

**TEXAS AETNA ADVANTAGE PLAN OPTIONS**

	<b>PPO 2500</b>	
<b>MEMBER BENEFITS</b>	In-Network	Out-of-Network <sup>+</sup>
Deductible		
Individual	\$2,500	\$5,000
Family	\$5,000	\$10,000
Member Coinsurance	20% after deductible	50% after deductible
Coinsurance Maximum		
Individual	\$2,500	\$2,500
Family	\$5,000	\$5,000
Out-of-Pocket Maximum		
Individual	\$5,000	\$7,500
Family	\$10,000	\$15,000
Lifetime Maximum*	\$5,000,000 per member lifetime	
Non-specialist Office Visit (General Physician, Family Practitioner, Pediatrician or Internist)	\$30 Copay not subject to deductible	30% after deductible
Specialist Visit**	\$40 Copay not subject to deductible	30% after deductible
Hospital Admission**	20% after deductible	50% after deductible
Outpatient Surgery	20% after deductible	50% after deductible
Emergency Room	\$100 Copay (waived if admitted) 20% after deductible	
Annual Routine Gyn Exam (Annual Pap/Mammogram)	No Copay not subject to deductible	30% after deductible
Preventive Health (Annual Physical <sup>++</sup> ) (\$200 per calendar year*)	\$30 Copay not subject to deductible	30% after deductible
Lab/X-Ray	20% after deductible	50% after deductible
Skilled Nursing (in lieu of hospital) (30 days per calendar year*)	20% after deductible	50% after deductible
Physical/Occupational Therapy and Chiropractic Care (24 visits per calendar year*)	20% after deductible	50% after deductible (Aetna will pay a maximum of \$25 per visit)
Home Health Care (30 visits per calendar year*)	20% after deductible	50% after deductible
Durable Medical Equipment (\$2,000 per calendar year*)	20% after deductible	50% after deductible
<b>PHARMACY BENEFITS</b>		
Pharmacy Deductible per Individual (does not apply to generic)*	\$500 (does not apply to generic)	\$500 (does not apply to generic)
Generic (Oral Contraceptives Included)	\$15 Copay not subject to deductible	\$15 Copay plus 30% not subject to deductible
Preferred Brand/Non-Preferred Brand (Oral Contraceptives Included)	\$25/\$40 Copay after deductible	\$25/\$40 Copay plus 30% after deductible
Calendar Year Maximum per Individual*	\$5,000	\$5,000

- \* Maximum applies to combined in and out-of-network benefits.
- \*\* Maternity and pregnancy related expenses are not covered, except for complications of pregnancy.
- + Payment for out-of-network facility care is determined based upon Aetna's Allowable Fee Schedule. Payment for other out-of-network care is determined based upon the negotiated charge that would apply if such services or supplies were received from a Preferred Provider.
- ++ No deductible, copayment or coinsurance applies to eligible dependent children to age 18 for childhood immunizations.

A summary of exclusions is listed on page 18. For a full list of benefit coverage and exclusions refer to the plan documents.

Underwritten by Aetna Life Insurance Company

