Aetna

Aetna Life Insurance Company

TEXAS PLAN DESIGN AND BENEFITS – Aetna PPO 1500 B

PLAN FEATURES	PREFERRED CARE	NON-PREFERRED CARE
Deductible (per calendar year)	$1500 per member 3 member maximum	$3000 per member 3 member maximum

All covered expenses accumulate separately toward the preferred and non-preferred Deductible. **Unless otherwise indicated, the Deductible must be met prior to benefits being payable**. Once three 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 cost sharing for certain services, including member cost sharing for prescription drugs, are excluded from charges to meet the Deductible.

Member Coinsurance	20%	40%
Coinsurance Maximum (per calendar year, excludes deductible)	$3500 per member 3 member maximum	$7000 per member 3 member maximum

Certain member cost sharing elements may not apply. All covered expenses accumulate separately toward the preferred and non-preferred Coinsurance Maximum. Once three individual members of a family each satisfy their Coinsurance Maximum separately, all family members will be considered as having met their Coinsurance Maximum for the remainder of the calendar year.

Lifetime Maximum – For Preferred and Non-Preferred combined	$5,000,000	$5,000,000
Payment for Non-Preferred Care	Not applicable	Recognized *
Primary Care Physician Selection	Not applicable	Not applicable
Referral Requirement	None	None

Precertification** Requirements – Precertification for certain types of Non-Preferred care must be obtained to avoid a reduction in benefits paid for that care. Precertification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care and Private Duty Nursing is required. Benefits will be reduced by $400 per occurrence if precertification is not obtained.

PREVENTIVE CARE	PREFERRED CARE	NON-PREFERRED CARE
Routine Adult Physical Exams / Immunizations (Limited to 1 exam every 24 months up to age 65 and 1 exam every 12 months for adults age 65 and older. Includes coverage for immunizations. Adult physicals have a maximum benefit of $300 per exam)	$35 copay, deductible waived	40% after deductible
Well Child Exams / Immunizations (Limited to 6 exams in first 12 months of life, 2 exams in the 13th – 24th months of life, 1 exam every 12 months of life thereafter up to age 18. Includes coverage for immunizations)	$35 copay, deductible waived	40% after deductible
Routine Gynecological Care Exams - Includes pap smear and related lab fees. (Limited to One Routine exam per calendar year)	Applicable office visit copay; deductible waived	40% after deductible
Routine Mammograms For covered females age 35 and over.	20%, deductible waived	40% after deductible
Routine Digital Rectal Exam / Prostate Specific Antigen Test For covered males age 40 and over.	Applicable office visit copay; deductible waived	40% after deductible
Colorectal Cancer Screening For all members age 50 and over.	Member cost sharing is based on the type of service performed and the place where it is rendered	40% after deductible
Routine Eye Exams – Performed as part of a physical exam; routine specialist exams/refraction not covered.	$35 copay, deductible waived	40% after deductible
Routine Hearing Exams - Performed as part of the physical exam	$35 copay, deductible waived	40% after deductible

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.	$35 copay, deductible waived	40% after deductible
Specialist Office Visits	$40 copay, deductible waived	40% after deductible

Aetna Life Insurance Company

TEXAS PLAN DESIGN AND BENEFITS – Aetna PPO 1500 B

PHYSICIAN SERVICES CONTINUED	PREFERRED CARE	NON-PREFERRED CARE
Prenatal/ OB Visits	20% after deductible	40% after deductible
Allergy Testing (given by a physician)	Covered as either specialist or non-specialist office visit	40% after deductible

PHARMACY – PRESCRIPTION DRUG BENEFITS	PREFERRED CARE	NON-PREFERRED CARE
Retail Up to a 30 day supply	$15 copay generic formulary, $40 copay brand formulary, and $60 copay non-formulary drugs	30% after $15 copay generic formulary, 30% after $40 copay brand formulary, and 30% after $60 copay non-formulary drugs
Mail Order	31 - 90 day supply; $45 copay generic formulary, $120 copay brand formulary, and $180 copay non-formulary drugs	Same as non-preferred retail
No Mandatory Generic (No MG) – Member is responsible to pay the applicable copay only		
Plan includes: contraceptive drugs and devices obtainable from a pharmacy, diabetic supplies and Precertification.		
Prescription drug calendar year deductible	None	None

DIAGNOSTIC PROCEDURES	PREFERRED CARE	NON-PREFERRED CARE
Outpatient Diagnostic Laboratory and 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)	20% deductible waived	40% after deductible
Outpatient Diagnostic X-ray for Complex Imaging Services (CAT, MRI, MRS/MRA and PET Scans)	30% after deductible	50% after deductible

EMERGENCY MEDICAL CARE	PREFERRED CARE	NON-PREFERRED CARE
Urgent Care Provider	$50 copay, deductible waived	40% after deductible
Non-Urgent Use of Urgent Care Provider	Not covered	Not covered
Emergency Room	20% after $150 copay, deductible waived	Paid as In-Network
Non-Emergency Care in an Emergency Room	Not covered	Not covered
Ambulance	20% after deductible	Paid as In-Network

HOSPITAL CARE	PREFERRED CARE	NON-PREFERRED CARE
Inpatient Coverage (Including maternity)	20% after deductible	40% after deductible
Outpatient Hospital Expenses	20% after deductible (includes facility and professional charges)	40% after deductible
Outpatient Surgery	20% after deductible	40% after deductible

MENTAL HEALTH SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Inpatient – Non-Serious Mental Illnesses (Limited to14 days per calendar year, Preferred and Non-Preferred combined)	20% after deductible (includes facility and professional charges)	40% after deductible
Outpatient – Non-Serious Mental Illnesses (Limited to 20 visits per calendar year, Preferred and Non-Preferred combined)	$40 copay, deductible waived	40% after deductible
Inpatient – Serious Mental Illness	Not covered	Not covered
Outpatient – Serious Mental Illness	Not covered	Not covered

Aetna Life Insurance Company

TEXAS PLAN DESIGN AND BENEFITS – Aetna PPO 1500 B

ALCOHOL/DRUG ABUSE SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Inpatient Detoxification (Limited to 3 series of treatments per lifetime, inpatient and outpatient combined, Preferred and Non-Preferred combined)	20% after deductible (includes facility and professional charges)	40% after deductible
Outpatient Detoxification (Limited to 3 series of treatments per lifetime, inpatient and outpatient combined, Preferred and Non-Preferred combined)	$40 copay, deductible waived	40% after deductible
Inpatient Rehabilitation (Limited to 3 series of treatments per lifetime, inpatient and outpatient combined, Preferred and Non-Preferred combined)	20% after deductible (includes facility and professional charges)	40% after deductible
Outpatient Rehabilitation (Limited to 3 series of treatments per lifetime, inpatient and outpatient combined, Preferred and Non-Preferred combined)	$40 copay, deductible waived	40% after deductible
OTHER SERVICES AND PLAN DETAILS	**PREFERRED CARE**	**NON-PREFERRED CARE**
Convalescent Facility (Limited to 30 days per calendar year, Preferred and Non-Preferred combined)	20% after deductible (includes facility and professional charges)	40% 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)	20% after deductible	40% after deductible
Hospice Care – Inpatient (Limited to 30 days per member per lifetime, Preferred and Non-Preferred combined.)	20% after deductible (includes facility and professional charges)	40% after deductible
Hospice Care – Outpatient (Limited up to a maximum benefit of $5000 per lifetime, Preferred and Non-Preferred combined)	20% after deductible	40% after deductible
Private Duty Nursing – Outpatient	Not covered	Not covered
Outpatient Short-Term Rehabilitation – Physical and Occupational Therapy (Limited to 20 visits per member per calendar year for Physical and Occupational Therapy services combined, Preferred and Non-Preferred combined)	20% after deductible	40% after deductible
Outpatient Short-Term Rehabilitation – Speech Therapy (Limited to 20 visits per member per calendar year, Preferred and Non-Preferred combined.)	20% after deductible	40% after deductible
Spinal Manipulation Therapy	Not covered	Not covered
Durable Medical Equipment (Maximum benefit of $2000 per member per calendar year, Preferred and Non-Preferred combined)	50% after deductible	50% after deductible
Vision Eyewear	Not covered	Not covered
Transplants	20% after deductible (includes facility and professional charges)	40% after deductible
FAMILY PLANNING	**PREFERRED CARE**	**NON-PREFERRED CARE**
Infertility Treatment (Coverage for diagnosis and treatment of underlying medical condition only)	Member cost sharing is based on the type of service performed and the place where it is rendered	Member cost sharing is based on the type of service performed and the place where it is rendered
Voluntary Sterilization (Including tubal ligation and vasectomy)	Member cost sharing is based on the type of service performed and the place where it is rendered	Member cost sharing is based on the type of service performed and the place where it is rendered

Aetna Life Insurance Company

TEXAS PLAN DESIGN AND BENEFITS – Aetna PPO 1500 B

SPECIAL PROGRAMS / SERVICES

Certain Special programs and services may be included in your plan: Aetna Navigator™, Fitness Program, Healthy Outlook Program®, Moms-to-Babies® Maternity Management Program, National Advantage™ Program, National Medical Excellence Program®, Natural Alternatives, Natural Products, Vision One® and Vitamin Advantage™.

* Payment for Non-Preferred facility care is determined based upon Aetna's Allowable Fee Schedule. 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.

** The term precertification (when granted) here does not mean a guarantee of payment, as it may under certain state laws.

What's Not Covered:

This **Consumer Choice of Benefits Health Insurance Plan**, either in whole or in part, does not provide state-mandated health benefits normally required in accident and sickness insurance policies in Texas. This standard health benefit plan may provide a more affordable health insurance policy for you although, at the same time, it may provide you with fewer health benefits than those normally included as state-mandated health benefits in policies in Texas.

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;
- Treatment of morbid obesity through gastric bypass or such methods recognized for the long term reversal of morbid obesity; Treatment of those services for or related to treatment of obesity or for diet or weight control.
- 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/private duty nursing.

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 90 days.

Generally, this period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage, the 90 day 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 less than 12 months of creditable coverage immediately before the date you enrolled, your plan's pre-existing conditions exclusion period will be reduced by the amount (that is, number of days) of that prior coverage. 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 1-888-802-3862 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.

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.

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TEXAS PLAN DESIGN AND BENEFITS – Aetna PPO 1500 B

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 nonpreferred provider, Member must 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.