TEXAS AETNA ADVANTAGE PLAN OPTIONS

	PPO 1000	
MEMBER BENEFITS	In-Network	Out-of-Network+
Deductible Individual Family	 $1,000 $2,000	 $2,000 $4,000
Member Coinsurance	20% after deductible	50% after deductible
Coinsurance Maximum Individual Family	 $1,500 $3,000	 $1,500 $3,000
Out-of-Pocket Maximum Individual Family	 $2,500 $5,000	 $3,500 $7,000
Lifetime Maximum*	$5,000,000 per member lifetime	
Non-specialist Office Visit (General Physician, Family Practitioner, Pediatrician or Internist)	$20 Copay not subject to deductible	30% after deductible
Specialist Visit**	$30 Copay not subject to deductible	30% after deductible
Hospital Admission**	20% after deductible	50% after deductible
Outpatient Surgery	20% after deductible	50% after deductible
Emergency Room	$100 Copay (waived if admitted) coinsurance 20%	
Annual Routine Gyn Exam (Annual Pap/Mammogram)	No Copay not subject to deductible	30% after deductible
Preventive Health (Annual Physical++) ($200 per calendar year*)	$20 Copay not subject to deductible	30% after deductible
Lab/X-Ray	20% after deductible	50% after deductible
Skilled Nursing (in lieu of hospital) (30 days per calendar year*)	20% after deductible	50% after deductible
Physical/Occupational Therapy and Chiropractic Care (24 visits per calendar year*)	20% after deductible (Aetna will pay a maximum of $25 per visit)	50% after deductible
Home Health Care (30 visits per calendar year*)	20% after deductible	50% after deductible
Durable Medical Equipment ($2,000 per calendar year*)	20% after deductible	50% after deductible
PHARMACY BENEFITS		
Pharmacy Deductible per Individual (does not apply to generic)*	$250 (does not apply to generic)	$250 (does not apply to generic)
Generic (Oral Contraceptives Included)	$15 copay not subject to deductible	$15 copay plus 30% not subject to deductible
Preferred Brand/Non-Preferred Brand (Oral Contraceptives Included)	$25/$40 Copay after deductible	$25/$40 copay plus 30% after deductible
Calendar Year Maximum per Individual*	$5,000	$5,000

* Maximum applies to combined in and out-of-network benefits.

** Maternity and pregnancy related expenses are not covered, except for complications of pregnancy.

\+ Payment for out-of-network facility care is determined based upon Aetna's Allowable Fee Schedule. Payment for other out-of-network care is determined based upon the negotiated charge that would apply if such services or supplies were received from a Preferred Provider.

++ No deductible, copayment or coinsurance applies to eligible dependent children to age 18 for childhood immunizations.

A summary of exclusions is listed on page 18. For a full list of benefit coverage and exclusions refer to the plan documents.

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