**PLAN DESIGN & BENEFITS**
**PROVIDED BY TEXAS HEALTH AND AETNA HEALTH PLAN, INC.**

| PLAN FEATURES | IN-NETWORK DESIGNATED PROVIDERS |
|---|---|
| **Benefit Limitations** - For any service or supply that is subject to a maximum visit, day, or dollar limitation on a per year basis, the benefit year begins on January 1st unless otherwise mandated. Refer to your plan documents for more information. | |
| **Deductible**(per calendar year) | $500 Individual<br>$1,000 Family |
| Unless otherwise indicated, the deductible must be met prior to benefits being payable.<br>Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible.<br>Pharmacy expenses do not apply towards the Deductible.<br>The family Deductible is a cumulative Deductible for all family members. The family Deductible can be met by a combination of family members; however, no single individual within the family will be subject to more than the individual Deductible amount. | |
| **Out-of-Pocket Maximum**(per calendar year) | $2,000 Individual<br>$4,000 Family |
| In-Network expenses include coinsurance/copays and deductibles.<br>Pharmacy expenses apply towards the Out-of-Pocket-Maximum.<br>The family Out-of-Pocket Maximum is a cumulative Out-of-Pocket Maximum for all family members. The family Out-of-Pocket Maximum can be met by a combination of family members; however no single individual within the family will be subject to more than the individual Out-of-Pocket Maximum amount. | |
| **Lifetime Maximum** | Unlimited except where otherwise indicated. |
| **Primary Care Physician Selection** | Required |
| **Referral Requirement** | Required |
| **Network Designations**- In order to be covered at the preferred in-network benefit level you must use a designated provider for care. If you receive care from a non-designated provider your care may not be covered. | |
| **PREVENTIVE CARE** | **IN-NETWORK DESIGNATED PROVIDERS** |
| **Routine Adult Physical Exams/ Immunizations** | Covered 100%; deductible waived |
| 1 exam per 12 months for members age 22 and older. | |
| **Routine Well Child Exams** (Age and frequency schedules apply) | Covered 100%; deductible waived |
| **Childhood Immunizations** | Covered 100%; deductible waived |
| **Routine Gynecological Care Exams** | Covered 100%; deductible waived |
| 1 exam per 12 months<br>Includes routine tests and related lab fees. | |
| **Routine Mammograms** | Covered 100%; deductible waived |
| Recommended: One annual mammogram for covered females age 35 and over. | |
| **Women's Health** | Covered 100%; deductible waived |
| Includes: Screening for gestational diabetes, HPV (Human- Papillomavirus) DNA testing, counseling for sexually transmitted infections, counseling and screening for human immunodeficiency virus, screening and counseling for interpersonal and domestic violence, breastfeeding support, supplies and counseling.<br>Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply. | |
| **Routine Digital Rectal Exams / Prostate Specific Antigen Test** | Covered 100%; deductible waived |
| Recommended for males age 40 and over. | |
| **Colorectal Cancer Screening** | Covered 100%; deductible waived |
| Recommended: For all members age 45 and over.<br>Frequency schedule applies. | |

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| **Routine Eye Exams**<br>1 routine exam per 24 months.<br>Direct access to participating providers without a referral. | Covered 100%; deductible waived |
| **Routine Hearing Screening** | Covered 100%; deductible waived |
| **Newborn Hearing Testing and Monitoring**<br>Includes one newborn screening in the first 30 days and follow up exams in the first 24 months of life. | Your cost sharing is based on the type of service and where it is performed |
| **PHYSICIAN SERVICES** | **IN-NETWORK DESIGNATED PROVIDERS** |
| **Primary Care Physician Visits**<br>Includes services of an internist, general physician, family practitioner or pediatrician. | $30 office visit copay; deductible waived |
| **Specialist Office Visits** | $50 copay; deductible waived |
| **Pre-Natal Maternity** | Covered 100%; deductible waived |
| **Walk-in Clinics**<br>Walk-in Clinics are free-standing health care facilities that (a) may be located in or with a pharmacy, drug store, supermarket or other retail store; and (b) provide limited medical care and services on a scheduled or unscheduled basis. Urgent care centers, emergency rooms, the outpatient department of a hospital, ambulatory surgical centers, and physician offices are not considered to be Walk-in Clinics. | $30 copay; deductible waived<br>**Designated Walk-in Clinics**<br>Covered 100%; deductible waived |
| **Allergy Testing** | Your cost sharing is based on the type of service and where it is performed |
| **Allergy Injections** | Your cost sharing is based on the type of service and where it is performed |
| **Hearing Exams** | Your cost sharing is based on the type of service and where it is performed |
| **DIAGNOSTIC PROCEDURES** | **IN-NETWORK DESIGNATED PROVIDERS** |
| **Diagnostic Laboratory**<br>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. | 20%; deductible waived |
| **Diagnostic X-ray**<br>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. | 20%; deductible waived |
| **Diagnostic X-ray for Complex Imaging Services**<br>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. | 20%; deductible waived |
| **EMERGENCY MEDICAL CARE** | **IN-NETWORK DESIGNATED PROVIDERS** |
| **Urgent Care Provider** | $75 copay; deductible waived |
| **Non-Urgent Use of Urgent Care Provider** | Not Covered |
| **Emergency Room**<br>Copay waived if admitted | $200 copay; deductible waived |
| **Non-Emergency Care in an Emergency Room** | Not Covered |
| **Emergency Use of Ambulance** | Covered 100%; deductible waived |
| **Non-Emergency Use of Ambulance** | Not Covered |
| **HOSPITAL CARE** | **IN-NETWORK DESIGNATED PROVIDERS** |
| **Inpatient Coverage**<br>Your cost sharing applies to all covered benefits incurred during your inpatient stay. | 20%; after deductible |
| **Inpatient Maternity Coverage** (includes delivery and postpartum care)<br>Your cost sharing applies to all covered benefits incurred during your inpatient stay. | Covered 100% for Physician maternity services; deductible waived;20% for Facility services; after deductible |

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| **Outpatient Hospital**<br>Your cost sharing applies to all covered benefits incurred during your outpatient visit. | 20%; after deductible |
| **MENTAL HEALTH SERVICES** | **IN-NETWORK DESIGNATED PROVIDERS** |
| **Inpatient**<br>Your cost sharing applies to all covered benefits incurred during your inpatient stay. | 20%; after deductible |
| **Mental Health Office Visits**<br>Your cost sharing applies to all covered benefits incurred during your outpatient visit. | $50 copay; deductible waived |
| **Other Mental Health Services** | Covered 100%; deductible waived |
| **SUBSTANCE ABUSE** | **IN-NETWORK DESIGNATED PROVIDERS** |
| **Inpatient**<br>Your cost sharing applies to all covered benefits incurred during your inpatient stay. | 20%; after deductible |
| **Residential Treatment Facility** | 20%; after deductible |
| **Substance Abuse Office Visits**<br>Your cost sharing applies to all covered benefits incurred during your outpatient visit. | $50 copay; deductible waived |
| **Other Substance Abuse Services** | Covered 100%; deductible waived |
| **OTHER SERVICES** | **IN-NETWORK DESIGNATED PROVIDERS** |
| **Skilled Nursing Facility**<br>Limited to 60 days per year<br>Your cost sharing applies to all covered benefits incurred during your inpatient stay. | 20%; after deductible |
| **Home Health Care**<br>Limited to 60 visits per year<br>Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less. | 20%; deductible waived |
| **Hospice Care - Inpatient**<br>Your cost sharing applies to all covered benefits incurred during your inpatient stay. | 20%; after deductible |
| **Hospice Care - Outpatient**<br>Your cost sharing applies to all covered benefits incurred during your outpatient visit. | 20%; deductible waived |
| **Outpatient Short-Term Rehabilitation**<br>Includes speech, physical, occupational therapy | $50 copay; deductible waived |
| **Spinal Manipulation Therapy**<br>Limited to 20 visits per year<br>Direct access to participating providers without a referral. | $50 copay; deductible waived |
| **Habilitative Services (Physical/Occupational/Speech Therapy)** | Covered 100%; deductible waived |
| **Autism Behavioral Therapy**<br>Covered same as any other Outpatient Mental Health benefit | Refer to MBH Outpatient Mental Health |
| **Autism Applied Behavior Analysis**<br>Covered same as any other Outpatient Mental Health Other Services benefit | Refer to MBH Outpatient Mental Health Other Services |
| **Autism Physical Therapy** | Covered 100%; deductible waived |
| **Autism Occupational Therapy** | Covered 100%; deductible waived |
| **Autism Speech Therapy** | Covered 100%; deductible waived |
| **Durable Medical Equipment** | 20%; deductible waived |
| **Prosthetics** | Covered 100%; deductible waived |
| **Orthotics**<br>Orthotic Appliances and Services | 20%; deductible waived |
| **Diabetic Supplies** | Pharmacy cost sharing applies if Pharmacy coverage is included; otherwise PCP office visit cost sharing applies. |

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| **Women's Contraceptive drugs and devices not obtainable at a pharmacy** | Covered 100%; deductible waived |
| **Affordable Care Act mandated Women's Contraceptives** | Covered 100%; deductible waived |
| **Hearing Aids**<br>1 benefit maximum per ear for hearing aids every 3 years. | Covered 100%; deductible waived |
| **Infusion Therapy**<br>Administered in the home or physician's office | Your cost sharing is based on the type of service and where it is performed |
| **Infusion Therapy**<br>Administered in an outpatient hospital department or freestanding facility | Your cost sharing is based on the type of service and where it is performed |
| **Transplants** | 20%; after deductible<br>Preferred coverage is provided at an IOE contracted facility only. |
| **Bariatric Surgery** | Not Covered |
| **FAMILY PLANNING** | **IN-NETWORK DESIGNATED PROVIDERS** |
| **Infertility Treatment**<br>Diagnosis and treatment of the underlying medical condition only. | Your cost sharing is based on the type of service and where it is performed |
| **Comprehensive Infertility Services**<br>Artificial insemination and ovulation induction | Not Covered |
| **Advanced Reproductive Technology (ART)**<br>In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery | Not Covered |
| **Vasectomy** | Your cost sharing is based on the type of service and where it is performed |
| **Tubal Ligation** | Covered 100%; deductible waived |
| **PRESCRIPTION DRUG BENEFITS** | |
| | Managed by CVS Caremark<br>800-388-2058 |
| **GENERAL PROVISIONS** | |
| **Dependents Eligibility** | Spouse, children from birth to age 26 regardless of student status. |

**Exclusions and Limitations**

**Health benefits and health insurance plans are offered and/or underwritten by Aetna Health Inc. Each insurer has sole financial responsibility for its own products.**

This material is for information only. Health benefits plans contain exclusions and limitations.

Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change.

You may be responsible for the health care provider's full charges for any non-covered services, including circumstances where you have exceeded a benefit limit contained in the plan. Providers are independent contractors and are not our agents. Provider participation may change without notice. We do not provide care or guarantee access to health services.

The following is a 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 and hospital services not specifically covered in, or which are limited or excluded by your plan documents.
• Cosmetic surgery, including breast reduction.
• Custodial care.
• Dental care and dental x-rays.
• Donor egg retrieval.
• Durable medical equipment.
• Experimental and investigational procedures, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
• Hearing aids.
• Home births.
• Immunizations for travel or work except where medically necessary or indicated.
• Implantable drugs and certain injectable drugs including injectable infertility drugs.
• Infertility services, including 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.
• Long-term rehabilitation therapy.
• Non-medically necessary services or supplies.
• Outpatient prescription drugs (except for treatment of diabetes), unless covered by a prescription plan rider and over-the-counter medications (except as provided in a hospital) and supplies.
• Radial keratotomy or related procedures.
• Reversal of sterilization.
• Services for the treatment of sexual dysfunction or inadequacies including therapy, supplies or counseling or prescription drugs.
• Special duty nursing.
• Therapy or rehabilitation other than those listed as covered.
• Treatment of behavioral disorders.
• Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including Morbid Obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.

In case of emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility.

**If you require language assistance, please call the Member Services number located on your ID card, and you will be connected with the language line if needed; or you may dial direct at 1-888-982-3862 (140 languages are available. You must ask for an interpreter). TDD 1-800-628-3323 (hearing impaired only).**

**Si requiere la asistencia de un representante que hable su idioma, por favor llame al número de Servicios al Miembro que aparece en su tarjeta de identificación y se le comunicará con la línea de idiomas si es necesario; de lo contrario, puede llamar directamente al 1-888-982-3862 (140 idiomas disponibles. Debe pedir un intérprete). TDD-1-800-628-3323 (sólo para las personas con impedimentos auditivos).**

Plan features and availability may vary by location and group size.

For more information about Aetna plans, refer to **www.aetna.com.** While this material is believed to be accurate as of the production date, it is subject to change.
Aetna and MinuteClinic, LLC (which either operates or provides certain management support services to MinuteClinic-branded walk-in clinics) are both within the CVS Health family.

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