aetna®

Rice University
Proposed Effective Date: 07-01-2017
Aetna Select^{SM} - ASC

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	PREFERRED CARE
Deductible (per plan year)	None Individual None Family
Member Coinsurance Applies to all expenses unless otherwise stated.	Covered 100%
Payment Limit (per plan year)	$3,000 Employee $6,000 Family
Certain member cost sharing elements may not apply toward the Out-of-Pocket Maximum. Pharmacy expenses apply towards the Payment Limit. Only those out-of-pocket expenses resulting from the application of coinsurance percentage, deductibles, copays and prescription drug copays (except any penalty amounts) may be used to satisfy the Payment Limit. Once Family Payment Limit is met, all family members will be considered as having met their Payment Limit for the remainder of the plan year.	
Lifetime Maximum	Unlimited
Primary Care Physician Selection	Required
Referral Requirement	Required
PREVENTIVE CARE	**PREFERRED CARE**
Routine Adult Physical Exams/ Immunizations 1 exam per 12 months for members age 22 and older.	Covered 100%
Routine Well Child Exams/Immunizations 7 exams in the first 12 months of life, 3 exams in the second 12 months of life, 3 exams in the third 12 months of life, 1 exam per 12 months thereafter to age 22.	Covered 100%
Routine Gynecological Care Exams 1 routine exam every twelve months. Includes related lab fees.	Covered 100%
Routine Mammograms One baseline mammogram for covered females age 35-39, one mammogram every twelve months for covered females age 40 and over.	Covered 100%
Women's Health 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. Contraceptive methods, sterilization procedures, patient education and counseling. Limitations may apply.	Covered 100%
Routine Digital Rectal Exam / Prostate-specific Antigen Test For covered males age 40 and over.	Covered 100%
Colorectal Cancer Screening For all members age 50 and over.	Covered 100%
Routine Eye Exams 1 routine exam per 12 months	Covered 100%
Routine Hearing Screenings	Covered 100%
PHYSICIAN SERVICES	**PREFERRED CARE**
Office Visits to PCP	$30 copay
Specialist Office Visits	$40 copay
Pre-Natal Maternity	Covered 100%
Allergy Testing	Same as applicable participating provider office visit member cost sharing
Allergy Injections	Same as applicable participating provider office visit member cost sharing

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DIAGNOSTIC PROCEDURES	PREFERRED CARE
Diagnostic X-ray	**$40 copay**
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.	
Diagnostic Laboratory	**Covered 100%**
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.	
Diagnostic X-ray for Complex Imaging Services	**$40 copay**
EMERGENCY MEDICAL CARE	**PREFERRED CARE**
Urgent Care Provider (benefit availability may vary by location)	$50 copay
Non-Urgent Use of Urgent Care Provider	Not Covered
Emergency Room	$200 copay, waived if admitted
Non-Emergency care in an Emergency Room	Not Covered
Ambulance	Covered 100%
HOSPITAL CARE	**PREFERRED CARE**
Inpatient Coverage	$300 per confinement copay
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	
Inpatient Maternity Coverage (includes delivery and postpartum care)	$300 per confinement copay for Facility services; and $35 copay for Physician Maternity services
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	
Outpatient Surgery	$175 copay
Outpatient Hospital Expenses (excluding surgery)	Covered 100%
The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit	
MENTAL HEALTH SERVICES	**PREFERRED CARE**
Inpatient	$300 per confinement copay
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	
Outpatient	$40 office visit copay
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit	
ALCOHOL/DRUG ABUSE SERVICES	**PREFERRED CARE**
Inpatient	$300 per confinement copay
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	
Residential Treatment Facility	$300 per confinement copay
Outpatient	$40 office visit copay
The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit	
OTHER SERVICES	**PREFERRED CARE**
Convalescent Facility	$300 per confinement copay
The member cost sharing applies to all covered benefits incurring during a member's inpatient stay	
Home Health Care	Covered 100%
Hospice Care - Inpatient	$300 per confinement copay
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay	
Hospice Care - Outpatient	Covered 100%
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit	
Outpatient Short-Term Rehabilitation Include Speech, Physical, and Occupational Therapy.	$40 office visit copay
Spinal Manipulation Therapy Limited to 20 visits per plan year	$40 office visit copay
Autism Behavioral Therapy	$40 office visit copay
Autism Applied Behavior Analysis	$40 office visit copay

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Autism Physical Therapy	$40 office visit copay
Autism Occupational Therapy	$40 office visit copay
Autism Speech Therapy	$40 office visit copay
Durable Medical Equipment	Covered 100%
Diabetic Supplies	Covered same as any other medical expense
Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%
Transplants Coverage is provided at an Institue Of Excellence contracted facility only.	$300 per confinement copay
Mouth, Jaws and Teeth (oral surgery procedures, medical in nature only)	Your cost sharing is based on the type of service and where it is performed
Out of Area Dependents	No coverage for non-emergency care received outside the service area
FAMILY PLANNING	**PREFERRED CARE**
Infertility Treatment Diagnosis and treatment of the underlying medical condition.	Your cost sharing is based on the type of service and where it is performed
Vasectomy	Your cost sharing is based on the type of service and where it is performed
Tubal Ligation	Covered 100%
PHARMACY	**PREFERRED CARE**
Pharmacy coverage is provided by Express Scripts, Inc.	
GENERAL PROVISIONS	
Dependents Eligibility	Spouse, children from birth to age 26, regardless of student status.

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; 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. 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.

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 limitations 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.