

RFP: 2013-14-15

Group Health  
Insurance

Addendum No. 3



City of Weslaco  
 Effective Date: 10-01-2013  
 Open Access<sup>®</sup> Managed Choice<sup>®</sup> POS - Texas

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

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
<b>Deductible</b> (per calendar year)	\$2,500 Individual \$5,000 Family	\$7,500 Individual \$15,000 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.            Once Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year.</p>		
<b>Member Coinsurance</b>	Covered 100%	30%
<p>Applies to all expenses unless otherwise stated.</p>		
<b>Payment Limit</b> (per calendar year)	None Individual None Family	\$6,000 Individual \$12,000 Family
<p>Certain member cost sharing elements may not apply toward the Payment Limit.            Pharmacy expenses do not apply towards the Payment Limit.            Only those out-of-pocket expenses resulting from the application of coinsurance percentage (except any deductibles 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 calendar year.</p>		
<b>Lifetime Maximum</b>		
Unlimited except where otherwise indicated.		
<b>Payment for Non-Preferred</b>	Not Applicable	Professional: 105% of Medicare Facility: 140% 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
PREVENTIVE CARE	IN-NETWORK	OUT-OF-NETWORK
<b>Routine Adult Physical Exams/ Immunizations</b>	Covered 100%; deductible waived	30%; after deductible
<p>1 exam every 12 months for members age 22 and older.</p>		
<b>Routine Well Child Exams/Immunizations</b>	Covered 100%; deductible waived	30%; 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	30%; after deductible
<p>One exam per calendar year. Includes routine tests and related lab fees.</p>		
<b>Routine Mammograms</b>	Covered 100%; deductible waived	30%; after deductible
<b>Women's Health</b>	Covered 100%; deductible waived	30%; after deductible
<p>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.</p>		



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<b>Routine Digital Rectal Exam</b>	Covered 100%; deductible waived	30%; after deductible
<b>Prostate-specific Antigen Test</b>	Covered 100%; deductible waived	30%; after deductible
<b>Colorectal Cancer Screening</b>	Covered 100%; deductible waived	30%; after deductible
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>	Not Covered	Not Covered
<b>Routine Hearing Screening</b>	Covered 100%; deductible waived	30%; after deductible
<b>Newborn Hearing Screening</b>	\$40 copay; deductible waived	30%; deductible waived
1 in the first 30 days of life and follow-up diagnostic care until the age of 24 months		
<b>PHYSICIAN SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Office Visits to PCP</b>	\$20 copay; deductible waived	30%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
<b>Specialist Office Visits</b>	\$40 copay; deductible waived	30%; after deductible
<b>Pre-Natal Maternity</b>	Covered 100%; deductible waived	30%; after deductible
<b>E-visit to PCP</b>	\$20 office visit copay; deductible waived	30%; after deductible
An E-visit is an online internet consultation between a physician and an established patient about a non-emergency healthcare matter. This visit must be conducted through an Aetna authorized internet E-visit service vendor.		
<b>E-visit to Specialist</b>	\$30 office visit copay; deductible waived	30%; after deductible
An E-visit is an online internet consultation between a physician and an established patient about a non-emergency healthcare matter. This visit must be conducted through an Aetna authorized internet E-visit service vendor.		
<b>Walk-in Clinics</b>	\$20 office visit copay; deductible waived	30%; 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; deductible waived	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible
<b>Allergy Injections</b>	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible
<b>DIAGNOSTIC PROCEDURES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Diagnostic X-ray</b>	\$20 copay; deductible waived	30%; 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%; after deductible	30%; 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>	Covered 100%; after deductible	30%; after deductible
<b>EMERGENCY MEDICAL CARE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Urgent Care Provider</b>	\$75 copay; deductible waived	30%; after deductible
<b>Non-Urgent Use of Urgent Care Provider</b>	Not Covered	Not Covered
<b>Emergency Room</b>	\$200 copay; deductible waived	Same as preferred care.
<b>Non-Emergency Care in an Emergency Room</b>	Not Covered	Not Covered
<b>Emergency Use of Ambulance</b>	Covered 100%; after deductible	Same as preferred 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>	\$250 per confinement copay; after deductible	30% after \$1,000 per confinement deductible; 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)	\$40 for Physician Services; deductible waived \$250 per confinement copay for Facility services; after deductible	30% after \$1,000 per confinement deductible; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
<b>Outpatient Hospital Expenses</b>	Covered 100%; after deductible	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
<b>Outpatient Surgery</b>	Covered 100%; after deductible	30%; 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>	\$250 per confinement copay; after deductible	30% after \$1,000 per confinement deductible; 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)	\$250 per confinement copay; after deductible	30% after \$1,000 per confinement deductible; after deductible
<b>Crisis Stabilization Units/ Residential Treatment Centers</b> (for children and adolescents)	\$250 per confinement copay; after deductible	30% after \$1,000 per confinement deductible; after deductible
<b>Outpatient</b>	\$40 copay; deductible waived	30%; 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>	\$250 per confinement copay; after deductible	30% after \$1,000 per confinement deductible; 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>	\$250 per confinement copay; after deductible	30% after \$1,000 per confinement deductible; after deductible
<b>Outpatient</b>	\$40 copay; deductible waived	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
<b>OTHER SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Convalescent Facility</b>	\$250 per confinement copay; after deductible	30% after \$1,000 per confinement deductible; 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.



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<b>Home Health Care</b> Limited to 60 visits 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.	Covered 100%; after deductible	30%; after deductible
<b>Hospice Care - Inpatient</b> The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.	\$250 per confinement copay; after deductible	30% after \$1,000 per confinement deductible; after deductible
<b>Hospice Care - Outpatient</b> The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.	Covered 100%; after deductible	30%; after deductible
<b>Private Duty Nursing - Outpatient</b> 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.	Covered 100%; after deductible	30%; after deductible
<b>Outpatient Short-Term Rehabilitation</b> Includes Speech, Physical, and Occupational Therapy, limited to 60 visits per calendar year.	\$40 copay; deductible waived	30%; after deductible
<b>Autism Behavioral Therapy</b> Covered same as any other Outpatient Mental Health benefit.	\$40 copay; deductible waived	30%; after deductible
<b>Autism Applied Behavior Analysis</b> To age 10, covered. Age 10 and over, no coverage.	Covered the same as any other expense based on the type of service performed and place of service where rendered	Covered the same as any other expense based on the type of service performed and place of service where rendered
<b>Autism Physical, Occupational and Speech Therapy</b> To age 10, covered same as any other Short Term Rehabilitation expense.	\$40 copay; deductible waived	30%; after deductible
<b>Spinal Manipulation Therapy</b> Limited to 20 visits per calendar year.	\$40 copay; deductible waived	30%; after deductible
<b>Durable Medical Equipment</b> Maximum benefit of \$2,500 per member per calendar year.	Covered 100%; after deductible	30%; after deductible
<b>Orthotics</b>	Covered 100%; after deductible	30%; after deductible
<b>Prosthetics</b>	Covered 100%; after deductible	30%; after deductible
<b>Diabetic Supplies -- (if not covered under Pharmacy benefit)</b>	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	Not Covered
<b>Transplants</b>	\$250 per confinement copay; after deductible Preferred coverage is provided at an IOE contracted facility only.	30% after \$1,000 per confinement deductible; after deductible 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.
<b>FAMILY PLANNING</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Infertility Treatment</b> Diagnosis and treatment of the underlying medical condition.	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible



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<b>Vasectomy</b>	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible.
<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; after deductible.
<b>PHARMACY</b>		
	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Retail</b>	\$15 copay for generic drugs, \$30 copay for formulary brand-name drugs, and \$50 copay for non-formulary brand-name drugs up to a 30 day supply at participating pharmacies.	20% of submitted cost after the applicable preferred copay
<b>Mail Order</b>	\$30 copay for generic drugs, \$60 copay for formulary brand-name drugs, and \$100 copay for non-formulary brand-name drugs up to a 31-90 day supply from Aetna Rx Home Delivery <sup>®</sup> .	Not Applicable

**Choose Generics** - 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.

**Plan Includes:** Diabetic supplies.

Oral fertility drugs included.

Precert for growth hormones included. Expanded Precert included.

Step Therapy included

Formulary generic FDA - approved Women's Contraceptives covered 100% in network

**GENERAL PROVISIONS**

**Dependents Eligibility** Spouse, children from birth to age 26 regardless of student status.

**Pre-existing Conditions Exclusion** On effective date: Waived  
After effective date: Waived

For members age 19 or over this plan imposes a pre-existing condition exclusion, which may be waived in some circumstances and may not be applicable to you. A pre-existing condition exclusion means that if you have a medical condition before coming to this plan, you may have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received or for which the individual took prescribed drugs within 90 days. Generally, this period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, 90 days ends on the day before the waiting period begins. The exclusion period, if applicable, may last up to 365 days from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. If you had prior creditable coverage within 90 days immediately before the date you enrolled under this plan, then the pre-existing conditions exclusion in your plan, if any, will be waived.



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If you had no prior creditable coverage within the 90 days prior to your enrollment date (either because you had no prior coverage or because there was more than a 90 day gap from the date your prior coverage terminated to your enrollment date), we will apply your plan's pre-existing conditions exclusion. In order to reduce or possibly eliminate your exclusion period based on your creditable coverage, you should provide us a copy of any certificates of creditable coverage you have. Please contact Aetna Member Services at 1-888-982-3862 if you need assistance in obtaining a certificate of creditable coverage from your prior carrier or if you have any questions on the information noted above. The pre-existing condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 31 days of birth, adoption, or placement for adoption. Note: For late enrollees, coverage will be delayed until the plan's next open enrollment, and the pre-existing condition exclusion will be applied from the individual's effective date of coverage.

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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 Aetna pays 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 Aetna "recognizes" 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 Aetna "recognizes" 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 Aetna plan "recognizes." Your doctor may bill you for the dollar amount that Aetna doesn'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 [Aetna.com](http://Aetna.com). Type "how Aetna pays" in the search box.

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 agents of Aetna. Provider participation may change without notice. Aetna does 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 **1-888-98-AETNA (1-888-982-3862)**.

Puede estar disponible la traducción de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-98-AETNA (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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<b>PLAN FEATURES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Deductible</b> (per calendar year)	\$1,500 Individual \$3,000 Family	\$7,500 Individual \$15,000 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. Once Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year.</p>		
<b>Member Coinsurance</b>	30%	50%
<p>Applies to all expenses unless otherwise stated.</p>		
<b>Payment Limit</b> (per calendar year)	\$5,000 Individual \$10,000 Family	\$10,000 Individual \$20,000 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 do not apply towards the Payment Limit. Only those out-of-pocket expenses resulting from the application of coinsurance percentage (except any copays, deductibles 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 calendar year.</p>		
<b>Lifetime Maximum</b>	Unlimited except where otherwise indicated.	
<b>Payment for Non-Preferred</b>	Not Applicable	Professional: 105% of Medicare Facility: 140% 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	30%; after deductible
<p>1 exam every 12 months for members age 22 and older.</p>		
<b>Routine Well Child Exams/Immunizations</b>	Covered 100%; deductible waived	30%; 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	30%; after deductible
<p>One exam per calendar year. Includes routine tests and related lab fees.</p>		
<b>Routine Mammograms</b>	Covered 100%; deductible waived	30%; after deductible
<b>Women's Health</b>	Covered 100%; deductible waived	30%; after deductible
<p>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.</p>		



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<b>Routine Digital Rectal Exam</b>	Covered 100%; deductible waived	30%; after deductible
<b>Prostate-specific Antigen Test</b>	Covered 100%; deductible waived	30%; after deductible
<b>Colorectal Cancer Screening</b>	Covered 100%; deductible waived	30%; after deductible
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>	Not Covered	Not Covered
<b>Routine Hearing Screening</b>	Covered 100%; deductible waived	30%; after deductible
<b>Newborn Hearing Screening</b>	\$55 copay; deductible waived	30%; deductible waived
1 in the first 30 days of life and follow-up diagnostic care until the age of 24 months		
<b>PHYSICIAN SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Office Visits to PCP</b>	\$35 copay; deductible waived	50%; after deductible
Includes services of an internist, general physician, family practitioner or pediatrician.		
<b>Specialist Office Visits</b>	\$55 copay; deductible waived	50%; after deductible
<b>Pre-Natal Maternity</b>	Covered 100%; deductible waived	50%; after deductible
<b>E-visit to PCP</b>	\$30 office visit copay; deductible waived	50%; after deductible
An E-visit is an online internet consultation between a physician and an established patient about a non-emergency healthcare matter. This visit must be conducted through an Aetna authorized internet E-visit service vendor.		
<b>E-visit to Specialist</b>	\$30 office visit copay; deductible waived	50%; after deductible
An E-visit is an online internet consultation between a physician and an established patient about a non-emergency healthcare matter. This visit must be conducted through an Aetna authorized internet E-visit service vendor.		
<b>Walk-in Clinics</b>	\$35 office visit copay; deductible waived	50%; 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; deductible waived	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible
<b>Allergy Injections</b>	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible
<b>DIAGNOSTIC PROCEDURES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Diagnostic X-ray</b>	\$35 copay; deductible waived	50%; 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>	30%; after deductible	50%; 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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Diagnostic Outpatient Complex Imaging	30%; after deductible	50%; after deductible
<b>EMERGENCY MEDICAL CARE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
Urgent Care Provider	30% after \$75 copay; deductible waived	50%; after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	30% after \$200 copay; deductible waived	Same as preferred care.
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	30%; after deductible	Same as preferred care.
Non-Emergency Use of Ambulance	Not Covered	Not Covered
<b>HOSPITAL CARE</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
Inpatient Coverage	30% after \$250 per confinement copay; after deductible	50% after \$1,000 per confinement deductible; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Inpatient Maternity Coverage (includes delivery and postpartum care)	\$55 for Physician Services; deductible waived; 30% after \$250 per confinement copay for Facility services; after deductible	50% after \$1,000 per confinement deductible; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Hospital Expenses	30%; after deductible	50%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Outpatient Surgery	30%; after deductible	50%; 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>
Inpatient	30% after \$250 per confinement copay; after deductible	50% after \$1,000 per confinement deductible; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Partial Hospitalization (for day/night care and treatment)	30% after \$250 per confinement copay; after deductible	50% after \$1,000 per confinement deductible; after deductible
Crisis Stabilization Units/ Residential Treatment Centers (for children and adolescents)	30% after \$250 per confinement copay; after deductible	50% after \$1,000 per confinement deductible; after deductible
Outpatient	\$55 copay; deductible waived	50%; 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>
Inpatient	30% after \$250 per confinement copay; after deductible	50% after \$1,000 per confinement deductible; after deductible
Member cost sharing is based on the type of service performed and the place of service where it is rendered		
Residential Treatment Facility	30% after \$250 per confinement copay; after deductible	50% after \$1,000 per confinement deductible; after deductible
Outpatient	\$55 copay; deductible waived	50%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
<b>OTHER SERVICES</b>	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
Convalescent Facility	30% after \$250 per confinement copay; after deductible	50%; after deductible

Limited to 60 days per calendar year.



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The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.

<b>Home Health Care</b>	30%; after deductible	50%; after deductible
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Limited to 60 visits 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>	30% after \$250 per confinement copay; after deductible	50% after \$1,000 per confinement deductible; after deductible
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The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.

<b>Hospice Care - Outpatient</b>	30%; after deductible	50%; after deductible
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The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.

<b>Private Duty Nursing - Outpatient</b>	30%; after deductible	50%; after deductible
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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>	\$55 copay; deductible waived	50%; after deductible
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**Rehabilitation**

Includes Speech, Physical, and Occupational Therapy, limited to 20 visits per calendar year.

<b>Spinal Manipulation Therapy</b>	\$55 copay; deductible waived	50%; after deductible
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Limited to 20 visits per calendar year.

<b>Autism Behavioral Therapy</b>	\$55 copay; deductible waived	50%; after deductible
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covered same as any other outpatient mental health benefit.

<b>Autism Applied Behavior Analysis</b>	covered the same as any other expense based on the type of service performed and place of service where rendered	covered the same as any other expense based on the type of service performed and place of service where rendered
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to age 10, covered. age 10 and over, no coverage.

<b>Autism Physical, Occupational and Speech Therapy</b>	\$55 copay; deductible waived	50%; after deductible
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to age 10, covered same as any other short term rehabilitation expense.

<b>Durable Medical Equipment</b>	30%; after deductible	50%; after deductible
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Maximum benefit of \$2,500 per member per calendar year.

<b>Orthotics</b>	30%; after deductible	50%; after deductible
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<b>Prosthetics</b>	30%; after deductible	50%; after deductible
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<b>Diabetic Supplies -- (if not covered under Pharmacy benefit)</b>	Covered same as any other medical expense.	Covered same as any other medical expense.
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<b>Contraceptive drugs and devices not obtainable at a pharmacy</b>	Covered 100%; deductible waived	Covered same as any other expense.
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<b>Generic FDA-approved Women's Contraceptives</b>	Covered 100%; deductible waived	Not Covered
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<b>Transplants</b>	30% after \$250 per confinement copay; after deductible Preferred coverage is provided at an IOE contracted facility only.	50% after \$1,000 per confinement deductible; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
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<b>Bariatric Surgery</b>	Not Covered	Not Covered
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<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>
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<b>Infertility Treatment</b>	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible
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Diagnosis and treatment of the underlying medical condition.



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<b>Vasectomy</b>	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible.
<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; after deductible.
<b>PHARMACY</b>		
	<b>IN-NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Retail</b>	\$15 copay for generic drugs, \$35 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 the applicable preferred copay
<b>Mail Order</b>	\$30 copay for generic drugs, \$70 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®.	Not Applicable

**Choose Generics** - 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.

- Plan Includes:** Diabetic supplies.  
 Oral fertility drugs included.  
 Precert for growth hormones included. Expanded Precert included  
 Step Therapy included  
 Formulary generic FDA - approved Women's Contraceptives covered 100% in network

**GENERAL PROVISIONS**

<b>Dependents Eligibility</b>	Spouse, children from birth to age 26 regardless of student status.
<b>Pre-existing Conditions Exclusion</b>	On effective date: Waived After effective date: Waived

For members age 19 or over this plan imposes a pre-existing condition exclusion, which may be waived in some circumstances and may not be applicable to you. A pre-existing condition exclusion means that if you have a medical condition before coming to this plan, you may have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received or for which the individual took prescribed drugs within 90 days. Generally, this period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, 90 days ends on the day before the waiting period begins. The exclusion period, if applicable, may last up to 365 days from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. If you had prior creditable coverage within 90 days immediately before the date you enrolled under this plan, then the pre-existing conditions exclusion in your plan, if any, will be waived.



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If you had no prior creditable coverage within the 90 days prior to your enrollment date (either because you had no prior coverage or because there was more than a 90 day gap from the date your prior coverage terminated to your enrollment date), we will apply your plan's pre-existing conditions exclusion. In order to reduce or possibly eliminate your exclusion period based on your creditable coverage, you should provide us a copy of any certificates of creditable coverage you have. Please contact Aetna Member Services at 1-888-982-3862 if you need assistance in obtaining a certificate of creditable coverage from your prior carrier or if you have any questions on the information noted above. The pre-existing condition exclusion does not apply to pregnancy nor to a child who is enrolled in the plan within 31 days of birth, adoption, or placement for adoption. Note: For late enrollees, coverage will be delayed until the plan's next open enrollment, and the pre-existing condition exclusion will be applied from the individual's effective date of coverage.

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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 Aetna pays 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 Aetna "recognizes" 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 Aetna "recognizes" 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 Aetna plan "recognizes." Your doctor may bill you for the dollar amount that Aetna doesn'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 [Aetna.com](http://Aetna.com). Type "how Aetna pays" in the search box.

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 agents of Aetna. Provider participation may change without notice. Aetna does 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 **1-888-98-AETNA (1-888-982-3862)**.

Puede estar disponible la traducción de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-98-AETNA (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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