



HIDALGO COUNTY

Aetna

JANUARY 1, 2018

PPO PLAN SUMMARY HIGHLIGHTS	BASIC PLAN - PLAN I		BUY-UP PLAN - PLAN II	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Deductible - Individual/Family Per-Admission Deductible Three Month Deductible carryover applies	\$1,250/\$2,500 \$350	\$2,000/\$4,000 \$350 Per Day-Maximum 2 days	\$ 750/\$1,250 \$350	\$1,000/\$2,000 \$350 Per Day-Maximum 2 days
Percentage Payable after deductible satisfied. (This applies to every benefit where only a % is shown).	70% of Allowable Amount	50% of Allowable Amount	80% of Allowable Amount	50% of Allowable Amount
Out of Pocket Limit Individual/Family	\$7,150/\$14,300 Includes deductible	\$10,000/\$20,000 Includes deductible	\$5,000/\$10,000 includes deductible	\$7,500/\$15,000 includes deductible
Doctor's Office Visit (per visit) Non-Specialist Specialist (excludes office surgery and physical therapy)	\$40 Co-Pay, then 100% \$50 Co-Pay, then 100%	50% of Allowable Amount	\$35 Co-Pay, then 100% \$45 Co-Pay, then 100%	50% of Allowable Amount
Routine Physical Exam/Preventive Care Well-baby care exams & immunizations and over, & any other preventative health services as determined by USPSTF	100% of Allowable Amount	50% of Allowable Amount after calendar year deductible	100% of Allowable Amount	50% of Allowable Amount after calendar year deductible
Emergency Room Services Copay waived if admitted, Inpatient Hospital expenses will apply.	\$350 Co-Pay Deductible, then 70%	\$350 Co-Pay Deductible, then 70%	\$250 Co-Pay Deductible, then 80%	\$250 Co-Pay Deductible, then 80%
Inpatient Hospital Services	70% after \$350 per admission deductible	50% after \$350 per day per admission deductible-2 day maximum, & calendar year deductible. \$250 Penalty for failure to pre-authorize	80%	50% after \$350 per day per admission deductible-2 day maximum, & calendar year deductible. \$250 Penalty for failure to pre-authorize
Outpatient Facility Services	Deductible, then 70%	Deductible, then 50%	Deductible, then 80%	Deductible, then 50%
Lab & X-Ray Services (does not include certain diagnosis procedures services) Certain Diagnostic Procedures-such as bone Scan, Cardiac Stress Test, CT, MRI, Myelogram & PET Scan, surgical services & all other supplies.	100% Allowable Amount 70% of Allowable Amount after deductible	50% of Allowable Amount after deductible 50% of Allowable Amount after deductible	100% Allowable Amount 80% of Allowable Amount after deductible	50% of Allowable Amount after deductible 50% of Allowable Amount after deductible
Urgent Care Services	\$40 Co-Pay, then 100%	Deductible, then 50%	\$35 Co-Pay, then 100%	Deductible, then 50%
Physician Maternity Services (Prenatal)	100% of Allowable Amount	Deductible, then 50%	100% of Allowable Amount	Deductible, then 50%
Physical Surgical Services (Inpatient & Outpatient)	Deductible, then 70%	Deductible, then 50%	Deductible, then 80%	Deductible, then 50%
Prescription Drugs - Retail (up to 30-90 day supply):	100% after:		100% after:	
Generic Drugs	\$10 Co-Pay	No Benefit	\$10 Co-Pay	No Benefit
Brand Name Drugs on Formulary	\$20 Co-Pay	No Benefit	\$20 Co-Pay	No Benefit
Brand Name Drugs not on Formulary	\$35 Co-Pay	No Benefit	\$35 Co-Pay	No Benefit
Prior preauthorization on specialty drugs				
Mail Order (up to 90 day supply per RX):				
Generic Drugs	\$20 Co-Pay	No Benefit	\$20 Co-Pay	No Benefit
Brand Name Drugs on Formulary	\$40 Co-Pay	No Benefit	\$40 Co-Pay	No Benefit
Brand Name Drugs not on Formulary	\$70 Co-Pay	No Benefit	\$70 Co-Pay	No Benefit
Prior preauthorization on specialty drugs				

This is a summary of your benefits. Please refer to your Summary of Benefits and Coverage (SBC). Please carefully review the plans limitations and exclusions.

EMPLOYEE COST & CONTACT INFORMATION

BASIC PLAN PLAN I					AETNA GROUP# 285608
MONTHLY PREMIUM	EMPLOYER CONTRIBUTION	EMPLOYEE MONTHLY COST	EMPLOYEE COST PER PAY CHECK		
EMPLOYEE ONLY	\$ 575.00	\$ 575.00	\$ -	\$ -	
EMPLOYEE & SPOUSE	\$ 959.00	\$ 575.00	\$ 384.00	\$ 192.00	
EMPLOYEE & CHILD(REN)	\$ 683.00	\$ 575.00	\$ 108.00	\$ 54.00	
EMPLOYEE & FAMILY	\$ 1,068.00	\$ 575.00	\$ 493.00	\$ 246.50	
BUY-UP PLAN PLAN II					
MONTHLY PREMIUM	EMPLOYER CONTRIBUTION	EMPLOYEE MONTHLY COST	EMPLOYEE COST PER PAY CHECK		
EMPLOYEE ONLY	\$ 736.00	\$ 575.00	\$ 161.00	\$ 80.50	
EMPLOYEE & SPOUSE	\$ 1,282.00	\$ 575.00	\$ 707.00	\$ 353.50	
EMPLOYEE & CHILD(REN)	\$ 902.00	\$ 575.00	\$ 327.00	\$ 163.50	
EMPLOYEE & FAMILY	\$ 1,499.00	\$ 575.00	\$ 924.00	\$ 462.00	
HIDALGO COUNTY- PREFERRED FACILITIES					Talk to a Doctor Anytime at Teladoc
<p align="center"> EDINBURG CHILDRENS HOSPITAL EDINBURG REGIONAL MEDICAL CENTER EDINBURG REGIONAL REHAB CENTER MCALLEN MEDICAL CENTER MCALLEN MEDICAL HEART CENTER SOUTH TEXAS BEHAVIORAL HEALTH CENTER SOUTH TEXAS HEALTH SYSTEM UHS REHABILITATION PAVILION CORNERSTONE REGIONAL DOCTORS HOSPITAL AT RENAISSANCE VALLEY BAPTIST- HARLINGEN </p>					<p align="center"> Call Teladoc when you need care now or if considering visiting an ER facility. Talk to a doctor anytime for \$40 or less! Phone: 1-855-835-2362 or www.Teladoc.com/Aetna </p>
					CLAIMS SUBMISSION
HIDALGO CONTACT INFORMATION					MEDICAL CLAIMS
Employee Benefits Division:			(956) 292-7025		<p align="center"> AETNA LIFE INSURANCE COMPANY CLAIMS DEPARTMENT P.O. BOX 981106 EL PASO, TX 79998-1106 </p>
Head Start Program:			(956) 383-0706		
Drainage District #1:			(956) 292-7080		
Appraisal District:			(956) 381-8466		
Community Service Agency:			(956) 383-6250		
INSURANCE GROUP CONTACT INFORMATION					PRESCRIPTION DRUG CLAIMS:
Local Agent: Jeff Everitt			(956) 968-5954		<p align="center"> Mail or Fax the Prescription Drug Claim form to: Aetna Pharmacy Management PO Box 52444 Phoenix, AZ 85072-2444 Fax: 1-888-472-1128 </p>
Local Agent: Bob Trevino			(888) 556-2825/(956) 781-7771		
GENERIC INCENTIVE	Members electing to purchase preferred/non-preferred brand name drugs when a generic equivalent is available will be required to pay the difference between the cost of the generic and preferred/non-preferred brand name drug plus the preferred brand name Co-Pay.				