

Aetna Health Inc.
Texas
Choice POS (In Network)

Rice University (Self-Funded Plan)

Referrals are not required for a member to access in-network, covered services. Preauthorization for certain services is required. The Physician (Primary Care) visits copay pertains to member visits to physicians for primary care; the applicable specialist copay applies to any other participating physician office visits.

Plan Features

In Network

Maximum Out of Pocket

(includes flat-dollar and percentage copays and deductible (if applicable); excludes member cost sharing for prescription drug benefits) \$1,500/\$3,000

Primary Care Physician Visits

Office Hours \$25 copay
After-Hours/Home \$30 copay

Specialty Care

Office Visits \$35 copay

Diagnostic OP Lab/X Ray Testing (at facility) \$35 copay.
Diagnostic OP Lab/X Ray Testing Included in Physician's Office Visit copay
(at physician's office)
Outpatient Therapy (speech, physical, occupational) \$35 copay.

Outpatient Dialysis/Chemotherapy \$35 copay
Allergy Testing/Treatment \$35 copay for testing.
\$25 copay for allergy injection in PCP office.
No allergy serum copay.

Preventive Care

Routine Physicals \$25 copay

Routine Child and Well Baby Care; \$25 copay. No additional copay for immunizations from birth through the
Immunizations date the child is 6 years old.

Routine GYN Care \$35 copay. One routine GYN visit and pap
smear/365 days.

Routine Mammography \$35 copay. One mammogram for females age 35 and older,
and within a plan year.

Routine Eye Exam \$35 copay. Frequency and age schedules may apply.

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<u>Plan Features</u>	<u>In Network</u>
Hearing Exam	\$25 copay; routine hearing screenings
Hearing Aids	Not covered
Emergency Care	\$75 copay
Urgent Care	\$75 copay
Ambulance	No copay
Outpatient Surgery	\$150 copay
Hospitalization (inpatient hospital admit - semi-private room)	\$350 copay
Skilled Nursing Facility Care (in lieu of hospitalization for medically necessary covered benefits)	\$350 copay
Maternity	
OB Visits	\$35 copay for initial visit only.
Hospital Confinement (Includes Newborn Services)	\$350 copay
Home Health Care/Hospice-Outpatient	No copay
Private Duty or Special Duty Nursing	Not covered unless pre-authorized by Aetna; no copay when covered.
Hospice - Inpatient	\$350 copay
Family Planning/Reproductive Services	
Sterilization Procedures	Covered with applicable specialist, outpatient surgery or inpatient hospital copay. Reversal of voluntary sterilization including related follow-up care and treatment of complications of such procedures is not covered.
Mental Health	
Inpatient	\$350 copay; Unlimited days per plan year.
Outpatient	\$35 copay; 52 visits per plan year.
Inpatient Serious Mental Illness	\$350 copay; Unlimited days per plan year
Outpatient Serious Mental Illness	\$35 copay; 52 visits per plan year
Substance Abuse Detoxification	
Inpatient Detoxification	\$350 copay
Outpatient Detoxification	\$35 copay

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Plan Features

In Network

Substance Abuse Rehabilitation

Inpatient Rehabilitation
Outpatient Rehabilitation

\$350 copay; Unlimited episodes per lifetime, IP/OP combined.
\$35 copay; Unlimited episodes per lifetime, IP/OP combined.

Diabetic Supplies

RX copay

Chiropractic Care

Not Covered

Durable Medical Equipment
(Subject to precertification)

No copay

Prescription Drug Rider

Retail Pharmacy: \$10 copay generic formulary; \$20 copay brand formulary; \$35 copay generic and brand non-formulary; up to 30 day supply.

Mail Order Delivery (MOD): 31 - 90 Day Supply Included for 2 times the 30 day supply.
Open formulary - covers drugs on the Formulary Exclusion List.

Additional Pharmacy Options

Contraceptives
Performance

Included in Prescription Drug Option.
Included in Prescription Drug Option.

Dental

Not covered

Vision Corrective Lenses/Contacts Allowance

Not covered

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 or program benefits and does not constitute a contract or any part of one. In case of a conflict between your plan documents and this information, the plan documents will govern. For a complete description of the benefits available to you, including procedures, exclusions and limitations refer to your specific plan documents from your employer. All the terms and conditions of your plan or program are subject to and governed by applicable contracts, laws, regulations and policies. The availability of a plan or program may vary by geographic service area, and not all plans or programs are available in all areas. Certain services, including but not limited to non-emergency inpatient hospital care, require precertification. Participating physicians, hospitals and other health care providers are neither agents nor employees of Aetna.

Aetna Health Inc.

Administered by Aetna Health Administrators or Aetna Life Insurance Company.

Texas

Choice POS non-network Benefits

Plan Features**Out of Network (Non-Referred Care)*******Financial**

Deductible (Individual/Family)	\$750-Individual/\$2,250-Family
Coinsurance Benefit Percentage Paid by Plan	70%
Coinsurance Limit: Individual/Family	\$5,000-Individual/\$15,000-Family
Lifetime Maximum Benefit	Unlimited

Primary Care Physician Visits (for illness and injury only)

Office Hours	70% after deductible
After-Hours/Home	70% after deductible

Specialty Care

Office Visits	70% after deductible
Diagnostic OP Lab/X Ray Testing (at facility)	70% after deductible
Diagnostic OP Lab/X Ray Testing (at physician's office)	70% after deductible

Outpatient Therapy (speech, physical, occupational)	70% after deductible.
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Outpatient Dialysis/Chemotherapy	70% after deductible
Allergy Testing/Treatment	70% after deductible

Preventive Care

Routine Physicals	70% after deductible
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Routine Child and Well Baby Care; Immunizations	70% after deductible.
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Routine GYN Care	70% after deductible. One GYN visit and pap smear/365 days. One direct access visit
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Routine Mammography	70% after deductible. One mammogram for females age 35 and older within a plan year.
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*** Member precertification required or benefits will be substantially reduced. Precertification requirements may vary. See your plan documents for a complete list of medical services that require precertification.

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Choice POS non-network Benefits

Plan Features**Out of Network (Non-Referred Care)*****

Routine Eye Exam	Not covered
Hearing Exam (For illness / injury)	70% after deductible
Hearing Aids	Not covered
Emergency Care	\$75 copay
Urgent Care	70% after deductible
Ambulance	No copay
Outpatient Surgery	70% after deductible
Hospitalization (inpatient hospital admit - semi-private room)	70% after deductible
Skilled Nursing Facility Care (in lieu of hospitalization for medically necessary covered benefits)	70% after deductible 240 days and 35 physician visits per contract year.
Maternity	
OB Visits	70% after deductible
Hospital Confinement (Includes Newborn Services)	70% after deductible
Home Health Care	70% after deductible. 1 visit per day, up to 4 hours per visit.
Private Duty or Special Duty Nursing	70% after deductible Not covered unless pre-authorized by Aetna
Hospice - Inpatient	70% after deductible, no maximum
Hospice - Outpatient	70% after deductible, no maximum

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Choice POS non-network Benefits

Plan Features**Out of Network (Non-Referred Care)*******Family Planning/Reproductive Services**

Sterilization Procedures

70% after deductible

Certain services are covered. Same limitations as in-network.

Mental Health

Inpatient

70% after deductible, Unlimited days per contract year

Outpatient

50% after deductible; 52 visits per contract year

Mental Health - Serious Mental Illness

Inpatient

70% after deductible.

Unlimited days per contract year.

Outpatient

70% after deductible

52 visits per contract year.

Substance Abuse Detoxification

Inpatient Detoxification

70% after deductible

Outpatient Detoxification

70% after deductible

Substance Abuse Rehabilitation

Inpatient Rehabilitation

70% after deductible

Unlimited episodes per lifetime, IP/OP combined

Outpatient Rehabilitation

70% after deductible

Unlimited episodes per lifetime, IP/OP combined

Diabetic Supplies and Equipment

70% after deductible

Durable Medical Equipment

70% after deductible, must pre-certify if over \$1,500

Chiropractic Care

70% after deductible; \$1,000 annual maximum.

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