

City of Wichita

2016 Premium & Select Aetna Choice POS II Benefit Comparison

Employee Share of:	Premium Choice POS II		Select Choice POS II	
Single Premium	\$104.74/ month \$52.37/ pay period		\$32.38/ month \$16.19/ pay period	
Family Premium	\$313.42/ month \$156.71/ pay period		\$96.86/ month \$48.43/ pay period	
Benefit Level	In Network	Out of Network	In Network	Out of Network
Deductibles	\$0/ Individual \$0/Family	\$200 / Individual \$400 / Family	\$500/ Individual \$1,000/Family	\$1,000/Individual \$2,000/Family
Coinsurance	0%	50%	20%	50%
Payment Limit	None	Includes Coinsurance only \$1,000 Individual \$2,000 Family	Includes Deductible & Coinsurance \$2,500 Individual \$5,000 Family	Includes Deductible & Coinsurance \$5,000 Individual \$10,000 Family
Medical Annual Lifetime	No Annual Maximum No Lifetime Maximum			
Pharmacy Lifetime	No Lifetime Limit			
Physician Services	\$20 Copayment	Deductible Plus 50% Coinsurance	\$25 Copayment*	Deductible Plus 50% Coinsurance
Specialist Services	\$20 Copayment	Deductible Plus 50% Coinsurance	\$50 Copayment*	Deductible Plus 50% Coinsurance
Preventive Care	\$20 Copayment	Deductible Plus 50% Coinsurance	Same as Office Visit*	Deductible and 50%
Prescription Drug Plan	\$5 Generic Copayment \$15 Brand Formulary Copayment \$40 Brand Non- Formulary Copayment	\$10 Generic Copayment \$30 Brand- Formulary Copayment \$80 Brand Non- Formulary Copayment	\$10 Generic Copayment \$25 Brand- Formulary Copayment \$50 Brand Non- Formulary Copayment	\$20 Generic Copayment \$50 Brand-Formulary Copayment \$100 Brand Non- Formulary Copayment
Formulary Generic Formulary Brand Non-Formulary	SEE www.MedTrakservices.com			
Inpatient Hospital Services	\$100 per Day Copayment up to a \$500 maximum. \$500 Inpatient Copayment limit per person per Calendar Year \$1,000 Inpatient Copayment per Calendar Year	Deductible Plus 50% Coinsurance	Deductible Plus 20% Coinsurance	Deductible Plus 50% Coinsurance
Outpatient Lab Services	\$0 Copayment	Deductible Plus 50% Coinsurance	\$0 Copayment	Deductible Plus 50% Coinsurance
Hospital Outpatient Surgery and Scopes	\$200 Copayment	Deductible Plus 50% Coinsurance	Deductible Plus 20% Coinsurance	Deductible Plus 50% Coinsurance

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Hospital Surgery and Scopes in an Ambulatory Surgery Center	\$200 Copayment	Deductible Plus 50% Coinsurance	Deductible Plus 20% Coinsurance	Deductible Plus 50% Coinsurance
Outpatient X-rays	\$0 Copayment	Deductible Plus 50% Coinsurance	\$0 Copayment	Deductible Plus 50% Coinsurance
Outpatient Diagnostic Testing and Services	\$0 Copayment	Deductible Plus 50% Coinsurance	\$0 Copayment	Deductible Plus 50% Coinsurance
Emergency Services At a Hospital Emergency Room (waived if admitted)	\$100 Copayment for facility charges	\$100 Copayment for facility charges	\$150 Copayment for facility charges	\$150 Copayment for facility charges
Ambulance Emergency Transportation (Ground or Air)	\$0 Copayment	\$0 Copayment	\$0 Copayment	\$0 Copayment
Urgent Care Facility	\$20 Copayment	\$20 Copayment	\$50 Copayment	\$50 Copayment
Short-Term Therapies Physical* Speech* Occupational* <i>Limited to 120 visits per Calendar Year</i>	\$20 Copayment	Deductible Plus 50% Coinsurance	\$50 Copayment	Deductible Plus 50% Coinsurance
Rehabilitation -Inpatient	\$100 per Day Copayment up to a \$500 Maximum <i>\$500 Inpatient Copayment limit per person per Calendar Year</i> <i>\$1,000 Inpatient Copayment per family per CalendarYear</i>	Deductible Plus 50% Coinsurance	Deductible Plus 20% Coinsurance	Deductible Plus 50% Coinsurance
Outpatient Pulmonary & Cardiac <i>Review for medical necessity</i>	\$20 Copayment	Deductible Plus 50% Coinsurance	Deductible Plus 20% Coinsurance	Deductible Plus 50% Coinsurance
Home Health Care	\$0 Copayment	Deductible Plus 50% Coinsurance	\$0 Copayment	Deductible Plus 50% Coinsurance
Skilled Nursing Facility	\$0 Copayment	Deductible Plus 50% Coinsurance	\$0 Copayment	Deductible Plus 50% Coinsurance
Hospice	\$0 Copayment	Deductible Plus 50% Coinsurance	\$0 Copayment	Deductible Plus 50% Coinsurance
Durable Medical	\$0 Copayment	Deductible Plus 50% Coinsurance	\$0 Copayment	Deductible Plus 50% Coinsurance
Prosthetics & Braces	\$0 Copayment	Deductible Plus 50% Coinsurance	\$0 Copayment	Deductible Plus 50% Coinsurance
Chiropractic Services / Spinal Manipulation <i>26 visits per Calendar Year</i>	\$20 Copayment	No coverage for out-of-network providers	\$25 Copayment	Not covered
Cochlear Implant <i>Limited to one implant per ear; per lifetime</i>	See Appropriate Benefits	Deductible Plus 50% Coinsurance	See Appropriate Benefits	Deductible Plus 50% Coinsurance

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Organ Transplant	See Appropriate Benefits	Not Covered	See Appropriate Benefits	Not Covered
Transportation, Lodging & Meals when related to Organ Transplants	\$0 Copayment <i>Limited to \$2,000 per Calendar Year Benefit Maximum at an IOE facility</i>	Not Covered	\$0 Copayment <i>Limited to \$2,000 per Calendar Year Benefit Maximum at an IOE facility</i>	Not Covered
Mental/Nervous Treatment <i>Inpatient – Limited to 45 days per Calendar Year Benefit Maximum</i>	\$100 per Day Copayment up to a \$500 Maximum <i>\$500 Inpatient Copayment limit per person per Calendar Year \$1,000 Inpatient copayment per family per Calendar Year</i>	Deductible Plus 50% Coinsurance	Deductible Plus 20% Coinsurance	Deductible Plus 50% Coinsurance
Mental/Nervous Treatment (continued) Outpatient <i>Limited to 45 visits per Calendar Year Benefit Maximum</i>	\$20 Copayment	Deductible Plus 50% Coinsurance	\$50 Copayment	Deductible Plus 50% Coinsurance
Substance Abuse & Chemical Dependency Inpatient <i>Limited to 30 days per Calendar Year Benefit Maximum</i>	\$100 per Day Copayment up to a \$500 Maximum <i>\$500 Inpatient Copayment limit per person per Calendar Year \$1,000 Inpatient Copayment per family per Calendar Year</i>	Deductible Plus 50% Coinsurance	Deductible Plus 20% Coinsurance	Deductible Plus 50% Coinsurance
Substance Abuse & Chemical Dependency Outpatient	\$20 Copayment	Deductible Plus 50% Coinsurance	\$50 Copayment	Deductible Plus 50% Coinsurance
Injectable Medications Not listed elsewhere	\$0 Copayment	Deductible Plus 50% Coinsurance	\$0 Copayment	Deductible Plus 50% Coinsurance
Outpatient Dialysis	\$0 Copayment	Deductible Plus 50% Coinsurance	\$0 Copayment	Deductible Plus 50% Coinsurance
Infertility Includes diagnosis and diagnostic surgical treatment only	\$20 Copayment	Deductible Plus 50% Coinsurance	Deductible Plus 20% Coinsurance	Deductible Plus 50% Coinsurance
Nutritional Evaluation & Diabetes Management / Self-Training	\$0 Copayment	Deductible Plus 50% Coinsurance	\$0 Copayment	Deductible Plus 50% Coinsurance

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Dental Services -Accidental Injury Limited to \$1,000 per accident during a consecutive 12 month period	\$0 Copayment	Deductible Plus 50% Coinsurance	\$0 Copayment	Deductible Plus 50% Coinsurance
Impacted Wisdom Teeth	Out of Network Deductible Plus 50% Coinsurance	Out of Network Deductible Plus 50% Coinsurance	Out of Network Deductible Plus 50% Coinsurance	Out of Network Deductible Plus 50% Coinsurance
Intraoral X-rays <i>When in connection with Covered oral surgery services</i>	\$0 Copayment	Deductible Plus 50% Coinsurance	\$0 Copayment	\$0 Copayment
Myofascial Pain & Temporomandibular Joint (TMJ) Dysfunction Syndromes	Out of Network Deductible Plus 50% Coinsurance	Out of Network Deductible Plus 50% Coinsurance	Out of Network Deductible Plus 50% Coinsurance	Out of Network Deductible Plus 50% Coinsurance

****Please refer to the Summary Plan Description and applicable modified documents for complete benefits. This document is for discussion purposes only. ****

Notes

* *Primary Care Physicians (PCP) generally include those physicians who practice in the specialties of Family Practice, Internal Medicine, General Practice, or Pediatrics. If you are not sure if a physician is a PCP, please contact the Customer Service Number on the back of your ID card. If you receive this service from a Primary Care Physician (PCP), your PCP payment will apply. If you receive these services from a Specialist, your Specialist payment will apply.*

***Please consult your Summary Plan Description and applicable modifications to determine the exact terms, conditions and scope of coverage including all exclusions and limitations. This summary is designed as a partial description of the plan being offered and in no way details all the benefits, limitations, or exclusions.*