Huston-Tillotson University
Proposed Effective Date: 01-01-2014
Open Access® Managed Choice® POS - Texas

PLAN DESIGN & BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	IN-NETWORK	OUT-OF-NETWORK
Deductible (per calendar year)	$3,000 Individual $6,000 Family	$6,000 Individual $12,000 Family
All covered expenses accumulate simultaneously toward both the preferred and non-preferred Deductible. Unless otherwise indicated, the deductible must be met prior to benefits being payable. Member cost sharing for certain services, as indicated in the plan, are excluded from charges to meet the Deductible. Pharmacy expenses apply towards the Deductible. 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.		
Member Coinsurance Applies to all expenses unless otherwise stated.	Covered 100%	30%
Payment Limit (per calendar year)	$3,000 Individual $6,000 Family	$6,000 Individual $12,000 Family
All covered expenses accumulate simultaneously toward both the preferred and non-preferred Payment Limit. 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, 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 Unlimited except where otherwise indicated.		
Payment for Non-Preferred	Not Applicable	Professional: 105% of Medicare Facility: 140% of Medicare
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	**IN-NETWORK**	**OUT-OF-NETWORK**
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months for members age 22 and older.	Covered 100%; deductible waived	30%; after deductible
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 year thereafter to age 22. The following immunizations will be covered at 100%: diphtheria; haemophilus influenza type b, hepatitis B; measles; mumps; pertussis; polio; rubella; tetanus and varicella and any other immunization that is required by law for the child.	Covered 100%; deductible waived	30%; after deductible
Routine Gynecological Care Exams One exam per calendar year. Includes routine tests and related lab fees.	Covered 100%; deductible waived	30%; after deductible
Routine Mammograms No age or frequency applies.	Covered 100%; deductible waived	30%; after deductible
Women's Health	Covered 100%; deductible waived	30%; after deductible

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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 No age or frequency applies.	Covered 100%; deductible waived	30%; after deductible
Prostate-specific Antigen Test No age or frequency applies.	Covered 100%; deductible waived	30%; after deductible
Colorectal Cancer Screening For all members age 50 and over. Coverage includes the following: Annual fecal occult blood test, Digital rectal exam and a flexible sigmoidoscopy every 5 years, Digital rectal exam and a double contrast barium enema every 5 years, and Digital rectal exam and a colonoscopy every 10 years.	Covered 100%; deductible waived	30%; after deductible
Routine Eye Exam I exam every 24 months	Covered 100%; deductible waived	30%; after deductible
Newborn Hearing Screening 1 in the first 30 days of life and follow-up diagnostic care until the age of 24 months Includes speech evaluation and therapy, hearing evaluation, hearing aid evaluation tests and hearing aids.	Covered 100%; deductible waived	30%; after deductible
PHYSICIAN SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Office Visits to PCP Includes services of an internist, general physician, family practitioner or pediatrician.	Covered 100% after deductible	30%; after deductible
Specialist Office Visits	Covered 100% after deductible	30%; after deductible
Pre-Natal Maternity	Covered 100%; deductible waived	30%; after deductible
E-visit to PCP An E-visit is an online internet consultation between a physician and an established patient about a non-emergency healthcare matter. This visit must be conducted through our authorized internet E-visit service vendor.	Covered 100% after deductible	30%; after deductible
E-visit to Specialist An E-visit is an online internet consultation between a physician and an established patient about a non-emergency healthcare matter. This visit must be conducted through our authorized internet E-visit service vendor.	Covered 100% after deductible	30%; after deductible
Walk-in Clinics Walk-in Clinics are network, free-standing health care facilities. They are an alternative to a physician's office visit for treatment of unscheduled, non-emergency illnesses and injuries and the administration of certain immunizations. It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room, nor the outpatient department of a hospital, shall be considered a Walk-in Clinic.	Covered 100% after deductible	30%; after deductible
Audiometric Hearing Exam I exam every 24 months	Covered 100%; deductible waived	30%; after deductible
Allergy Testing	Member cost sharing is based on the type of service performed and the place of service where it is rendered; deductible waived	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible
Allergy Injections	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible
DIAGNOSTIC PROCEDURES	**IN-NETWORK**	**OUT-OF-NETWORK**
Diagnostic X-ray 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.	Covered 100% after deductible	30%; after deductible

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Diagnostic Laboratory	Covered 100% after deductible	30%; 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 Outpatient Complex Imaging	Covered 100% after deductible	30%; after deductible
EMERGENCY MEDICAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Urgent Care Provider	Covered 100% after deductible	30%; after deductible
Emergency Room	Covered 100% after deductible	30%; after deductible
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	Covered 100% after deductible	30%; after deductible
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient Coverage	Covered 100% after deductible	30%; 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)	Covered 100% after deductible	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Outpatient Hospital Expenses	Covered 100% after deductible	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Outpatient Surgery	Covered 100% after deductible	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
MENTAL HEALTH SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	Covered 100% after deductible	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Partial Hospitalization (for day/night care and treatment)	Covered 100% after deductible	30%; after deductible
Crisis Stabilization Units/ Residential Treatment Centers (for children and adolescents)	Covered 100% after deductible	30%; after deductible
Outpatient	Covered 100% after deductible	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
ALCOHOL/DRUG ABUSE SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Inpatient	Covered 100% after deductible	30%; after deductible
Member cost sharing is based on the type of service performed and the place of service where it is rendered		
Residential Treatment Facility	Covered 100% after deductible	30%; after deductible
Outpatient	Covered 100% after deductible	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
OTHER SERVICES	**IN-NETWORK**	**OUT-OF-NETWORK**
Convalescent Facility	Covered 100% after deductible	30%; after deductible
Limited to 60 days per calendar year. The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Home Health Care	Covered 100% after deductible	30%; after deductible
Limited to 60 visits 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	Covered 100% after deductible	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		

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Hospice Care - Outpatient	Covered 100% after deductible	30%; after deductible
The member cost sharing applies to all covered benefits incurred during a member's outpatient visit.		
Private Duty Nursing - Outpatient	Covered 100%; after deductible	30%; after deductible
Limited to 70 eight hour shifts per calendar year. Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.		
Outpatient Short-Term Rehabilitation	Covered 100% after deductible	30%; after deductible
Includes Speech, Physical, and Occupational Therapy. Limited to 20 visits per calendar year		
Autism Behavioral Therapy	Covered 100% after deductible	30%; after deductible
Covered same as any other Outpatient Mental Health benefit.		
Autism Applied Behavior Analysis	Covered same as any other Outpatient Mental Health benefit	Covered same as any other Outpatient Mental Health benefit
Autism Physical, Occupational and Speech Therapy	Covered 100% after deductible	30%; after deductible
Covered same as any other Short Term Rehabilitation expense with no age or visit limitations.		
Spinal Manipulation Therapy	Covered 100% after deductible	30%; after deductible
Durable Medical Equipment	Covered 100% after deductible	30%; after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived	Covered same as any other expense.
Generic FDA-approved Women's Contraceptives	Covered 100%; deductible waived	Not Covered
Transplants	Covered 100% after deductible Preferred coverage is provided at an IOE contracted facility only.	30%; after deductible Non-Preferred coverage is provided at a Non-IOE facility.
Bariatric Surgery	Not Covered	Not Covered
The member cost sharing applies to all covered benefits incurred during a member's inpatient stay.		
Out of Area Dependents	Coverage provided at the non-preferred benefit level of the plan.	
FAMILY PLANNING	**IN-NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment	Member cost sharing is based on the type of service performed and the place of service where it is rendered	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible
Diagnosis and treatment of the underlying medical condition.		
Comprehensive Infertility Services	Not Covered	Not Covered
Coverage includes Artificial Insemination and Ovulation Induction, limited to 4 attempts per lifetime.		
Advanced Reproductive Technology (ART)	Not Covered	Not Covered
ART coverage includes: In vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery.		
Vasectomy	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible.
Tubal Ligation	Covered 100%; deductible waived	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible.

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PHARMACY	IN-NETWORK	OUT-OF-NETWORK
The full cost of the drug is applied to the deductible before any benefits are considered for payment under the pharmacy plan.		
Retail	Covered 100% after combined medical/RX deductible for generic drugs, formulary brand-name drugs and non-formulary brand-name drugs up to a 30 day supply at participating pharmacies	20% of submitted cost after the applicable preferred copay
Mail Order	Covered 100% after combined medical/RX deductible for generic drugs, formulary brand-name drugs and non-formulary brand-name drugs up to a 31-90 day supply from Aetna Rx Home Delivery®.	Not Applicable
Plan Includes: Diabetic supplies and Contraceptive drugs and devices obtainable from a pharmacy. Oral fertility drugs included. Precert for growth hormones included. Formulary Generic FDA-approved Women's Contraceptives and certain over-the-counter preventive medications covered 100% in network.		
GENERAL PROVISIONS		
Dependents Eligibility	Spouse, children from birth to age 26 regardless of student status.	

**We cover the cost of services based on whether doctors are "in network" or "out of network." We want to help you understand how much we pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this "out-of-network" care.

• For doctors and other professionals the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

• For hospitals and other facilities, the amount is based on what Medicare pays for these services. The government sets the Medicare rate. Exactly how much we "recognize" depends on the plan you or your employer picks.

Your doctor sets his or her own rate to charge you. It may be higher -- sometimes much higher -- than what your plan "recognizes." Your doctor may bill you for the dollar amount that we don't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit our website.

Plans are provided by: Aetna Life Insurance Company. While this material is believed to be accurate as of the production date, it is subject to change.

Health benefits and health insurance 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.

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If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists and hospitals that are affiliated with the delivery system or physician group.
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.

• 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.
• Orthotics except diabetic orthotics.
• 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.

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. The charges that Aetna negotiates with Aetna Rx Home Delivery may be higher than the cost they pay for the drugs and the cost of the mail order pharmacy services they provide. For these purposes, the pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

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

Translation of the material into another language may be available. Please call Member Services at **1-888-982-3862.**

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Puede estar disponible la traduccion de este material en otro idioma. Por favor llame a Servicios al Miembro al **1-888-982-3862.**
Plan features and availability may vary by location and group size.
For more information about Aetna plans, refer to **www.aetna.com.**