



City of Seguin  
Effective 1/1/2016

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**PLAN DESIGN & BENEFITS  
PROVIDED BY AETNA LIFE INSURANCE COMPANY**

<b>PLAN FEATURES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Deductible</b> (per calendar year)	\$1,000 Individual \$3,000 Family	\$2,000 Individual \$6,000 Family
<p>All covered expenses accumulate simultaneously toward both the preferred and non-preferred Deductible. 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.</p>		
<b>Member Coinsurance</b>	20%	40%
<p>Applies to all expenses unless otherwise stated.</p>		
<b>Payment Limit</b> (per calendar year)	\$4,000 Individual \$12,000 Family	\$8,000 Individual \$24,000 Family
<p>All covered expenses accumulate simultaneously toward both the preferred and non-preferred Payment Limit. 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.</p>		
<b>Lifetime Maximum</b>	Unlimited except where otherwise indicated.	
<b>Payment for Non-Preferred</b>	Not Applicable	Professional: 90% of Medicare Facility: 100% of Medicare
<b>Primary Care Physician Selection</b>	Optional	Not Applicable
<b>Certification Requirements -</b>	<p>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.</p>	
<b>Referral Requirement</b>	None	None
<b>PREVENTIVE CARE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Routine Adult Physical Exams/ Immunizations</b>	Covered 100%; deductible waived	40%; after deductible
<p>1 exam every 12 months for members age 22 to age 65; 1 exam every 12 months for adults age 65 and older.</p>		
<b>Routine Well Child Exams/Immunizations</b>	Covered 100%; deductible waived	40%; after deductible
<p>7 exams in the first 12 months of life, 3 exams in the second 12 months of life, 3 exams in the third 12 months of life, 1 exam per year thereafter to age 22. The following immunizations will be covered at 100%: diphtheria; haemophilus influenza type b, hepatitis B; measles; mumps; pertussis; polio; rubella; tetanus and varicella and any other immunization that is required by law for the child.</p>		
<b>Routine Gynecological Care Exams</b>	Covered 100%; deductible waived	40%; after deductible
<p>Recommended: One exam per calendar year. Includes routine tests and related lab fees.</p>		
<b>Routine Mammograms</b>	Covered 100%; deductible waived	40%; after deductible
<p>No age or frequency applies.</p>		



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<b>Women's Health</b>	Covered 100%; deductible waived	40%; after deductible
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.		
<b>Routine Digital Rectal Exam</b>	Covered 100%; deductible waived	40%; after deductible
No age or frequency applies.		
<b>Prostate-specific Antigen Test</b>	Covered 100%; deductible waived	40%; after deductible
Recommended: For covered males age 40 and over.		
<b>Colorectal Cancer Screening</b>	Covered 100%; deductible waived	Covered under Routine Adult Exams
Recommended: For all members age 50 and over. Coverage includes the following: Annual fecal occult blood test, Digital rectal exam and a flexible sigmoidoscopy every 5 years, Digital rectal exam and a double contrast barium enema every 5 years, and Digital rectal exam and a colonoscopy every 10 years.		
<b>Routine Eye Exams</b>	Covered 100%; deductible waived	40%; after deductible
1 routine exam per 24 months.		
<b>Newborn Hearing Screening</b>	\$35 copay; deductible waived	40%; deductible waived
1 in the first 30 days of life and follow-up diagnostic care until the age of 24 months		
<b>Routine Hearing Screening</b>	Covered 100%; deductible waived	40%; after deductible
<b>PHYSICIAN SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Office Visits to PCP</b>	\$20 copay; deductible waived	40%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
<b>Specialist Office Visits</b>	\$35 copay; deductible waived	40%; after deductible
<b>Audiometric Hearing Exam</b>	Not Covered	Not Covered
<b>Office Based Surgery</b>	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered
<b>Pre-Natal Maternity</b>	Covered 100%; deductible waived	Covered according to standard claim practice.
<b>Walk-in Clinics</b>	\$20 copay; deductible waived	40%; after deductible
Walk-in Clinics are network, free-standing health care facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor the outpatient department of a hospital, shall be considered a Walk-in Clinic.		
<b>Allergy Testing</b>	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered
<b>Allergy Injections</b>	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered
<b>DIAGNOSTIC PROCEDURES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Diagnostic X-ray</b>	Covered 100%; deductible waived	40%; after deductible
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.		
<b>Diagnostic Laboratory</b>	Covered 100%; deductible waived	40%; after deductible
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.		



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<b>Diagnostic Outpatient Complex Imaging</b>	20%; after deductible	40%; after deductible
<b>EMERGENCY MEDICAL CARE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Urgent Care Provider</b>	\$50 copay; deductible waived	40%; after deductible
<b>Non-Urgent Use of Urgent Care Provider</b>	Not Covered	Not Covered
<b>Emergency Room</b> Copay waived if admitted	\$200 copay; deductible waived	Same as in-network care
<b>Non-Emergency Care in an Emergency Room</b>	Not Covered	Not Covered
<b>Emergency Use of Ambulance</b>	20%; after deductible	Same as in-network care
<b>Non-Emergency Use of Ambulance</b>	Not Covered	Not Covered
<b>HOSPITAL CARE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Inpatient Coverage</b>	20%; after deductible	40% after \$250 copay; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
<b>Inpatient Maternity Coverage</b> (includes delivery and postpartum care)	20%; after deductible	40% after \$250 copay; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
<b>Outpatient Hospital Expenses</b>	20%; after deductible	40%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
<b>Outpatient Surgery</b>	20%; after deductible	40%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
<b>Outpatient Surgery - Freestanding Facility</b>	20%; after deductible	40%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
<b>MENTAL HEALTH SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Inpatient</b>	20%; after deductible	40% after \$250 copay; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
<b>Partial Hospitalization</b> (for day/night care and treatment)	20%; after deductible	40% after \$250 copay; after deductible
<b>Crisis Stabilization Units/ Residential Treatment Centers</b> (for children and adolescents)	20%; after deductible	40% after \$250 copay; after deductible
<b>Outpatient</b>	\$35 copay; deductible waived	40%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
<b>ALCOHOL/DRUG ABUSE SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Inpatient</b>	20%; after deductible	40% after \$250 copay; after deductible
Member cost sharing is based on the type of service performed and the place of service where it is rendered		
<b>Residential Treatment Facility</b>	20%; after deductible	40% after \$250 copay; after deductible
<b>Outpatient</b>	\$35 copay; deductible waived	40%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		



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<b>OTHER SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Convalescent Facility</b>	20%; after deductible	40% after \$250 copay; after deductible
Limited to 60 days per calendar year. The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
<b>Home Health Care</b>	20%; after deductible	40%; after deductible
Limited to 60 days per calendar year. Each visit by a nurse or therapist is one visit. Each visit up to 4 hours by a home health care aide is one visit.		
<b>Hospice Care - Inpatient</b>	20%; after deductible	40%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
<b>Hospice Care - Outpatient</b>	20%; after deductible	40%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
<b>Private Duty Nursing - Outpatient</b>	20%; after deductible	40%; after deductible
Limited to 70 eight hour shifts per calendar year. Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.		
<b>Outpatient Short-Term Rehabilitation</b>	\$35 copay; deductible waived	40%; after deductible
Includes Speech, Physical, and Occupational Therapy, limited to 20 visits per calendar year.		
<b>Autism Behavioral Therapy</b>	\$35 copay; deductible waived	40%; after deductible
Covered same as any other Outpatient Mental Health benefit		
<b>Autism Applied Behavior Analysis</b>	\$35 copay; deductible waived	40%; after deductible
Covered same as any other Outpatient Mental Health benefit with no age or visit limitations.		
<b>Autism Physical Therapy</b>	\$35 copay; deductible waived	40%; after deductible
<b>Autism Occupational Therapy</b>	\$35 copay; deductible waived	40%; after deductible
<b>Autism Speech Therapy</b>	\$35 copay; deductible waived	40%; after deductible
<b>Spinal Manipulation Therapy</b>	\$35 copay; deductible waived	40%; after deductible
Limited to 20 visits per calendar year.		
<b>Hearing Aids</b>	Not Covered	Not Covered
<b>Durable Medical Equipment</b>	20%; after deductible	40%; after deductible
<b>Diabetic Supplies</b> -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
<b>Contraceptive drugs and devices not obtainable at a pharmacy</b>	Covered 100%; deductible waived	Covered same as any other expense.
<b>Generic FDA-approved Women's Contraceptives</b>	Covered 100%; deductible waived	40%; after deductible
<b>Infusion Therapy</b> Administered in the home or physician's office	20%; deductible waived	40%; after deductible
<b>Infusion Therapy</b> Administered in an outpatient hospital department or freestanding facility	20%; after deductible	40%; after deductible
<b>Transplants</b>	20%; after deductible	40% after \$250 copay; after deductible
	Preferred coverage is provided at an IOE contracted facility only.	Non-Preferred coverage is provided at a Non-IOE facility.
<b>Bariatric Surgery</b>	Not Covered	Not Covered
<b>Out of Area Dependents</b>	Coverage provided at the non-preferred benefit level of the plan.	



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<b>FAMILY PLANNING</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Infertility Treatment</b>	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Diagnosis and treatment of the underlying medical condition.		
<b>Comprehensive Infertility Services</b>	Not Covered	Not Covered
Coverage includes Artificial Insemination and Ovulation Induction, limited to 4 attempts per lifetime.		
<b>Advanced Reproductive Technology (ART)</b>	Not Covered	Not Covered
<b>Vasectomy</b>	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered
<b>Tubal Ligation</b>	Covered 100%; deductible waived	Member cost sharing is based on the type of service performed and the place of service where it is rendered
<b>PHARMACY</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Pharmacy Plan Type</b>	Aetna Premier Open Formulary	
<b>Retail</b>	\$10 copay for generic drugs, \$30 copay for formulary brand-name drugs, and \$60 copay for non-formulary brand-name drugs up to a 30 day supply at participating pharmacies.	20% of submitted cost; after applicable copay
<b>Mail Order</b>	\$20 copay for generic drugs, \$60 copay for formulary brand-name drugs, and \$120 copay for non-formulary brand-name drugs. Up to a 31-90 day supply from Aetna Rx Home Delivery <sup>®</sup> .	Not Applicable
<b>Aetna Premier Specialty Drugs</b>	\$10 copay for generic drugs, \$30 copay for formulary brand-name drugs, and \$60 copay for non-formulary brand-name drugs up to a 30 day supply at participating pharmacies.	Not Applicable
Premier Specialty Drug List		
<b>Choose Generics</b> - If the member or the physician requests brand when generic is available, the member pays the applicable copay plus the difference between the generic price and the brand price.		
<b>Plan Includes:</b> 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 fertility drugs included.		
Premier Pre-certification included		
Premier Step Therapy included		
One transition fill allowed within 90 days of member's effective date		
Formulary Generic FDA-approved Women's Contraceptives and certain over-the-counter preventive medications covered 100% in network.		
<b>GENERAL PROVISIONS</b>		
<b>Dependents Eligibility</b>	Spouse, children from birth to age 26 regardless of student status.	



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\*\*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.

- For doctors and other professionals the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.
- For hospitals and other facilities, the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

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.

Plans are provided by: Aetna Life Insurance Company. 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.

If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.

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.



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- 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.
- Durable medical Equipment
- 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 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.
- Orthotics except diabetic orthotics.
- 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 or inadequacies, including therapy, supplies or counseling or prescription drugs.
- Special duty nursing.
- Therapy or rehabilitation other than those listed as covered.
- Treatment of behavioral disorders.
- 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.

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

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 traducción 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**.

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