PLAN DESIGN AND BENEFITS - Texas Limited Benefit 50/50-08

PLAN FEATURES	PREFERRED CARE	NON-PREFERRED CARE
Deductible (per calendar year)	$1,500 Individual $4,500 Family 3 Individuals per Family	$3,000 Individual $9,000 Family 3 Individuals per Family
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. All covered expenses accumulate separately toward the preferred and non-preferred Deductible. Once 3 individual members of a family each satisfy their Deductible amount separately, all family members will be considered as having met their Deductible for the remainder of the calendar year.		
Member Coinsurance (applies to all expenses unless otherwise stated)	50%	50%
Payment Limit (per calendar year; excludes deductible)	$5,000 Individual $15,000 Family 3 Individuals per Family	$10,000 Individual $30,000 Family 3 Individuals per Family
All covered expenses accumulate separately toward the preferred and non-preferred Payment Limit. Only those preferred & non-preferred expenses resulting from the application of coinsurance percentage (except any penalty amounts) may be used to satisfy the Payment Limit. Certain member cost sharing elements including copays, pharmacy, deductible, mental health and substance abuse do not apply toward the Payment Limit. Once 3 individual members of a family each satisfy their Payment Limit separately, all family members will be considered as having met their Payment Limit for the remainder of the calendar year.		
Lifetime Maximum (per member lifetime, Preferred and Non-Preferred combined)	$5,000,000	
Annual Benefit maximum (per member, per calendar year, Preferred and Non-Preferred combined)	$25,000	
Payment for Non-Preferred Care	Not Applicable	Recognized Charge*
Primary Care Physician Selection	Not Applicable	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, and Hospice Care is required. Benefits will be reduced by $400 per occurrence if Certification is not obtained.		
Referral Requirement	None	None
PHYSICIAN SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Office Visits to Non-Specialist Includes services of an internist, general physician, family practitioner or pediatrician for routine care as well as diagnosis and treatment of an illness or injury and in-office surgery	50% after deductible	50% after deductible
Specialist Office Visits	50% after deductible	50% after deductible
Maternity OB Visits	50% after deductible	50% after deductible
Surgery (in office)	50% after deductible	50% after deductible
Allergy Testing (given by a physician)	50% after deductible	50% after deductible
Allergy Injections (not given by a physician)	50% after deductible	50% after deductible

PLAN DESIGN AND BENEFITS - Texas Limited Benefit 50/50-08

PREVENTIVE CARE	PREFERRED CARE	NON-PREFERRED CARE
Routine Adult Physical Exams / Immunizations 1 exam every 24 months to age 65; 1 exam every 12 months after age 65; $300 max benefit per exam	$35 copay; deductible waived	50% after deductible
Well Child Exams / Immunizations 7 exams in first 12 months; 2 exams in months 13-24; 1 exam every 12 months to age 18	$35 copay; deductible waived	50% after deductible
Routine Gynecological Exams Includes Pap smear and related lab fees Frequency schedule applies	$35 copay; deductible waived	50% after deductible
Routine Mammograms Includes Pap smear and related lab fees. 1 routine exam per calendar year.	$35 copay; deductible waived	50% after deductible
Routine Digital Rectal Exam / Prostate-Specific Antigen Test For covered males age 40 and over; Frequency schedule applies	50% after deductible	50% after deductible
Colorectal Cancer Screening For all members age 50 and over; Frequency schedule applies	Member cost sharing is based on the type of service performed and the place rendered.	50% after deductible
Routine Hearing Exams Covered only as part of a routine physical exam by a non-specialist physician	$35 copay; deductible waived	50% after deductible
DIAGNOSTIC PROCEDURES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Outpatient Diagnostic Laboratory	50% after deductible	50% after deductible
Outpatient X-ray (except for Complex Imaging Services) If performed as a part of a physician's office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	50% after deductible	50% after deductible
Outpatient Diagnostic X-ray for Complex Imaging Services Including, but not limited to, MRI, MRA, PET and CT Scans	50% after deductible	50% after deductible
EMERGENCY MEDICAL CARE	**PREFERRED CARE**	**NON-PREFERRED CARE**
Urgent Care Provider	50% after deductible	50% after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room Copay waived if admitted; Copay applies to facility charges only	50% after deductible	Paid as preferred
Non-Emergency care in an Emergency Room	Not Covered	Not Covered
Emergency Ambulance	50% after deductible	Paid as preferred

PLAN DESIGN AND BENEFITS - Texas Limited Benefit 50/50-08

HOSPITAL CARE	PREFERRED CARE	NON-PREFERRED CARE
Inpatient Coverage Including maternity (prenatal, delivery and postpartum) and transplants	50% after deductible	50% after deductible
Transplants If transplant is performed through an Institute of Excellence® facility, benefits will be paid at the preferred level. If procedure is not performed through an Institutes of Excellence® facility, benefits will be paid at the non-preferred level.	50% after deductible	50% after deductible $25,000 maximum benefit per transplant
Outpatient Surgery Provided in an outpatient hospital department or a freestanding surgical facility	50% after deductible	50% after deductible
Outpatient Hospital Services other than Surgery Including, but not limited to, lab, x-ray, physical therapy, speech therapy, occupational therapy, spinal manipulation, dialysis, radiation therapy	50% after deductible	50% after deductible
MENTAL HEALTH SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient Limited to 14 days per member per calendar year, SMI & non-SMI combined, Preferred and Non-Preferred combined	50% after deductible	50% after deductible
Outpatient Limited to 20 visits per member per calendar year, SMI & non-SMI combined, Preferred and Non-Preferred combined	50% after deductible	50% after deductible
ALCOHOL / DRUG ABUSE SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient Detox and Rehabilitation - Limited to 3 treatment episodes per member per lifetime, IP and OP combined, Participating and Non-Participating combined	50% after deductible	50% after deductible
Outpatient Detox and Rehabilitation - Limited to 3 treatment episodes per member per lifetime, IP and OP combined, Participating and Non-Participating combined	50% after deductible	50% after deductible

PLAN DESIGN AND BENEFITS - Texas Limited Benefit 50/50-08

OTHER SERVICES AND PLAN DETAILS	PREFERRED CARE	NON-PREFERRED CARE
Convalescent Facility (Skilled Nursing Facility) Limited to 30 days per member per calendar year; Preferred and Non-Preferred combined	50% after deductible	50% after deductible
Home Health Care Limited to 60 visits per member per calendar year; Preferred and Non-Preferred combined; 1 visit equals a period of 4 hours or less	50% after deductible	50% after deductible
Infusion Therapy Provided in the home or physician's office	50% after deductible	50% after deductible Aetna pays up to $50 per visit after deductible
Infusion Therapy Provided in an outpatient hospital department or freestanding facility	50% after deductible	50% after deductible Aetna pays up to $50 per visit after deductible
Inpatient Hospice Care Limited to 30 days per member per calendar year; Preferred and Non-Preferred combined	50% after deductible	50% after deductible
Outpatient Hospice Care Up to a maximum benefit of $5,000; Preferred and Non-Preferred combined	50% after deductible	50% after deductible
Private Duty Nursing - Outpatient	Not Covered	Not Covered
Outpatient Speech Therapy (if provided in the outpatient hospital department, paid under outpatient hospital benefit) Limited to 20 visits per member per calendar year; Preferred and Non-Preferred combined	50% after deductible	50% after deductible
Outpatient Physical and Occupational therapy, and Chiropractic	50% after deductible	50% after deductible
Durable Medical Equipment Maximum benefit of $2,500 per member per calendar year; Preferred and Non-Preferred combined	50% after deductible	50% after deductible
FAMILY PLANNING	**PREFERRED CARE**	**NON-PREFERRED CARE**
Infertility Treatment Covered only for the diagnosis and treatment of the underlying medical condition	50% after deductible	50% after deductible
Comprehensive Infertility Services	Not Covered	Not Covered
Advanced Reproductive Technology (ART) ART coverage includes: In vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery	Not Covered	Not Covered
Voluntary Sterilization Including tubal ligation and vasectomy	50% after deductible	50% after deductible

PLAN DESIGN AND BENEFITS - Texas Limited Benefit 50/50-08

PHARMACY - PRESCRIPTION DRUG BENEFITS	PARTICIPATING PHARMACIES	NON-PARTICIPATING PHARMACIES
Retail Up to a 30-day supply	$15 copay for generic drugs. Member pays 100% for brand name drugs	30% after $15 copay for generic drugs. Member pays 100% for brand name drugs
Mail Order Delivery 31-90 day supply	$45 copay for generic drugs. Member pays 100% for brand name drugs	Not covered
Plan includes: Contraceptive drugs and devices obtainable from a pharmacy and diabetic supplies obtainable from a pharmacy.		
Plan excludes: Lifestyle/performance drugs		

SPECIAL PROGRAMS
Special programs automatically included in your plan: National Advantage, Aetna Navigator™, External Review, Fitness, Healthy Outlook, Moms-to-Babies Maternity Management™, National Medical Excellence, Informed Healthline, Natural Alternatives and Vision One®

*Payment for Non-Preferred facility care is determined based upon Aetna's Allowable Fee Schedule, which is subject to change. Payment for other Non-Preferred care is determined based upon the negotiated charge that would apply if such services or supplies were received from a Preferred Provider. These charges are referred to in your plan documents as "recognized" charges.

PLAN DESIGN AND BENEFITS - Texas Limited Benefit 50/50-08

What's not covered:

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**.

- All medical or hospital services no 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, counseling and prescription drugs
- Special duty nursing
- Treatment of those services for or related to treatment of obesity or for diet or weight control

Pre-existing Conditions Exclusion Provision

This plan imposes a pre-existing conditions exclusion, which may be waived in some circumstances (that is, creditable coverage) and may not be applicable to you. A pre-existing condition exclusion means that if you have a medical condition before coming to our plan, you might 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 or treatment was recommended or received or for which the individual took prescribed drugs within 3 months.

Generally, this period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the 3 month period ends on the day before the waiting period begins. The exclusion period, if applicable, may last up to 12 months 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 credible coverage within 63 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 63 days prior to your enrollment date (either because you had no prior coverage or because there was more than a 63 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 your Aetna Member Services representative at (888) 802-3862 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 after birth, adoption, or placement for adoption. Note: For late enrollees, coverage will be delayed until the plan's next open enrollment; the pre-existing exclusion will be applied from the individual's effective date of coverage.

PLAN DESIGN AND BENEFITS - Texas Limited Benefit 50/50-08

Plans are provided by Aetna Life Insurance Company.

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. Precertification requirements may vary.

If your plan covers outpatient prescription drugs, your plan may include a drug formulary (preferred drug list). A formulary is a list of prescription drugs generally covered under your prescription drug benefits plan on a preferred basis subject to applicable limitations and conditions. Your pharmacy benefit is generally not limited to the drugs listed on the formulary. The medications listed on the formulary are subject to change in accordance with applicable state law. For information regarding how medications are reviewed and selected for the formulary, formulary information, and information about other pharmacy programs such as precertification and step-therapy, please refer to Aetna's website at Aetna.com, or the Aetna Medication Formulary Guide. Many drugs, including many of those listed on the formulary, are subject to rebate arrangements between Aetna and the manufacturer of the drugs. Rebates received by Aetna from drug manufacturers are not reflected in the cost paid by a member for a prescription drug. In addition, in circumstances where your prescription plan utilizes copayments or coinsurance calculated on a percentage basis or a deductible, use of formulary drugs may not necessarily result in lower costs for the member. Members should consult with their treating physicians regarding questions about specific medications. Refer to your plan documents or contact Member Services for information regarding the terms and limitations of coverage.

Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a subsidiary of Aetna, Inc., that is a licensed pharmacy providing mail-order pharmacy services. Aetna's negotiated charge with Aetna Rx Home Delivery may be higher than Aetna Rx Home Delivery's cost of purchasing drugs and providing mail-order pharmacy services.

While this information is believed to be accurate as of the print date, it is subject to change.

Plans are provided by Aetna Life Insurance Company.

I have read and understand the benefits for Texas Limited Benefit 50/50-08 plan which includes a $25,000 calendar year maximum benefit per individual - Preferred and Non-Preferred combined, and have distributed a description of the benefits for the Texas Limited Benefit 50/50-08 plan which includes a $25,000 calendar year maximum benefit per individual - Preferred and Non-Preferred combined to the employees of _____

_____

Signature _____Date: _____