City of La Porte
Proposed Effective Date: 01-01-2011
Aetna HealthFund™ Aetna Choice™ POS II - ASC

PLAN DESIGN & BENEFITS - HRA $1500 Plan
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

FUND FEATURES		
HealthFund Amount	$500	Individual
	$1,000	Family

Amount contributed to the Fund by the employer
Fund amount reflected is on a per calendar year basis. The fund received may be prorated based on your effective date of coverage.

Fund Coinsurance	100%

Percentage at which the Fund will reimburse

Fund Administration	The Fund will be used to pay for your member responsibility, including your deductible and coinsurance. Once the deductible is met, the underlying medical plan provides coverage and if a Fund balance still exists, the Fund will pay your member responsibility (i.e. your share of coinsurance) until the Out-of-Pocket Maximum has been reached or the Fund has been exhausted, whichever comes first. Services covered at 100% with no deductible will be paid by the plan and not by the Fund.
Employee Termination from Aetna HealthFund	Any remaining HealthFund benefit amount is forfeited (or terminated) when the employee's Aetna HealthFund coverage terminates.
Fund Rollover	Any remaining HealthFund benefit amount at end of plan year is rolled over into next years HealthFund benefit amount.
Annual Maximum Rollover	No maximum rollover applies. All remaining benefits at plan year end rollover.
Cumulative Maximum Rollover	No maximum rollover applies. All remaining funds rollover.
Fund Maximum (Cap)	No maximum rollover applies. All remaining benefits at plan year end rollover.
Eligible Fund Expenses	Fund covers same expenses as the medical and if included, pharmacy plan. Expenses above the Reasonable & Customary limit, any plan limits, and any non covered expenses are not eligible for reimbursement under the Fund.
Fund Payment/Assignment	Network Providers: Automatic Assignment to provider. Non-Network Providers: Member may assign payment to provider.
Pro-ration for New Employees	Monthly
Pro-ration for Family Status Change	No pro-ration. Change to new tier based on new employee status.
Prescription Drug Plan	Prescription Drug expenses are integrated with the Fund (eligible for reimbursement from the Fund) but are not integrated with the medical plan (not subject to deductible and are not applied towards Out-of-Pocket Limit).

PLAN FEATURES	PREFERRED CARE		NON-PREFERRED CARE	
Deductible (per calendar year)	$1,500	Individual	$3,000	Individual
	$4,500	Family	$9,000	Family

All covered expenses, excluding prescription drugs, accumulate toward both the preferred and non-preferred Deductible.
Unless otherwise indicated, the Deductible must be met prior to benefits being payable.
Once Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year.

Member Coinsurance	20%		40%	

Applies to all expenses unless otherwise stated.

Out-of-Pocket Maximum (per calendar year)	$4,500	Individual	$9,000	Individual
	$13,500	Family	$27,000	Family

All covered expenses, excluding prescription drugs, accumulate toward both the preferred and non-preferred Out-of-Pocket
Certain member cost sharing elements may not apply toward the Out-of-Pocket Maximum.
Only those out-of-pocket expenses resulting from the application of coinsurance percentage and deductibles, (except any penalty amounts) may be used to satisfy the Out-of-Pocket Maximum.

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Once Family Out-of-Pocket Maximum is met, all family members will be considered as having met their Out-of-Pocket Maximum for the remainder of the calendar year.

Lifetime Maximum	Unlimited	
Primary Care Physician Selection	Optional	Not applicable

Certification Requirements -
Certification for certain types of Non-Preferred care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is $400 per occurrence.

Referral Requirement	None	None
PREVENTIVE CARE	**PREFERRED CARE**	**NON-PREFERRED CARE**
Preventive Care Maximum (applies per member)	Covered 100%, deductible waived	40%
Routine Adult Physical Exams/ Immunizations	Covered 100%, deductible waived	40%
1 exam per 24 months for members age 18 to age 65; 1 exam per 12 months for adults age 65 and older.		
Routine Well Child Exams/Immunizations	Covered 100%, deductible waived	40%
7 exams in the first 12 months of life, 2 exams in the 13th-24th months of life; 1 exam per 12 months thereafter to age 18.		
Routine Gynecological Care Exams Includes routine tests and related lab fees	Covered 100%, deductible waived	40%
Routine Mammograms For covered females age 40 and over.	Covered 100%, deductible waived	40%
Routine Digital Rectal Exam / Prostate-specific Antigen Test For covered males age 40 and over.	Covered 100%, deductible waived	40%
Colorectal Cancer Screening For all members age 50 and over.	Covered 100%, deductible waived	40%
Routine Hearing Exams 1 routine exam per 24 months	Covered 100%, deductible waived	40%
PHYSICIAN SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Office Visits to PCP Includes services of an internist, general physician, family practitioner or pediatrician.	20%	40%
Specialist Office Visits	20%	40%
Allergy Testing	Covered as either PCP or Specialist office visit	40%
Allergy Injections	Covered 100%; deductible waived	40%
DIAGNOSTIC PROCEDURES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Diagnostic Laboratory and X-ray 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	20%	40%
EMERGENCY MEDICAL CARE	**PREFERRED CARE**	**NON-PREFERRED CARE**
Urgent Care Provider (benefit availability may vary by location)	20%	40%
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	20%	20%
Non-Emergency care in an Emergency Room	Not Covered	Not Covered
Ambulance	20%	40%

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HOSPITAL CARE	PREFERRED CARE	NON-PREFERRED CARE
Inpatient Coverage	20%	40%
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Inpatient Maternity Coverage	20%	40%
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient Surgery	20%	40%
Outpatient Hospital Expenses (excluding surgery)	20%	40%
The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit		
MENTAL HEALTH SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient	20%	40%
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient	20%	40%
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit		
ALCOHOL/DRUG ABUSE SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient	20%	40%
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient	20%	40%
The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit		
OTHER SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Convalescent Facility	20%	40%
Limited to 100 days per calendar year.		
The member cost sharing applies to all covered benefits incurring during a member's inpatient stay		
Home Health Care	20%	40%
Limited to 120 visits per calendar year. Includes Private Duty Nursing limited to 70 eight hour shifts 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.		
Hospice Care - Inpatient	20%	40%
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Hospice Care - Outpatient	20%	40%
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit		
Outpatient Short-Term Rehabilitation	20%	40%
Includes Speech, Physical, and Occupational, limited to 60 visits per calendar year.		
Spinal Manipulation Therapy	20%	40%
Limited to 20 visits per calendar year.		
Durable Medical Equipment	20%	40%
Diabetic Supplies	Covered same as any other medical expense	Covered same as any other medical expense
Contraceptive drugs and devices not obtainable at a pharmacy (includes coverage for contraceptive visits)	20% (payable as any other covered expense)	40% (payable as any other covered expense)
Transplants	20% Preferred coverage is provided at an IOE contracted facility only	40% Non-Preferred coverage is provided at a Non-IOE facility
Mouth, Jaws and Teeth (oral surgery procedures, whether medical or dental in nature)	Member cost sharing is based on the type of service performed and the place of service where it is rendered	40%
Out of Area Dependents	Coverage provided at the non-preferred benefit level of the plan; after deductible	

FAMILY PLANNING	PREFERRED CARE	NON-PREFERRED CARE
Infertility Treatment	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.		
Voluntary Sterilization Including tubal ligation and vasectomy.	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

PHARMACY	PREFERRED CARE	NON-PREFERRED CARE
Retail	$10 copay for generic drugs, $25 copay for formulary brand-name drugs, and $50 copay for non-formulary brand-name drugs up to a 30 day supply at participating pharmacies.	30% of submitted charges after a $10 copay for generic drugs, $25 copay for formulary brand-name drugs, or $50 copay for non-formulary brand-name drugs up to a 30 day supply.
Mail Order	$20 copay for generic drugs, $50 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®.	Not applicable

Pharmacy Managed Self Injectables (PMSI)
First prescription fill at any retail or mail order drug facility. Subsequent fills must be through Aetna Specialty Pharmacy®

No Mandatory Generic (NO MG) - Member is responsible to pay the applicable copay only.

Plan Includes: Contraceptive drugs and devices obtainable from a pharmacy, Oral fertility drugs, Diabetic supplies.

Precert for growth hormones included

GENERAL PROVISIONS	
Dependents Eligibility	Spouse, children from birth to age 26
Pre-existing Conditions Exclusion	Waived

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.

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.

This plan does not cover all health care expenses and includes exclusions and limitations. Members should refer to their plan documents to determine which health care services are covered and to what extent. The following is a partial list of services and supplies that are generally not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s) purchased by your employer.

All medical or hospital services not specifically covered in, or which are limited or excluded in the plan documents; Charges related to any eye surgery mainly to correct refractive errors; Cosmetic surgery, including breast reduction; Custodial care; Dental care and X-rays; Donor egg retrieval; Experimental and investigational procedures; Hearing aids; Immunizations for travel or work; Infertility services, including, but not limited to, artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents; Nonmedically necessary services or supplies; Orthotics; Over-the-counter medications and supplies; Reversal of sterilization; Services for the treatment of sexual dysfunction or inadequacies, including therapy, supplies, or counseling; and special duty nursing. 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.

This material is for informational purposes only and is neither an offer of coverage nor medical advice. It contains only a partial, general description of plan benefits or programs and does not constitute a contract. Aetna does not provide health care services and, therefore, cannot guarantee results or outcomes. Consult the plan documents (i.e. Group Insurance Certificate and/or Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitation relating to the plan. With the exception of Aetna Rx Home Delivery, all preferred providers and vendors are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change without notice.

Some benefits are subject to limitations or visit maximums. Certain services require precertification, or prior approval of coverage. Failure to precertify for these services may lead to substantially reduced benefits or denial of coverage. Some of the benefits requiring precertification may include, but are not limited to, inpatient hospital, inpatient mental health, inpatient skilled nursing, outpatient surgery, substance abuse (detoxification, inpatient and outpatient rehabilitation). When the Member's preferred provider is coordinating care, the preferred provider will obtain the precertification. When the member utilizes a non-preferred provider, Member must obtain the precertification. Precertification requirements may vary. Depending on the plan selected, new prescription drugs not yet reviewed by our medication review committee are either available under plans with an open formulary or excluded from coverage unless a medical exception is obtained under plans that use a closed formulary.

They may also be subject to precertification or step-therapy. Non-prescription drugs and drugs in the Limitations and Exclusions section of the plan documents (received after open enrollment) are not covered, and medical exceptions are not available for them. While this information is believed to be accurate as of the print date, it is subject to change.

Plans are administered by Aetna Life Insurance Company.