Rice University
Effective Date: 07-01-2017
Aetna Choice™ POS II - ASC

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	PREFERRED CARE		NON-PREFERRED CARE	
Deductible (per plan year)	$500	Individual	$2,000	Individual
	$1,000	Family	$4,000	Family
All covered expenses, excluding prescription drugs, accumulate toward both the preferred and non-preferred Deductible. Unless otherwise indicated, the Deductible must be met prior to benefits being payable. Once Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the plan year.				
Member Coinsurance	Covered 100%		40%	
Applies to all expenses unless otherwise stated.				
Payment Limit (per plan year)	$4,000	Individual	$6,000	Individual
	$8,000	Family	$18,000	Family
All covered expenses, including prescription drugs, accumulate toward both the preferred and non-preferred Payment Limit. Certain member cost sharing elements may not apply toward 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		Unlimited	
Primary Care Physician Selection	Optional		Not applicable	
Certification Requirements - Certification for certain types of Non-Preferred care must be obtained to avoid a reduction in benefits paid for that care. Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required - excluded amount applied separately to each type of expense is $400 per occurrence.				
Referral Requirement	None		None	

PREVENTIVE CARE	PREFERRED CARE	NON-PREFERRED CARE
Routine Adult Physical Exams/ Immunizations	Covered 100%; deductible waived	40% after deductible
1 exam per 12 months for members age 22 and older.		
Routine Well Child Exams/Immunizations	Covered 100%; deductible waived	40% after deductible
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 year thereafter to age 22.		
Routine Gynecological Care Exams	Covered 100%; deductible waived	40% after deductible
1 routine exam every twelve months. Includes related lab fees.		
Routine Mammograms	Covered 100%; deductible waived	40% after deductible
One baseline mammogram for covered females age 35-39, one mammogram every twelve months for covered females age 40 and over.		
Women's Health	Covered 100%; deductible waived	40% after deductible
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.		
Routine Digital Rectal Exam / Prostate-specific Antigen Test	Covered 100%; deductible waived	40% after deductible
For covered males age 40 and over.		
Colorectal Cancer Screening	Covered 100%; deductible waived	40% after deductible
For all members age 50 and over.		
Routine Eye Exams	Covered 100%; deductible waived	Not Covered
1 routine exam per 12 months.		
Routine Hearing Screening	Covered 100%; deductible waived	40% after deductible

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PHYSICIAN SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Office Visits to PCP	$35 office visit copay; deductible waived	40% after deductible
Includes services of an internist, general physician, family practitioner or pediatrician if the physician is not the member's selected PCP.		
Specialist Office Visits	$45 office visit copay; deductible waived	40% after deductible
Pre-Natal Maternity	Covered 100%; deductible waived	40% after deductible
Allergy Testing	Your cost sharing is based on the type of service and where it is performed	40% after deductible
Allergy Injections	Your cost sharing is based on the type of service and where it is performed	40% after deductible
Audiometric Hearing Exams 1 routine exam per 12 months	Covered 100%; deductible waived	40% after deductible
DIAGNOSTIC PROCEDURES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Diagnostic Laboratory	Covered 100%; after deductible	40% after deductible
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	$45 office visit copay; after deductible	40% after deductible
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 Service	$45 office visit copay; after deductible	40% after deductible
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		
EMERGENCY MEDICAL CARE	**PREFERRED CARE**	**NON-PREFERRED CARE**
Urgent Care Provider (benefit availability may vary by location)	$50 copay; deductible waived	40% after deductible
Non-Urgent Use of Urgent Care Provider	Not Covered	Not Covered
Emergency Room	$200 copay; deductible waived	Same as preferred care.
Non-Emergency care in an Emergency Room	Not Covered	Not Covered
Ambulance	Covered 100%; after deductible	Same as preferred care.
HOSPITAL CARE	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient Coverage	$400 per confinement copay; after deductible	40% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Inpatient Maternity Coverage (includes delivery and postpartum care)	$400 per confinement copay for Facility services; after deductible and $45 copay for Physician Maternity services; deductible waived	40% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient Surgery	$200 copay; after deductible	40% after deductible
Outpatient Hospital Expenses (excluding surgery)	Covered 100%; after deductible	40% after deductible
The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit		
MENTAL HEALTH SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Inpatient	$400 per confinement copay; after deductible	40% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Outpatient	$45 office visit copay; deductible waived	40% after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit		

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ALCOHOL/DRUG ABUSE SERVICES	PREFERRED CARE	NON-PREFERRED CARE
Inpatient	$400 per confinement copay; after deductible	40% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Residential Treatment Facility	$400 per confinement copay; after deductible	40% after deductible
Outpatient	$45 office visit copay; deductible waived	40% after deductible
The member cost sharing applies to all Covered Benefits incurred during a member's outpatient visit		
OTHER SERVICES	**PREFERRED CARE**	**NON-PREFERRED CARE**
Convalescent Facility	$400 per confinement copay; after deductible	40% after deductible
The member cost sharing applies to all covered benefits incurring during a member's inpatient stay		
Home Health Care	Covered 100%; after deductible	40% after deductible
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	$400 per confinement copay; after deductible	40% after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay		
Hospice Care - Outpatient	Covered 100%; after deductible	40% after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit		
Private Duty Nursing - Outpatient (Limited to 70 eight hour shifts per plan year)	Covered 100%; after deductible	40% after deductible
Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift. Each visiting nurse care or private duty nursing care shift of 4 hours or less counts as one home health visit. Each such shift		
Outpatient Short-Term Rehabilitation	$45 office visit copay; deductible waived	40% after deductible
Includes Speech, Physical, and Occupational Therapy.		
Autism Applied Behavioral Analysis	$45 office visit copay; deductible waived	40% after deductible
Autism Behavioral Therapy	$45 office visit copay; deductible waived	40% after deductible
Autism Physical Therapy	$45 office visit copay; deductible waived	40% after deductible
Autism Occupational Therapy	$45 office visit copay; deductible waived	40% after deductible
Autism Speech Therapy	$45 office visit copay; deductible waived	40% after deductible
Spinal Manipulation Therapy	$45 office visit copay; deductible waived	40% after deductible
Limited to 20 visits per plan year.		
Durable Medical Equipment	Covered 100%; after deductible	40% after deductible
Diabetic Supplies	Covered same as any other medical expense	Covered same as any other medical expense; after deductible
Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered same as any other medical expense.
Transplants	$400 per confinement copay; after deductible Preferred coverage is provided at an Institute Of Excellence contracted facility only.	40% after deductible Non-Preferred coverage is provided at a Non-Institute Of Excellence facility
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	40% after deductible
Out of Area Dependents	Coverage provided at the non-preferred benefit level of the plan; after deductible	
FAMILY PLANNING	**PREFERRED CARE**	**NON-PREFERRED CARE**

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Infertility Treatment	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Diagnosis and treatment of the underlying medical condition.		
Vasectomy	Your cost sharing is based on the type of service and where it is performed	Your cost sharing is based on the type of service and where it is performed
Tubal Ligation	Covered 100%; deductible waived	Your cost sharing is based on the type of service and where it is performed

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PHARMACY	PREFERRED CARE	NON-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 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.