aetna℠

Lee County BOCC
Effective Date:01-01-2018
Choice™ POS II - ASC

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	PREFERRED CARE	NON-PREFERRED CARE
Deductible (per calendar year)	None Individual None Family	$500 Individual $1,000 Family
All covered expenses, excluding prescription drugs, accumulate toward both the preferred and non-preferred Deductible. Unless otherwise indicated, the Deductible must be met prior to benefits being payable. Once Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year.		
Member Coinsurance Applies to all expenses unless otherwise stated.	Covered 100%	30%
Payment Limit (per calendar year)	$1,500 Individual $3,000 Family	$2,000 Individual $4,000 Family
All covered expenses, excluding prescription drugs, accumulate toward both the preferred and non-preferred Payment Limit. Certain member cost sharing elements may not apply toward the Payment Limit. Only those out-of-pocket expenses resulting from the application of coinsurance percentage (except any deductibles, copays, and penalty amounts) may be used to satisfy the Payment Limit. Once Family Payment Limit is met, all family members will be considered as having met their Payment Limit for the remainder of the calendar year.		
Lifetime Maximum	Unlimited except where otherwise	Unlimited except where otherwise
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 $500 per occurrence.		
Referral Requirement	None	None
PREVENTIVE CARE	**PREFERRED CARE**	**NON-PREFERRED CARE**
Routine Adult Physical Exams/ Immunizations 1 exam per 12 months for members age 18 to age 65; 1 exam per 12 months for adults age 65 and older.	Covered 100%	Not Covered
Routine Well Child Exams/Immunizations 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 12 months thereafter to age 18.	Covered 100%	30% after deductible
Routine Gynecological Care Exams Includes routine tests and related lab fees; 1 exam per calendar year.	Covered 100%	Not Covered
Routine Mammograms One baseline mammogram for covered females aged 35-39 and 1 routine mammogram per calendar year for covered females age 40 and over.	Covered 100%	30% after deductible
Women's Health 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.	Covered 100%	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible
Routine Digital Rectal Exam / Prostate-specific Antigen Test For covered males age 40 and over.	Covered 100%	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible
Colorectal Cancer Screening For all members age 50 and over.	Covered 100%	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible
Routine Eye Exams	Covered 100%	Not Covered

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1 routine exam per 12 months

Routine Hearing Exams 1 routine exam per 12 months	Covered 100%	Not Covered
PHYSICIAN SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Office Visits to PCP Includes services of an internist, general physician, family practitioner or pediatrician.	$10 office visit copay	30% after deductible
Specialist Office Visits	$35 office visit copay	30% after deductible
Pre-Natal Maternity	Covered 100%	Not Covered
Maternity Delivery and Post Partum care	Covered same as Specialist Office Visit;	30% after deductible
Allergy Testing	**Covered as either PCP or specialist office visit**	30% after deductible
Allergy Injections	Covered as either PCP or specialist office visit	30% after deductible
DIAGNOSTIC PROCEDURES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Diagnostic Laboratory and X-ray except for 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	$35 copay	30% after deductible
Diagnostic X-ray for Complex Imaging Services	$50 copay	30% after deductible
EMERGENCY MEDICAL CARE	**PREFERRED CARE**	**NON-PREFERRED CARE**
Urgent Care Provider (benefit availability may vary by location)	$50 copay	30% after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	$150 copay	Same as preferred care; after deductible
Non-Emergency care in an Emergency Room	Not Covered	Not Covered
Ambulance	Covered 100%	100%; deductible waived
HOSPITAL CARE	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient Coverage The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	Covered 100% after $500 per confinement copay	30% after $500 per confinement deductible after deductible
Inpatient Maternity Coverage The newborn child will also be subject to the per confinement copay and if applicable the non-preferred calendar year deductible, separate from the mother's. The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	Covered 100% after $500 per confinement copay	30% after $500 per confinement deductible after deductible
Outpatient Surgery	Covered 100% after $200 outpatient surgery copay	30% after deductible
Outpatient Hospital Expenses (excluding surgery) The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit	Covered 100%	30% after deductible
MENTAL HEALTH SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	Covered 100% after $500 per confinement copay	30% after $500 per confinement deductible after deductible
Outpatient The member cost sharing applies to all covered benefits incurred during a member's outpatient visit	$35 copay	30% after deductible
ALCOHOL/DRUG ABUSE SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	Covered same as Inpatient Hospital services.	Covered same as Inpatient Hospital services; after deductible

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Outpatient	$35 copay	Covered same as Specialist Office visit; after deductible
The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit		

OTHER SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Convalescent Facility	Covered 100% after $500 per confinement copay	30% after $500 per confinement deductible after deductible
Limited to 120 days per calendar year. The member cost sharing applies to all covered benefits incurring during a member's inpatient stay		
Home Health Care Limited to 120 visits per calendar year. Each visit by a nurse or therapist is one visit. Each visit up to 4 hours by a home health care aide is one visit.	Covered 100%	50% after deductible
Hospice Care - Inpatient	Covered 100% after $500 per confinement copay	30% after $500 per confinement deductible after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Hospice Care - Outpatient The member cost sharing applies to all covered benefits incurred during a member's outpatient visit	Covered 100%	30% after deductible
Private Duty Nursing - Outpatient (Limited to 70 eight hour shifts per calendar year) Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift. Each visiting nurse care or private duty nursing care shift of 4 hours or less counts as one home health visit. Each such shift of over 4 hours and up to 8 hours counts as two home health care visits.	Covered 100%	30% after deductible
Outpatient Short-Term Rehabilitation Include Speech, Physical, and Occupational Therapy, limited to 80 visits per calendar year.	$35 copay	30% after deductible
Chiropractic Care Limited to 20 visits per calendar year	$35 copay	30% after deductible
Durable Medical Equipment	Covered 100%	30% after deductible
Diabetic Supplies	Covered same as any other medical expense.	Covered same as any other medical expense; after deductible
Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100% (payable as any other covered expense)	30% (payable as any other covered expense) after deductible
Generic FDA-approved Women's Contraceptives	Covered 100%	Not Covered
Transplants	Covered 100% after $500 per confinement copay Preferred coverage is provided at an IOE contracted facility only	30% Non-Preferred coverage is provided at a Non-IOE facility; after deductible
Mouth, Jaws and Teeth (oral surgery procedures, whether medical or dental in nature)	Member cost sharing is based on the type of service performed and the place of service where it is rendered	30% after deductible
Out of Area Dependents	Coverage provided at 20%, all non-preferred benefits and limitations apply.	

FAMILY PLANNING	PREFERRED CARE	NON-PREFERRED CARE
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; after deductible
Diagnosis and treatment of the underlying medical condition.		
Comprehensive Infertility Services	Covered 100%	Not Covered
Coverage includes Artificial Insemination (limited to six courses of treatment per member's lifetime) and Ovulation Induction Induction (limited to six courses of treatment per member's lifetime). Lifetime maximum applies to all procedures covered by any Aetna plan except where prohibited by law.		

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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; after deductible
Tubal Ligation	Covered 100%;	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible
PHARMACY	**PREFERRED CARE**	**NON-PREFERRED CARE**
Retail	$10 copay for generic drugs, $20 copay for formulary brand-name drugs, and $35 copay for non-formulary brand-name drugs up to a 30 day supply at participating pharmacies.	Not Covered
Mail Order	$0 copay for generic drugs, $40 copay for formulary brand-name drugs, and $70 copay for non-formulary brand-name drugs up to a 31-90 day supply from Aetna Rx Home Delivery®.	Not applicable

No Mandatory Generic (NO MG) - Member is responsible to pay the applicable copay only.

Plan Includes: Contraceptive drugs and devices obtainable from a pharmacy, Oral fertility drugs, Injectable fertility drugs (injectable, physician charges for injections are not covered under RX, medical coverage may be limited), Diabetic supplies.

Precert for growth hormones included

Formulary Generic FDA-approved Women's Contraceptives covered 100% in network

GENERAL PROVISIONS	
Dependents Eligibility	Spouse, children from birth to age 26
Pre-existing Conditions Exclusion	On effective date: Waived After effective date: Waived

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a partial 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 or hospital services not specifically covered in, or which are limited or excluded in the plan documents; Charges related to any eye surgery mainly to correct refractive errors; Cosmetic surgery, including breast reduction; Custodial care; Dental care and X-rays; Donor egg retrieval; Experimental and investigational procedures; Hearing aids; Immunizations for travel or work; Infertility services, including, but not limited to, 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.

Nonmedically necessary services or supplies; Orthotics; Over-the-counter medications and supplies; Reversal of sterilization; Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, or counseling; and 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.

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This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. Aetna does not provide health care services and, therefore, cannot guarantee results or outcomes. Consult the plan documents (i.e. Group Insurance Certificate and/or Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitation relating to the plan. With the exception of Aetna Rx Home Delivery, all preferred providers and vendors are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change without notice.

Some benefits are subject to limitations or visit maximums. Certain services require precertification, or prior approval of coverage. Failure to precertify for these services may lead to substantially reduced benefits or denial of coverage. Some of the benefits requiring precertification may include, but are not limited to, inpatient hospital, inpatient mental health, inpatient skilled nursing, outpatient surgery, substance abuse (detoxification, inpatient and outpatient rehabilitation). When the Member's preferred provider is coordinating care, the preferred provider will obtain the precertification. When the member utilizes a non-preferred provider, Member must obtain the precertification. Precertification requirements may vary. Depending on the plan selected, new prescription drugs not yet reviewed by our medication review committee are either available under plans with an open formulary or excluded from coverage unless a medical exception is obtained under plans that use a closed formulary.

They may also be subject to precertification or step-therapy. Non-prescription drugs and drugs in the Limitations and Exclusions section of the plan documents (received after open enrollment) are not covered, and medical exceptions are not available for them. While this information is believed to be accurate as of the print date, it is subject to change.

Plans are administered by Aetna Life Insurance Company.