Lee County BOCC
Effective Date: 01-01-2022
Open Access® Aetna Select℠ - ASC

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	PREFERRED CARE
Deductible (per calendar year)	None
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	Covered 100%
Applies to all expenses unless otherwise stated.	
Payment Limit - Out of Pocket Maximum (per calendar year)	$1,500 Individual $3,000 Family
Certain member cost sharing elements may not apply toward the Payment Limit. Pharmacy expenses apply towards the Payment Limit. Only those preferred expenses resulting from the application of coinsurance percentage, deductibles, and copays (except any 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. Payment Limit refers to Out of Pocket Maximum.	
Lifetime Maximum	Unlimited except where otherwise indicated.
Primary Care Physician Selection	Optional
Referral Requirement	None
PREVENTIVE CARE	**PREFERRED CARE**
Routine Adult Physical Exams/ Immunizations	Covered 100%
1 exam per 12 months for members age 18 to age 65; 1 exam per 12 months for adults age 65 and older.	
Routine Well Child Exams/Immunizations	Covered 100%
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.	
Routine Gynecological Care Exams	Covered 100%
Includes routine tests and related lab fees	
Routine Mammograms	Covered 100%
One baseline mammogram for covered females age 35-39 and 1 routine mammogram per calendar year for covered females age 40 and over.	
Women's Health	Covered 100%
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 / Prostate-specific Antigen Test	Covered 100%
For covered males age 40 and over.	
Colorectal Cancer Screening	Covered 100%
For all members age 50 and over.	
Routine Eye Exams	Covered 100%
1 routine exam per 12 months	
Routine Hearing Exams	Covered 100%
1 routine exam per 12 months	
PHYSICIAN SERVICES	**PREFERRED CARE**
Office Visits to PCP	$10 office visit copay
Includes services of an internist, general physician, family practitioner or pediatrician.	
Specialist Office Visits	$25 office visit copay
Pre-Natal Maternity	Covered 100%
Maternity Delivery and Post Partum care	Covered same as Specialist Office Visit;
Allergy Testing	**Covered as either PCP or specialist office visit**
Allergy Injections (Copay waived when an office visit is not made)	Covered as either PCP or specialist office visit
DIAGNOSTIC PROCEDURES	**PREFERRED CARE**
Diagnostic Laboratory and X-ray except for Complex Imaging Services	$25 copay
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 X-ray for Complex Imaging Services	$50 copay (Prior Authorization Required)

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EMERGENCY MEDICAL CARE	PREFERRED CARE
Urgent Care Provider (benefit availability may vary by location)	$50 copay
Non-Urgent Use of Urgent Care Provider	Not Covered
Emergency Room	$150 copay
Non-Emergency care in an Emergency Room	Not Covered
Ambulance	Covered 100%
HOSPITAL CARE	**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
Inpatient Maternity Coverage The newborn child will also be subject to the per confinement copay and if applica ble the non-preferred calendar year deductible, separate from the mother's.	Covered 100% after $500 copay/stay per member
Outpatient Surgery	Covered 100% after $200 outpatient surgery copay
Outpatient Hospital Expenses (excluding surgery) The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit	Covered 100%
MENTAL HEALTH SERVICES	**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.
Outpatient The member cost sharing applies to all covered benefits incurred during a member's outpatient visit	$10 copay
ALCOHOL/DRUG ABUSE SERVICES	**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.
Outpatient The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit	$10 copay
OTHER SERVICES	**PREFERRED CARE**
Convalescent Facility Limited to 120 days per calendar year. The member cost sharing applies to all covered benefits incurring during a member's inpatient stay	Covered 100% after $500 per confinement copay
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%
Hospice Care - Inpatient Unlimited number of days. The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	Covered 100% after $500 per confinement copay
Hospice Care - Outpatient The member cost sharing applies to all covered benefits incurred during a member's outpatient visit	Covered 100%
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%
Outpatient Short-Term Rehabilitation Include Speech, Physical, and Occupational Therapy, limited to 80 visits per calendar year.	$25 copay
Chiropractic Care Limited to 20 visits per calendar year	$25 copay
Durable Medical Equipment	Covered 100%
Diabetic Supplies	Covered same as any other medical expense.
Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100% (payable as any other covered expense)
Generic FDA-approved Women's Contraceptives	Covered 100%
Transplants Coverage is provided at an IOE contracted facility only.	Covered 100% after $500 per confinement copay
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
Out of Area Dependents	Coverage provided at 20%, all benefits and limitations apply.

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FAMILY PLANNING	PREFERRED CARE
Infertility Treatment Diagnosis and treatment of the underlying medical condition.	Member cost sharing is based on the type of service performed and the place of service where it is rendered.
Comprehensive Infertility Services	Covered 100%
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.	
Vasectomy	Member cost sharing is based on the type of service performed and the place of service where it is rendered;
Tubal Ligation	Covered 100%;
PHARMACY	**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.
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®.
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, Diabetic supplies.	
Precert for growth hormones included	
Formulary Generic FDA-approved Women's Contraceptives covered 100% in network	
Prescription Drug Annual Out of Pocket Maximum	Individual

Family

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

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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

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.