aetna

Lee County BOCC
Effective Date: 01-01-2025
Aetna 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<br>None Family | $500 Individual<br>$1,000 Family |
| Unless otherwise indicated, the Deductible must be met prior to benefits being payable.<br>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**<br>Applies to all expenses unless otherwise stated. | Covered 100% | 30% |
| **Out of Pocket Maximum** (per calendar year) | $1,500 Individual<br>$3,000 Family | $2,000 Individual<br>$4,000 Family |
| All covered expenses, including prescription drugs, accumulate toward both the preferred and non-preferred Payment Limit.<br>Certain member cost sharing elements may not apply toward the Payment Limit.<br>Only those out-of-pocket expenses resulting from the application of coinsurance percentage, deductibles, copays,(except penalty amounts) may be used to satisfy the Payment Limit.<br>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 | Unlimited except where otherwise |
| **Primary Care Physician Selection** | Optional | Not applicable |
| **Certification Requirements -**<br>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**<br>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**<br>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**<br>Includes routine tests and related lab fees; 1 exam per calendar year. | Covered 100% | Not Covered |
| **Routine Mammograms**<br>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**<br>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.<br>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**<br>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**<br>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 |

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| **Routine Eye Exams**<br>1 routine exam per 12 months | Covered 100% | Not Covered |
| **Routine Hearing Exams**<br>1 routine exam per 12 months | Covered 100% | Not Covered |
| **PHYSICIAN SERVICES** | **PREFERRED CARE** | **NON-PREFERRED CARE** |
| **Office Visits to PCP**<br>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**<br>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 (Prior Authorization Required) | 30% after deductible |
| **EMERGENCY MEDICAL CARE** | **PREFERRED CARE** | **NON-PREFERRED CARE** |
| **Urgent Care Provider**<br>(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**<br>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 copay after deductible |
| **Inpatient Maternity Coverage**<br>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.<br>The member cost sharing applies to all covered benefits incurred during a member's inpatient stay | Covered 100% after $500 per copay/stay per member | 30% after $500 per copay/stay per member after deductible |
| **Outpatient Surgery** | Covered 100% after $200 outpatient surgery copay | 30% after deductible |
| **Outpatient Hospital Expenses** (excluding surgery)<br>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**<br>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 copay after deductible |
| **Outpatient**<br>The member cost sharing applies to all covered benefits incurred during a member's outpatient visit | $10 copay | 30% after deductible |

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| ALCOHOL/DRUG ABUSE SERVICES | PREFERRED CARE | NON-PREFERRED CARE |
|---|---|---|
| **Inpatient** | Covered same as Inpatient Hospital services. | Covered same as Inpatient Hospital services; after deductible |
| The member cost sharing applies to all covered benefits incurred during a member's inpatient stay | | |
| **Outpatient** | $10 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 copay after deductible |
| Limited to 120 days per calendar year.<br>The member cost sharing applies to all covered benefits incurring during a member's inpatient stay | | |
| **Home Health Care** | Covered 100% | 50% after deductible |
| Limited to 120 visits per calendar year.<br>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% after $500 per confinement copay | 30% after $500 per confinement copay after deductible |
| The member cost sharing applies to all covered benefits incurred during a member's inpatient stay | | |
| **Hospice Care - Outpatient** | Covered 100% | 30% after deductible |
| The member cost sharing applies to all covered benefits incurred during a member's outpatient visit | | |
| **Private Duty Nursing -** Outpatient (Limited to 70 eight hour shifts per calendar year)<br>Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.<br>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**<br>Include Speech, Physical, and Occupational Therapy, limited to 80 visits per calendar year. | $35 copay | 30% after deductible |
| **Chiropractic Care**<br>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**<br>(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. | | |

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| **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. | | |
| **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.

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| Precert for growth hormones included | | |
| Formulary Generic FDA-approved Women's Contraceptives covered 100% in network | | |
| **Prescription Drug Annual Out of Pocket Maximum** | Individual<br><br>Family | Not Covered |
| **GENERAL PROVISIONS** | | |
| **Dependents Eligibility** | Spouse, children from birth to age 26 | |
| **Pre-existing Conditions Exclusion** | On effective date: Waived<br>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 statemandates 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.

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.