aetna

City of Hialeah
Effective Date: 01-01-2023
Open Access® Elect Choice® - Florida

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	IN-NETWORK
Benefit Limitations - For any service or supply that is subject to a maximum visit, day, or dollar limitation on a per year basis, the benefit year begins on January 1st unless otherwise mandated. Refer to your plan documents for more information.	
Deductible (per calendar year)	$6,000 Individual $12,000 Family
Unless otherwise indicated, the deductible must be met prior to benefits being payable. Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible. Pharmacy expenses do not apply towards the Deductible. The family Deductible is a cumulative Deductible for all family members. The family Deductible can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Deductible amount.	
Member Coinsurance	30%
Applies to all expenses unless otherwise stated.	
Payment Limit (per calendar year)	$7,900 Individual $15,800 Family
Certain member cost sharing elements may not apply toward the Payment Limit. Pharmacy expenses apply towards the Payment Limit. Only those out-of-pocket expenses resulting from the application of coinsurance percentage, copays, and deductibles (except any penalty amounts) may be used to satisfy the Payment Limit. The family Payment Limit is a cumulative Payment Limit for all family members. The family Payment Limit can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Payment Limit amount.	
Lifetime Maximum	
Unlimited except where otherwise indicated.	
Primary Care Physician Selection	Optional
Referral Requirement	None
Telemedicine Consultations - Covered services for telemedicine consultations are available from a number of different kinds of providers under your plan. Log onto your secure Aetna website at https://www.aetna.com/ to review our telemedicine provider listings and get more information about your options, including specific cost sharing amounts.	
PREVENTIVE CARE	**IN-NETWORK**
Routine Adult Physical Exams/ Immunizations	Covered 100%; deductible waived
1 exam every 12 months up to age 65, 1 exam every 12 months age 65 and older	
Routine Well Child Exams/Immunizations	Covered 100%; deductible waived
7 exams first 12 months, 3 exams 13th - 24th months, 3 exams 25th - 36th months, 1 exam per 12 months thereafter to age 22.	
Virtual Primary Care (VPC) preventive care consultations	Covered 100%; deductible waived
Includes screening and counseling services for members age 18 and older	
Routine Gynecological Care Exams	Covered 100%; deductible waived
1 obgyn exam and pap smear per year	
Routine Mammograms	Covered 100%; deductible waived
Women's Health	Covered 100%; deductible waived
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.	

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

Routine Digital Rectal Exam	Covered 100%; deductible waived
Recommended: For covered males age 40 and over.	
Prostate-specific Antigen Test	Covered 100%; deductible waived
Recommended: For covered males age 40 and over.	
Colorectal Cancer Screening	Covered 100%; deductible waived
Recommended: For all members age 45 and over.	
Routine Eye Exams	Not Covered
Routine Hearing Screening	Covered 100%; deductible waived
PHYSICIAN SERVICES	**IN-NETWORK**
Office Visits to Non-Specialist	$10 office visit copay; deductible waived
Includes services of an internist, general physician, family practitioner or pediatrician.	
Telemedicine Consultation with Non-Specialist	$10 copay; deductible waived
Virtual Primary Care (VPC) consultations	Covered 100%; deductible waived
Includes basic medical services' consultations for members age 18 and older	
Specialist Office Visits	$60 office visit copay; deductible waived
Telemedicine Consultation with Specialist	$60 copay; deductible waived
Hearing Exams	Not Covered
Pre-Natal Maternity	Covered 100%; deductible waived
Walk-in Clinics	$10 office visit copay; deductible waived **Designated Walk-in Clinics** Covered 100%; deductible waived
Walk-in Clinics are free-standing health care facilities that (a) may be located in or with a pharmacy, drug store, supermarket or other retail store; and (b) provide limited medical care and services on a scheduled or unscheduled basis. Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices are not considered to be Walk-in Clinics.	
Allergy Testing	Your cost sharing is based on the type of service and where it is performed
Allergy Injections	Your cost sharing is based on the type of service and where it is performed
DIAGNOSTIC PROCEDURES	**IN-NETWORK**
Diagnostic X-ray	Covered 100%; deductible waived
(other than Complex Imaging Services)	
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 Laboratory	Covered 100%; deductible waived
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 Outpatient Complex Imaging	$75 copay; deductible waived
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.	
EMERGENCY MEDICAL CARE	**IN-NETWORK**
Urgent Care Provider	$50 office visit copay; deductible waived
Non-Urgent Use of Urgent Care Provider	Not Covered
Emergency Room	$350 copay; deductible waived
Copay waived if admitted	
Non-Emergency Care in an Emergency Room	Not Covered
Emergency Use of Ambulance	Covered 100%; deductible waived

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

Non-Emergency Use of Ambulance	Not Covered
HOSPITAL CARE	**IN-NETWORK**
Inpatient Coverage	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Inpatient Maternity Coverage (includes delivery and postpartum care)	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Outpatient Hospital Expenses	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
Outpatient Surgery - Hospital	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
Outpatient Surgery - Freestanding Facility	$250 copay; deductible waived
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
MENTAL HEALTH SERVICES	**IN-NETWORK**
Inpatient	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Mental Health Office Visits	$60 copay; deductible waived
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
Mental Health Telemedicine Consultations	$60 copay; deductible waived
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
Other Mental Health Services	Covered 100%; deductible waived
SUBSTANCE ABUSE	**IN-NETWORK**
Inpatient	30%; after deductible
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Residential Treatment Facility	30%; after deductible
Substance Abuse Office Visits	$60 copay; deductible waived
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
Substance Abuse Telemedicine Consultations	$60 copay; deductible waived
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
Other Substance Abuse Services	Covered 100%; deductible waived
OTHER SERVICES	**IN-NETWORK**
Skilled Nursing Facility	Covered 100%; deductible waived
Limited to 30 days per year	
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Home Health Care	Covered 100%; deductible waived
Limited to 60 visits per year. Coverage includes nutritional counseling and services of a medical social worker. Coverage includes nutritional counseling and services of a medical social worker. Reimbursement may not be limited to less than $1,000 per year even if the maximum number of visits has been reached.	
Private Duty Nursing not covered	
Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less.	
Hospice Care - Inpatient	Covered 100%; deductible waived
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Hospice Care - Outpatient	Covered 100%; deductible waived
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

Private Duty Nursing - Outpatient	Not Covered
Outpatient Short-Term Rehabilitation Limited to 60 visits per year. Includes speech, physical, occupational therapy	$60 copay; deductible waived
Spinal Manipulation Therapy Limited to 60 visits per year	$60 copay; deductible waived
Acupuncture Limited to 10 visits per year	$10 copay; deductible waived
Habilitative Physical Therapy	Refer to MBH Outpatient Mental Health All Other
Habilitative Occupational Therapy	Refer to MBH Outpatient Mental Health All Other
Habilitative Speech Therapy	Refer to MBH Outpatient Mental Health All Other
Autism Behavioral Therapy Covered same as any other Outpatient Mental Health benefit	Refer to MBH Outpatient Mental Health
Autism Applied Behavior Analysis Covered same as any other Outpatient Mental Health Other Services benefit	Refer to MBH Outpatient Mental Health Other Services
Autism Physical Therapy	Refer to MBH Outpatient Mental Health All Other
Autism Occupational Therapy	Refer to MBH Outpatient Mental Health All Other
Autism Speech Therapy	Refer to MBH Outpatient Mental Health All Other
Durable Medical Equipment	Covered 100%; deductible waived
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.
Affordable Care Act Mandated Women's Contraceptives	Covered 100%; deductible waived
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived
Infusion Therapy Administered in the home or physician's office	$60 copay; deductible waived
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	Your cost sharing is based on the type of service and where it is performed
Vision Eyewear	Not Covered
Transplants	30%; after deductible Preferred coverage is provided at an IOE contracted facility only.
Bariatric Surgery Your cost sharing applies to all covered benefits incurred during your inpatient stay.	Not Covered
FAMILY PLANNING	**IN-NETWORK**
Infertility Treatment Diagnosis and treatment of the underlying medical condition only.	Your cost sharing is based on the type of service and where it is performed
Advanced Reproductive Technology (ART) ART coverage includes: In vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery. Limited to 3 courses of treatment per member's lifetime. Maximum applies to all procedures covered by any of our plans except where prohibited by law.	30%; after deductible

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

Comprehensive Infertility Services	30%; after deductible
Coverage includes artificial insemination and ovulation induction limited to six courses of treatment combined per member lifetime. Lifetime maximum applies to all procedures covered by any of our plans except where prohibited by law.	
Vasectomy	Your cost sharing is based on the type of service and where it is performed
Tubal Ligation	Covered 100%; deductible waived
PHARMACY	**IN-NETWORK**
Pharmacy Plan Type	Advanced Control Plan - Aetna
Preferred Generic Drugs	
Retail	$10 copay
Mail Order	$20 copay
Preferred Brand-Name Drugs	
Retail	$50 copay
Mail Order	$100 copay
Non-Preferred Generic and Brand-Name Drugs	
Retail	$75 copay
Mail Order	$150 copay
Retail Out-of-Network Coverage	Not Covered
Specialty Drugs	
Preferred Specialty	20%
Non-Preferred Specialty	20%
Pharmacy Day Supply and Requirements	
Retail	Up to a 30 day supply from Aetna National Network
Mail Order	A 31-90 day supply from CVS Caremark® Mail Service Pharmacy
Specialty	Up to a 30 day supply All prescription fills must be through our preferred specialty pharmacy network. Advanced Control Formulary Aetna Insured List
Choose Generics - If the member or the physician requests brand-name when generic is available, the member pays the applicable copay plus the difference between the generic price and the brand-name price.	
Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy. A limited list of over-the-counter medications are covered when filled with a prescription. Oral chemotherapy drugs covered 100% Precertification and quantity limits included Advanced Control Formulary Aetna Insured Step Therapy Seasonal Vaccinations covered 100% in-network Preventive Vaccinations covered 100% in-network One transition fill allowed within 90 days of member's effective date Affordable Care Act mandated female contraceptives and preventive medications covered 100% in-network.	
GENERAL PROVISIONS	
Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status.

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. 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. You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. 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.

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

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 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;
• Hearing aids;
• Home births;
• Immunizations for travel or work except where medically necessary or indicated;
• Implantable drugs and certain 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 procedure, 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.

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

Translation of the material into another language may be available. Please call Member Services at **1-888-982-3862.**
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.
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.

© 2014 Aetna Inc.