aetna

Harris County
Effective Date: 01-01-2027
Base Plan- Aetna Choice® POS II -- ASC

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

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Benefit limitations - Some service or supplies have limits on them per year. There might be a maximum number of visits or days, or a dollar limit per year. In such cases, the benefit year begins on January 1 (unless otherwise noted). Refer to your plan documents to learn more.		
Deductible (per calendar year)	$600 per Individual $1,800 per Family	$1,000 per Individual $3,000 per Family
Covered expenses in-network add up towards your in-network deductible. Covered expenses out-of-network add up towards your out-of-network deductible. You must first meet the deductible before the plan begins paying benefits, unless otherwise noted. The amount you pay (cost sharing) for some medical services does not count toward your deductible. Prescription drug costs do not count toward the deductible. Refer to your plan documents for details. Your family will have one deductible. You will meet it when the expenses of several family members add up to the family deductible. No one person will have to pay more than the individual deductible.		
Member coinsurance Applies to all expenses except as noted.	You pay 20%	You pay 50%
Out-of-pocket limit (per calendar year)	$7,350 per Individual $14,700 per Family	$10,000 per Individual $30,000 per Family
Covered expenses in-network add up towards your in-network out-of-pocket limit. Covered expenses out-of-network add up towards your out-of-network out-of-pocket limit. Some of your cost sharing may not count toward the out-of-pocket limit. Your pharmacy expenses count toward your out-of-pocket limit. In-network expenses include coinsurance/copays and deductibles. Out-of-network expenses include coinsurance and deductibles. Penalty amounts do not apply. Your family will have one out-of-pocket limit. You will meet it when the expenses of several family members add up to the family out-of-pocket limit. No one person will have to pay more than the individual out-of-pocket limit amount.		
Lifetime maximum Unlimited except where otherwise indicated.		
Payment for out-of-network care**	Does not apply	Professional: Prevailing Charges Facility: Facility Charge Review
Primary care physician selection	Encouraged	Does not apply
Precertification requirements - Some out-of-network services need approval by us in advance (precertification). Without this approval, we reduce benefits by $400. Refer to your plan documents for a full list of services that need this approval.		
Referral requirement	Not required	None
Telehealth consultations - You can access covered services for telehealth visits from different kinds of providers in your plan. Log on to **Aetna.com** to see a list of telehealth providers. You'll also find more about your options, including cost share amounts.		
PREVENTIVE CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine adult physical exams/ immunizations 1 exam per calendar year for all ages	Covered 100%; no deductible	50%; after deductible

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Routine well child exams/immunizations • 7 exams in the first 12 months • 3 exams from age 13 through 24 months • 3 exams from age 25 through 36 months • 1 exam per calendar year from age 3 until age 22 years	Covered 100%; no deductible	50%; after deductible
Routine gynecological care exams 1 exam and pap smear per year, including related fees	Covered 100%; no deductible	50%; after deductible
Routine mammogram Recommended: One per year for members age **35** and over	Covered 100%; no deductible	50%; 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. Also includes: contraceptive methods (ACA mandated contraceptives, including contraceptives and devices you can't get at a pharmacy), sterilization procedures (including tubal ligation), patient education and counseling. Limits may apply.	Covered 100%; no deductible	50%; after deductible
Pre-natal maternity (initial visit copay applies)	Covered 100%; no deductible	50%; after deductible
Routine digital rectal exam Recommended: For members age 40 and over	Covered 100%; no deductible	50%; after deductible
Prostate-specific antigen test Recommended: For members age 40 and over	Covered 100%; no deductible	50%; after deductible
Colorectal cancer screening Recommended: For members age 40 and over, covers preventative & diagnostic services	Covered 100%; no deductible	50%; after deductible
Routine eye exams	Not Covered	Not Covered
Routine hearing screening (in providers office)	Covered 100%; no deductible	50%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office visits to primary care physician (PCP) Includes services of an internist, general physician, family practitioner or pediatrician.	$20 office visit copay; no deductible	50%; after deductible
Telehealth consultation with non-specialist	$20 office visit copay; no deductible	50%; after deductible
Specialist office visits	$40 office visit copay; no deductible	50%; after deductible
Telehealth consultation with specialist	$40 office visit copay; no deductible	50%; after deductible
Hearing exams	Not Covered	Not Covered
Walk-in clinics & Retail (includes Designated Walk-in clinics)	$30 copay | Designated CVS Minute Clinic covered 100%	50%; after deductible

Walk-in clinics are free-standing health care facilities. Sometimes they may be within a pharmacy, drug store, supermarket, or other retail store. They offer some limited medical care and services.
Not walk-in clinics: Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices.

Harris County has an administered employee clinic by Kelsey:	$0 office visit copay	
Allergy testing	Covered 100%: no deductible	50%: after deductible

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Allergy injections/ Serum (up to 150 does per calendar year)	Covered 100%: no deductible	50%: after deductible
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray (Other than complex imaging services)	Covered 100%; no deductible	50%; after deductible
When your physician performs and bills for this service at their office, covered 100%: no deductible		
Diagnostic laboratory	Covered 100%; no deductible	50%; after deductible
When your physician performs and bills for this service at their office, covered 100%: no deductible.		
Diagnostic complex imaging	10%; after deductible	50%; after deductible
When your physician performs and bills for this service at their office, you pay your office visit cost share amount. **Aetna in review of custom network similar to EviCore preferred /designated locations is Covered 100%: no deductible. List of these locations is approved by county.		
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent care provider	$50 office visit copay; no deductible	50%; after deductible
Non-urgent use of urgent care provider	Not Covered	Not Covered
Emergency room Copay waived if admitted	$300 copay; no deductible	Same as in-network care
Non-emergency care in an emergency room	Not Covered	Not Covered
Emergency use of ambulance	$300 copay; no 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 deductible
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.		
Inpatient maternity coverage (includes delivery & postpartum care)	20%; after deductible	50%; after deductible
All Newborn charges are to be paid as follows: a) If baby and mom are discharged together all charges regarding time spent in hospital are processed under the mom's file; after the baby is discharged, all future claims are to be processed under the baby. b) If baby stays in the hospital after mom all charges are paid under the baby's file. Confirmed baby is covered 1st 31 days.		
Outpatient hospital	20%; after deductible	50%; after deductible
When you receive outpatient care at a hospital but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.		
Outpatient surgery - hospital	20%; after deductible	50%; after deductible
When you receive outpatient care at a hospital but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.		
Outpatient surgery - freestanding facility	20%; after deductible	50%; after deductible
When you receive outpatient care at a hospital but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	20%; after deductible	50%; after deductible
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.		
Mental health office visits	$40 copay; no deductible	50%; after deductible
Mental health telehealth consultations	$40 office visit copay; no deductible	50%; after deductible
Outpatient Mental health services	20%; after deductible	50%; after deductible

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When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit. (example: 23 hour BH observation, Psychological testing)

SUBSTANCE ABUSE	IN-NETWORK	OUT-OF-NETWORK
Inpatient	20%; after deductible	50%; after deductible
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.		
Residential treatment facility	20%; after deductible	50%; after deductible
When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive.		
Substance abuse office visits	$40 copay; no deductible	50%; after deductible
Substance abuse telehealth consultations	$40 office visit copay; no deductible	50%; after deductible
Outpatient substance abuse	20%; after deductible	50%; after deductible
When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit. (example: Treatment for withdrawal symptoms)		
THERAPY SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Spinal manipulation therapy	Covered 100%; no deductible	50%; after deductible
Limited to 10 visits per year		
Outpatient short-term rehabilitation	$25 copay; no deductible	50%; after deductible
Limited to 60 visits per year		
Includes physical, occupational, Pulmonary Rehab, Cognitive Therapy and speech therapies		
Habilitative physical therapy	$25 copay; no deductible	50%; after deductible
Habilitative occupational therapy	$25 copay; no deductible	50%; after deductible
Habilitative speech therapy	$25 copay; no deductible	50%; after deductible
Autism related physical therapy	$25 copay; no deductible	50%; after deductible
Autism related occupational therapy	$25 copay; no deductible	50%; after deductible
Autism related speech therapy	$25 copay; no deductible	50%; after deductible
Autism related behavioral therapy	$25 copay; no deductible	50%; after deductible
These benefits are combined with outpatient mental health visits		
Autism related applied behavior analysis	$25 copay; no deductible	50%; after deductible
Your benefits for these services are the same as any other outpatient mental health other services benefit		
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Skilled nursing facility	10%; after deductible	50%; after deductible
Limited to 100 days per year		
When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive.		
Home health care	10%; after deductible	50%; after deductible
Limited to 100 visits per year		
Home health care services include private duty nursing		
Limited to three visits per day by staff from a home health care agency. One visit equals a period of four hours or less.		
Hospice care - inpatient	10%; after deductible	50%; after deductible
When you're admitted into a facility for the care you need, your cost sharing amount counts toward all covered benefits you receive.		
Hospice care - outpatient	10%; after deductible	50%; after deductible
When you receive outpatient care at a facility but don't stay overnight, your cost sharing amount counts toward all covered benefits during your visit.		
Private duty nursing	Covered as part of home health care	Covered as part of home health care
We count each period of up to 8 hours as one private duty nursing shift.		

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Durable medical equipment Includes External Prosthetic	10%; after deductible	50%; after deductible
Hearing Aids	20%; no deductible	20%; after deductible
Limited to 2 devices every 36 months, includes Testing & Fitting of hearing aid devices		
Diabetic supplies --	Not covered by Medical- refer to pharmacy coverage. You pay your prescription drug cost sharing amount if you have prescription drug coverage. If not, you pay your PCP visit cost sharing amount.	Covered same as any other medical expense. You pay your prescription drug cost sharing amount if you have prescription drug coverage. If not, you pay your PCP visit cost sharing amount.
Infusion therapy - home/office	$40 copay; no deductible	50%; after deductible
Dialysis Infusion therapy - home/office	20%; after deductible	50%; after deductible
Infusion therapy - outpatient hospital/freestanding facility	Your cost sharing amount depends on the type of service and where you receive it.	Your cost sharing amount depends on the type of service and where you receive it.
Gene-based, Cellular, and other Innovative Therapies (GCIT™)	Your cost sharing amount depends on the type of service and where you receive it. **20%: after deductible** In-network coverage is provided at GCIT™ designated facilities only.	Not Covered
Transplants	100%; no deductible at Institutes of Excellence (IOE) contracted facility. 20%; after deductible for all other In-network	Not Covered
Bariatric surgery	20%; after deductible	Not Covered
When you're admitted into a hospital for the care you need, your cost sharing amount counts toward all covered benefits you receive.		
Acupuncture	Covered 100%; no deductible	Covered 100%; no deductible
Limited to 10 visits per year		
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility treatment	Your cost sharing amount depends on the type of service and where you receive it.	Your cost sharing amount depends on the type of service and where you receive it.
You have coverage for the diagnosis and treatment of the underlying cause of infertility.		
Comprehensive infertility services	50%; after deductible	50%; after deductible
Artificial insemination and ovulation induction, **fertility drugs excluded**.		
Advanced Reproductive Technology (ART)	**Not Covered**	**Not Covered**
In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery		
Vasectomy	Your cost sharing amount depends on the type of service and where you receive it.	50%; after deductible
Tubal ligation	Covered 100%; no deductible	50%; after deductible
PHARMACY	**IN-NETWORK**	**OUT-OF-NETWORK**
Pharmacy plan type	Aetna Standard Open Formulary	

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Prescription drug out-of-pocket limit	Prescription drug expenses apply to your medical out-of-pocket limit.	
Generic drugs		
Retail	25% Minimum $5 Maximum $50	Not Covered
Mail order	25% Minimum $10 Maximum $100	Not Covered
Preferred brand-name drugs		
Retail	30% Minimum $25 Maximum $150	Not Covered
Mail order	30% Minimum $50 Maximum $300	Not Covered
Non-preferred brand-name drugs		
Retail	35% Minimum $50 Maximum $250	Not Covered
Mail order	35% Minimum $100 Maximum $500	Not Covered
Specialty drugs		
	30% Minimum $75 Maximum $350	Not Covered

Pharmacy day supply and requirements

Retail	You can get up to a **90**-day supply from retail pharmacies in the Extended Day Supply Network. Percentage copays will not be doubled
Mail order	You can get a 31-90-day supply from CVS Caremark® Mail Service Pharmacy.
Specialty	You can get up to a 30-day supply of specialty drugs You must fill all specialty drugs through our preferred specialty pharmacy network. Aetna Specialty Performance Network Drug List

Your prescription drug plan also includes:
• Diabetic supplies and blood glucose monitors
•• Erectile Dysfunction for 8 scripts

Family planning
• All fertility drugs are excluded.

The following are covered 100% in-network:
• Oral chemotherapy drugs
• Seasonal vaccinations
• Preventive vaccinations
• Affordable Care Act (ACA) eligible preventive medications and contraceptives
Refer to **Aetna.com** for a complete list of eligible prescription drugs.

Precertification requirements

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Some covered prescription drugs need approval from us before we will cover the drug.
To get the most up-to-date precertification requirements, see your plan documents or go online to your member website.

Choose generics with dispense as written (DAW) override - Sometimes your physician may say you need a brand-name prescription drug even if a generic is available. If so, you will pay the brand-name copay. If you ask for a brand-name prescription drug when a generic is available, you will pay the applicable brand-name copay plus the difference between the generic price and the brand-name price.

GENERAL PROVISIONS	
Dependents who are eligible to be on your plan	Spouse, children from birth to age 26. Student status of children does not matter.

**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.
You may choose a provider (doctor or hospital) in our network. You may choose to visit an out-of-network provider. If you choose a doctor who is out of network, your health plan may pay some of that doctor's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor or hospital.

When you choose out-of-network care, we limit the amount it will pay. This limit is called the "recognized" or "allowed" amount.
This amount is based on the out-of-network plan you or your employer picks.
• For doctors and other professionals the amount is based on the "prevailing" charges. We get this data from an external database.

• For hospitals and other facilities, the amount is based on the Facility Fee Schedule.

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your plan "recognizes." Your doctor may bill you for the dollar amount that we don't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit our website.
You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to www.aetna.com and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Navigator member site.
This applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident, or for other emergency services), we will pay the bill as if you got care in network. You pay cost sharing and deductibles for your in-network level of benefits. Contact us if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your cost sharing and deductibles.
This way of paying out-of-network doctors and hospitals applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident), we will pay the bill as if you got care in-network. You pay your plan's copayments and deductibles for your in-network level of benefits. Contact us if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your copayments and deductibles.

Plans are provided by: Aetna Health Inc. 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.

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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.
• Weight Loss Drugs
All Infertility Drugs
• 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.
• 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.
• Therapy or rehabilitation other than those listed as covered.
• 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.
* Dialysis out of network is not covered

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

Translation of this material into another language may be available. Please call Member Services at the number on the back of your ID card.

Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862.**

Plan features and availability may vary by location and group size.

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For more information about Aetna plans, refer to **www.aetna.com.**

Aetna and MinuteClinic, LLC (which either operates or provides certain management support services to MinuteClinic-branded walk-in clinics) are both within the CVS Health family.

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