visits combined with Short Term Rehabilitation.	$50 copay; deductible waived change to $40 copay)	50%; after deductible
Autism Occupational Therapy Visits combined with Short Term Rehabilitation.	$50 copay; deductible waived change to $40 copay)	50%; after deductible
Autism Speech Therapy Visits combined with Short Term Rehabilitation.	$50 copay; deductible waived change to $40 copay)	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 per day copay (2 max); after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery **IOQ facility required, Two year employment required.**	30%: after $350 copay; after deductible. $15,000 maximum benefit.	Not Covered (in-network only at IOQ facility)
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment 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	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

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

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
PHARMACY	**IN-NETWORK**	**OUT-OF-NETWORK**
Pharmacy Plan Type	Aetna Premier Plus Open Formulary (change to Value 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.

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

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.

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.

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

aetna

County of Hidalgo – Buy-Up
Draft- Effective Date: 01-01-2018
Aetna Choice® POS II -- ASC

PLAN DESIGN & BENEFITS
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PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	$750 Individual $1,250 Family	$1,000 Individual $2,000 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.		
Member Coinsurance	20%	50%
Applies to all expenses unless otherwise stated.		
Payment Limit (per calendar year)	$5,000 Individual $10,000 Family	$7,500 Individual $15,000 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, includes hearing screening.		
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	$35 copay; deductible waived	20%; after deductible
1 routine exam per calendar year.		
Hearing Exam (audiological)	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)	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	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	20%; after deductible	50%; after $350 per day copay (2 max); 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)	20%; after deductible	50%; after $350 per day copay (2 max); after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Hospital Expenses	20%; after deductible	50%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Outpatient Surgery - Hospital	20%; 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	20%; 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	20%; after deductible	50%; after $350 per day copay (2 max); 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 per day copay (2 max); 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 (change to $35 copay)	50%; after deductible
Limited to 120 visits per calendar year. Prior hospital confinement required. 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.	20%; after deductible (change to $35 copay)	50%; after deductible
Physical and Occupational Therapy Rehabilitation Limited to 60 visits per calendar year.	20%; after deductible (change to $35 copay)	50%; after deductible
Spinal Manipulation Therapy Limited to 20 visits per calendar year.	20%; after deductible (change to $35 copay)	50%; after deductible

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Autism Behavioral Therapy Combined with outpatient mental health visits	Refer to MBH Outpatient Mental Health (change to $35 copay)	Refer to MBH Outpatient Mental Health
Autism Applied Behavior Analysis	20%; after deductible (change to $35 copay)	50%; after deductible
Autism Physical Therapy Visits combined with Short Term Rehabilitation.	20%; after deductible (change to $35 copay)	50%; after deductible
Autism Occupational Therapy Visits combined with Short Term Rehabilitation.	20%; after deductible (change to $35 copay)	50%; after deductible
Autism Speech Therapy Visits combined with Short Term Rehabilitation.	20%; after deductible (change to $35 copay)	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 per day copay (2 max); after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery **IOQ facility required, Two Year employment required**	20%; after deductible. $15,000 Maximum benefit.	Not Covered (in-network only at IOQ facility)
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment 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	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

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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
PHARMACY	**IN-NETWORK**	**OUT-OF-NETWORK**
Pharmacy Plan Type	Aetna Premier Plus Open Formulary (Value 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.