

Open Access Aetna Select - Non HRA



## PLAN DESIGN & BENEFITS ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

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PLAN FEATURES	In-Network Designated Providers		No Out of Network Coverage	
Deductible (per plan year)	\$1,750	Individual		
	\$5.250	Family		

All covered expenses, excluding prescription drugs, accumulate toward the 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 plan year.

 Member Coinsurance
 20%

 Applies to all expenses unless otherwise stated.
 Individual

 Payment Limit (per plan year)
 \$5,000
 Individual

 \$14,700
 Family

All covered expenses accumulate toward the preferred Payment Limit.

Certain member cost sharing elements may not apply toward the Payment Limit. Additional in-network Federal OOP \$7,150 for all copays. 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.

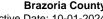
Once Family Payment Limit is met, all family members will be considered as having met their Payment Limit for the remainder of the plan year.

Lifetime Maximum	Unlimited except where otherwise indicated.
Primary Care Physician Selection	Optional

#### 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 \$400 per occurrence.

Referral Requirement	None	
PREVENTIVE CARE	In-Network Designated Providers	
Routine Adult Physical Exams/	Covered 100%; deductible waived	
Immunizations		
1 exam per calendar year for members age 18		
Routine Well Child Exams/Immunizations	Covered 100%; deductible waived	
7 exams in the 1st 12 months of life, 3 exams i age 18.	n the 2nd 12 months of life, 3 exams in the 3rd 12 months of life, 1 exam per calendar year thereafter to	
Routine Gynecological Care Exams	Covered 100%; deductible waived	
1 exam per calendar year - Includes routine tes	sts and related lab fees	
All Mammograms	Covered 100%; deductible waived	
1 exam per calendar year for covered females	age 35 and over.	
Routine Digital Rectal Exam / Prostate-	Covered 100%; deductible waived	
specific Antigen Test		
1 exam per calendar year for covered males		
age 40 and over.		
Colorectal Cancer Screening	Covered 100%; deductible waived	
No age limit: Fecal occult blood test every year	r, Sigmoidoscopy (1 every 5 years), Double contrast barium enema (1 every 5 years), <b>All Colonoscopies</b>	
Routine Eye Exams 1 routine exam per calendar year	Covered 100%; deductible waived	
PHYSICIAN SERVICES	In-Network Designated Providers	
Office Visits to PCP	100% after \$40 office visit copay; deductible waived	
Includes services of an internist, general physic	cian, family practitioner or pediatrician.	
Specialist Office Visits	100% after \$60 office visit copay; deductible waived	
Allergy Testing	Member cost sharing is based on the type of service	
	performed and the place of service where it is rendered	
Allergy Injections	Member cost sharing is based on the type of service	
	performed and the place of service where it is rendered	

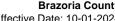




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DIAGNOSTIC PROCEDURES	PREFERRED CARE
Diagnostic Laboratory and X-ray*	Covered 100%; deductible waived
Complex Imaging	20% after deductible
*If performed as a part of a physician office visi	t and billed by the physician, expenses are covered subject to the applicable physician's office visit
member cost sharing	
EMERGENCY MEDICAL CARE	In-Network Designated Providers
Walk-In Clinic	100% after \$40 copay; deductible waived
Immunizations and routine consults performed	
by Nurse Practitioners outside of traditional	
office visit setting (benefit availability may vary	
by location)	
Urgent Care Provider	100% after \$50 copay; deductible waived
(benefit availability may vary by location)	
Non-Urgent Use of Urgent Care Provider	100% after \$50 copay; deductible waived
Emergency Room	20% after deductible and \$500 copay; copay waived if
	admitted
Non-Emergency care in an Emergency	Not Covered
Room	
Ambulance	20% after deductible
HOSPITAL CARE	In-Network Designated Providers
Inpatient Coverage	20% after deductible and \$200 per confinement copay
Inpatient Maternity Coverage	20% after deductible and \$200 per confinement copay; Deductible & copay waived for newborns
	Deductible & copay waived for newborns
Outpatient Hospital Expenses Hospitals and other facilities. Includes STR in a hospital outpatient setting (unless otherwise noted below the Short Term Rehab benefit below).	20% after deductible, deductible waived for newborn.
Outpatient Surgery Facility Charges Performed in outpatient dept. of hospital or ambulatory surgery center setting	20% after deductible and \$100 copay
MENTAL HEALTH SERVICES	In-Network Designated Providers
Inpatient	20% after plan deductible and \$200 copay per
·	admission
Outpatient	100% after \$60 copay; deductible waived
ALCOHOL/DRUG ABUSE SERVICES	In-Network Designated Providers
Inpatient	20% after plan deductible and \$200 copay per admission
Outpatient	100% after \$60 copay; deductible waived





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OTHER SERVICES	In-Network Designated Providers
Convalescent Facility	20% after deductible
Limited to 120 days per calendar year	
The member cost sharing applies to all covere	d benefits incurring during a member's inpatient stay
Home Health Care	20% after deductible
	s Private Duty Nursing limited to 70 eight hour shifts per calendar year.
	ach visit up to 4 hours by a home health care aide is one visit.
Hospice Care - Inpatient Unlimited	100%, deductible waived
Hospice Care - Outpatient Unlimited	100%, deductible waived
Outpatient Physical, Occupational and	20% after deductible
<b>Speech Therapy</b> performed in an office setting No visit limit per calendar year.	
	20% after deductible
Outpatient Physical, Occupational and	
Speech Therapy performed in an outpatient	
hospital / outpatient facility setting (non-office)	
Spinal Manipulation Therapy	100% after \$60 copay; deductible waived
Durable Medical Equipment	20% after deductible
Contraceptive drugs and devices not	Covered 100%: deductible waived. Device obtained as
obtainable at a pharmacy, including office	part of the contraceptive office visit, it is covered at
visit visit	100%.
VISIC	
Transplants Coverage is provided at an IOE	20% after plan deductible and \$200 copay per
contracted facility only.	admission
Bariatric Surgery	20% after deductible, \$12,000 maximum
Mouth, Jaws and Teeth	Member cost sharing is based on the type of service
(oral surgery procedures, whether medical or	performed and the place of service where it is rendered;
dental in nature)	after deductible
Out of Area Dependents	Preferred Plan Applies; dependent selects PCP from network of residence
FAMILY PLANNING	In-Network Designated Providers
Infertility Treatment	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 med	lical condition.
Advanced Reproductive Technology (ART)	Not Covered
	F), zygote intra-fallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo
transfers, intracytoplasmic sperm injection (ICS	
Voluntary Sterilization	Member cost sharing is based on the type of service
Including tubal ligation and vasectomy.	performed and the place of service where it is rendered;
	after deductible
Pharmacy	In-Network Designated Providers
Deductible (Generics and Mail Order are	Individual Rx Deductible \$150,
not subject to the Rx deductible)	Family Rx Deductible \$450
Retail	\$5 for generics (retail), \$30 for
	preferred brand (retail), and \$60
	for non-preferred brand (retail)
	2X copay for 90 day supply at
	retail



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Mail Order 2X the applicable copay based

on formulary tier.

AetnaSpecialty Rx \$150 copay

GENERAL PROVISIONS	
Dependents Eligibility	Spouse, children from birth to age 26

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

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.