Aetna EPO Texas Medical Neighborhood (Exclusive Provider Network)

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	IN-NETWORK CARE TIER 1 (Preferred providers & facilities)	Tier 2 is only for Specialist services
Deductible (per calendar year)	$1,000 Individual $3,000 Family	
All covered expenses accumulate simultaneously toward the deductible in in both preferred tiers. Pharmacy expenses do not apply towards the deductible. Unless otherwise indicated, the Deductible must be met prior to benefits being payable. The family Deductible is a cumulative Deductible for all family members. The family Deductible can be met by a combinaiton of family members; however, no single individual within the family will be subject to more than the individual Deductible amount.		
Member Coinsurance Applies to all expenses unless otherwise stated.	20%	
Payment Limit (per calendar year)	$4,000 Employee $8,000 Family	
Certain member cost sharing elements may not apply toward the Payment Limit. Pharmacy expenses apply towards the Payment Limit. Only those out-of-pocket expenses resulting from the application of coinsurance percentage, copays, Pharmacy and deductibles (except any penalty amounts) may be used to satisfy the Payment Limit. The family Payment Limit is a cumulative Payment Limit for all family members. The family Payment Limit can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Payment Limit amount.		
Lifetime Maximum All covered expenses accumulate simultaneously toward the Lifetime Maximum in each of the two benefit tiers.	Unlimited except where otherwise	
Primary Care Physician Selection	**Required**	
Referral Requirement	**None**	
PREVENTIVE CARE	**IN-NETWORK TIER 1**	
Routine Adult Physical Exams/ Immunizations 1 exam per calendar year for members age 18 to age 65; 1 exam per calendar year for adults age 65 and older.	Covered 100%; deductible waived	
Routine Well Child Exams/Immunizations 7 exams in the first 12 months of life, 3 exams in the 13th-36th months of life; 1 exam per calendar year to age 18.	Covered 100%; deductible waived	
Routine Gynecological Care Exams Routine tests & lab fees, 1 exam per calendar	Covered 100%; deductible waived	
Routine Mammograms For covered females age 35 and over, 1 exam per calendar year. Member cost sharing is based on the type of service performed and the place of service where it is rendered	Covered 100%; deductible waived	
Routine Digital Rectal Exam / Prostate-specific Antigen Test For covered males age 40 and over.	Covered 100%; deductible waived	
Colorectal Cancer Screening For all members age 45 and over.	Covered 100%; deductible waived	
Routine Hearing Exams 1 routine exam per 24 months	Covered as either PCP or specialist office visit.	
Newborn Hearing Screening	Covered 100%; deductible waived	

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1 in the first 30 days of life and follow-up diagnostic care untill the age of 24 months.

PHYSICIAN SERVICES	IN-NETWORK TIER 1	Specialist office Tier 2
Office Visits (non surgical) to PCP Includes services of an internist, general physician, family practitioner or pediatrician.	$30 office visit copay	
Specialist Office Visits Maternity OB visits: copay for initial visit only, there after covered 100%.	**$40 office visit copay**	**$60 office visit copay**
Outpatient Surgery (hospital or other facility) The member cost sharing applies to all covered benefits incurred during a member's outpatient visit, however specialist services performed in a hospital or other facility may be billed separately for the product and covered as Physician Services for Non-Office Care.	20% after Deductible	
Physician Services for Non-Office Care	20% after Deductible	
Allergy Testing	Covered as either PCP or specialist office visit	
Allergy Injections	Covered as either PCP or specialist office visit	

DIAGNOSTIC PROCEDURES	IN-NETWORK TIER 1
Diagnostic Laboratory and X-ray except for Complex Imaging Services If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing	$40 copay
Complex Imaging Services (examples: MRI/CAT/PET scans)	20% after Deductible

EMERGENCY MEDICAL CARE	IN-NETWORK TIER 1
Walk-in Clinic	$30 copay
Urgent Care Provider (benefit availability may vary by location)	$40 copay
Non-Urgent Use of Urgent Care Provider	Not Covered
Emergency Room	20% after Deductible
Non-Emergency care in an Emergency Room	Not Covered
Ambulance	20% after Deductible

HOSPITAL CARE	IN-NETWORK TIER 1
Inpatient Coverage The member cost sharing applies to all covered benefits incurred during a member's inpatient stay, however specialist services performed in a hospital or other facility may be billed separately for the product and covered as Physician Services for Non-Office Care.	20% after Deductible , after $500 per confinement copay
Inpatient Maternity Coverage The member cost sharing applies to all covered benefits incurred during a member's inpatient stay, however specialist services performed in a hospital or other facility may be billed separately for the product and covered as Physician Services for Non-Office Care.	20% after Deductible , after $500 per confinement copay

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Outpatient Hospital Expenses (including surgery)	20% after Deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit, however specialist services performed in a hospital or other facility may be billed separately for the product and covered as Physician Services for Non-Office Care.	
MENTAL HEALTH SERVICES	**IN-NETWORK TIER 1**
Inpatient	20% after Deductible , after $500 per confinement copay
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	
Outpatient	$40 copay
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit Maximums are combined for Mental Health and Alcohol/Drug services	
ALCOHOL/DRUG ABUSE SERVICES	**IN-NETWORK TIER 1**
Inpatient	20% after Deductible , after $500 per confinement copay
3 episodes per lifetime, Inpatient / outpatient combined.	
Outpatient	$40 copay
The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit Maximums are combined for Mental Health and Alcohol/Drug services	
OTHER SERVICES	**IN-NETWORK TIER 1**
Convalescent Facility	20% after Deductible , after $500 per confinement copay
Limited to 100 days per calendar year. The member cost sharing applies to all covered benefits incurring during a member's inpatient stay	
Home Health Care	20% after deductible
Includes Private Duty Nursing limited to 70 eight hour shifts per calendar year. Each visit by a nurse or therapist is one visit. Each visit up to 4 hours by a home health care aide is one visit.	
Hospice Care - Inpatient	20% after Deductible , after $500 per confinement copay
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	
Hospice Care - Outpatient	$40 copay
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit	
Outpatient Short-Term Rehabilitation	$40 copay
Includes Speech, Physical, Occupational Therapy at 60 visit limit per calendar year.	
Spinal Manipulation Therapy	$40 copay
Limited to 20 visits per calendar year	
Autism Behavioral Therapy	Refer to MBH Outpatient Mental Health, Other Services
Autism Applied Behavioral Analysis	Refer to MBH Outpatient Mental Health, Other Services
Autism Physical Therapy	$40 copay, deductible waived
Autism Occupational Therapy	$40 copay, deductible waived

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Autism Speech Therapy	$40 copay, deductible waived
Durable Medical Equipment	20% after deductible
Prosthetics	20% after deductible
Orthotics	20% after deductible
Diabetic Supplies	Covered 100% for supplies only.
Prescription Drugs	Not Covered
Contraceptive devices not obtainable at a pharmacy (includes coverage for contraceptive visits)	Covered 100%; deductible waived
Transplants Coverage is provided at an IOE contracted facility only.	20% after Deductible , after $500 per confinement copay
Bariatric Surgery	Not Covered
Mouth, Jaws and Teeth (oral surgery procedures, whether medical or dental in nature)	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Out of Area Dependents	No coverage for non-emergency care received outside the service area.

FAMILY PLANNING	**IN-NETWORK TIER 1**
Infertility Treatment	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Diagnosis and treatment of the underlying medical condition.	
Comprehensive Infertility Services	Not Covered
Vasectomy	Your cost shareing is based on the type of service and where it is performed.
Tubal Ligation	Covered 100%, deductible waived

GENERAL PROVISIONS	
Dependents Eligibility	Spouse, children from birth to age 19 or to age 26.
Pre-existing Conditions Exclusion	On effective date: Waived After effective date: Waived

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.

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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; 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 duty nursing.

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. When the member utilizes a non-preferred provider, Member must obtain the precertification. Precertification requirements may vary. Depending on the plan selected, new prescription drugs not yet reviewed by our medication review committee are either available under plans with an open formulary or excluded from coverage unless a medical exception is obtained under plans that use a closed formulary.

They may also be subject to precertification or step-therapy. Non-prescription drugs and drugs in the Limitations and Exclusions section of the plan documents (received after open enrollment) are not covered, and medical exceptions are not available for them. While this information is believed to be accurate as of the print date, it is subject to change.

Plans are administered by Aetna Life Insurance Company.