

Lee County BOCC Effective Date: 01-01-2017

Choice[™] POS II - ASC

PLAN DESIGN & BENEFITS ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	PREFER	RED CARE	NON-PRI	EFERRED CARE
Deductible (per calendar year)	None	Individual	\$500	Individual
	None	Family	\$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	Covered	100%	30%	
Applies to all expenses unless otherwise state	d.			
Payment Limit (per calendar year)	\$1,500	Individual	\$2,000	Individual
	\$3,000	Family	\$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/	Covered 100%	Not Covered
Immunizations		
1 exam per 12 months for members age 18 to a	ge 65; 1 exam per 12 months for adults	age 65 and older.
Routine Well Child Exams/Immunizations	Covered 100%	30% after deductible
7 exams in the first 12 months of life, 3 exams in	n 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%	Not Covered
Includes routine tests and related lab fees; 1 ex	am per calendar year.	
Routine Mammograms	Covered 100%	30% after deductible
One baseline mammogram for covered females	aged 35-39 and 1 routine mammogram	per calendar year for covered
females age 40 and over.		
Women's Health	Covered 100%	Member cost sharing is based on the
		type of service performed and the
		place of service where it is rendered;

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.

after deductible

Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.

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

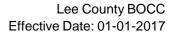




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1 routine exam per 12 months

Routine Hearing Exams	Covered 100%	Not Covered
1 routine exam per 12 months		NON PREFERRED CARE
PHYSICIAN SERVICES Office Visits to PCP	PREFERRED CARE	NON-PREFERRED CARE 30% after deductible
Office Visits to PCP Includes services of an internist, general physici	\$10 office visit copay	30 /o arter deductible
		200/ ofter deducatible
Specialist Office Visits	\$35 office visit copay Covered 100%	30% after deductible Not Covered
Pre-Natal Maternity		30% after deductible
Maternity Delivery and Post Partum care	Covered same as Specialist Office Visit;	
Allergy Testing	Covered as either PCP or specialist office visit	
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	\$35 copay	30% after deductible
Complex Imaging Services If performed as a part of a physician office visit a physician's office visit member cost sharing Diagnostic X-ray for Complex Imaging	and billed by the physician, expenses are \$50 copay	covered subject to the applicable 30% after deductible
Services CARE		NON PREFERRED CARE
EMERGENCY MEDICAL CARE	PREFERRED CARE	NON-PREFERRED CARE 30% after deductible
Urgent Care Provider	\$50 copay	30% after deductible
(benefit availability may vary by location)	Not Covered	Not Covered
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
	Covered 100% after \$500 per	30% after \$500 per confinement
Inpatient Coverage	confinement copay	deductible after deductible
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Inpatient Coverage The member cost sharing applies to all covered	confinement copay benefits incurred during a member's inpa Covered 100% after \$500 per	deductible after deductible tient stay 30% after \$500 per confinement
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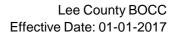
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Outpatient\$35 copayCovered same as Specialist Office visit;

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	30% after \$500 per confinement
	confinement copay	deductible after deductible
Limited to 120 days per calendar year.		
The member cost sharing applies to all covered		
Home Health Care	Covered 100%	50% after deductible
Limited to 120 visits per calendar year.		
Each visit by a nurse or therapist is one visit. Ea		care aide is one visit.
Hospice Care - Inpatient	Covered 100% after \$500 per	30% after \$500 per confinement
	confinement copay	deductible after deductible
The second on each shorten and live to all second		ations above
The member cost sharing applies to all covered		
Hospice Care - Outpatient	Covered 100%	30% after deductible
The member cost sharing applies to all covered		
Private Duty Nursing - Outpatient (Limited to	Covered 100%	30% after deductible
70 eight hour shifts per calendar year)		
Each period of private duty nursing of up to 8 ho		
Each visiting nurse care or private duty nursing		ne home health visit. Each such shift of over 4
hours and up to 8 hours counts as two home he		
Outpatient Short-Term Rehabilitation	\$35 copay	30% after deductible
Include Speech, Physical, and Occupational Th		
Chiropractic Care	\$35 copay	30% after deductible
Limited to 20 visits per calendar year		
Durable Medical Equipment	Covered 100%	30% after deductible
Diabetic Supplies	Covered same as any other medical	Covered same as any other medical
	expense.	expense; after deductible
Contraceptive drugs and devices not	Covered 100% (payable as any other	30% (payable as any other covered
obtainable at a pharmacy	covered expense)	expense) after deductible
Generic FDA-approved Women's	Covered 100%	Not Covered
Contraceptives		
Transplants	Covered 100% after \$500 per	30% Non-Preferred coverage is provided
	confinement copay Preferred	at a Non-IOE facility; after deductible
	coverage is provided at an IOE	
	contracted facility only	
Mouth, Jaws and Teeth	Member cost sharing is based on the	30% after deductible
(oral surgery procedures, whether medical or	type of service performed and the	
dental in nature)	place of service where it is rendered	
Out of Area Dependents	Coverage provided at 20%, all non-pre	eferred benefits and limitations apply.
FAMILY PLANNING	PREFERRED CARE	NON-PREFERRED CARE
Infertility Treatment	Member cost sharing is based on the	Member cost sharing is based on the type
moranty recument	type of service performed and the	of service performed and the place of
	place of service where it is rendered	service where it is rendered; after
	place of convice where it is remained	deductible
Diagnosis and treatment of the underlying medi	cal condition.	
Comprehensive Infertility Services	Covered 100%	Not Covered
Coverage includes Artificial Insemination (limite	d to six courses of treatment per member	r's lifetime) and Ovulation Induction
Induction (limited to six courses of treatment pe		
covered by any Aetna plan except where prohib	•	11
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Vasectomy	Member cost sharing is based on the	Member cost sharing is based on the
	type of service performed and the	type of service performed and the
	place of service where it is rendered;	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	Not Covered
	copay for formulary brand-name	
	drugs, and \$35 copay for non-	
	formulary brand-name drugs up to a	
	30 day supply at participating	
	pharmacies.	AL CONTRACTOR OF THE CONTRACTO
Mail Order	\$0 copay for generic drugs, \$40 copay	Not applicable
	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 dru	ugs and devices obtainable from a pharmacy, Oral ferti	ility drugs, Injectable fertility drugs
(injectable, physician charges for	injections are not covered under RX, medical coverage	e may be limited), Diabetic supplies.
Precert for growth hormones inclu	uded	
Formulary Generic FDA-approved	d Women's Contraceptives covered 100% in network	
GENERAL PROVISIONS		

GEN	IERAL	- PRO	VISIO	NS

Dependents Eligibility Spouse, children from birth to age 26

Pre-existing Conditions ExclusionOn 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.