TEXAS AETNA ADVANTAGE PLAN OPTIONS

	PREVENTATIVE AND HOSPITAL CARE 3000 (HSA-COMPATIBLE)	
MEMBER BENEFITS	In-Network	Out-of-Network+
Deductible Individual Family	 $3,000 $6,000	 $6,000 $12,000
Member Coinsurance	20% after deductible	50% after deductible
Coinsurance Maximum Individual Family	 $2,000 $4,000	 $4,000 $8,000
Out-of-Pocket Maximum Individual Family	 $5,000 $10,000	 $10,000 $20,000
Lifetime Maximum *	$5,000,000	
Non-specialist Office Visit (General Physician, Family Practitioner, Pediatrican or Internist)	Not Covered	Not Covered
Specialist Visit	Not Covered	Not Covered
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)	$0 Copay not subject to deductible	50% after deductible
Maternity	Not covered	Not covered
Preventive Health (Physical – every 24 months*) ($200 per exam)	$35 copay not subject to deductible	50% after deductible
Lab/X-Ray	Not Covered	Not Covered
Skilled Nursing (In lieu of Hospital) (30 days per calendar year*)	20% after deductible	50% after deductible
Physical/Occupational Therapy and Chiropractic Care	Not Covered	Not Covered
Home Health Care (30 visits per calendar year*)	20% after deductible	50% after deductible
Durable Medical Equipment ($2000 per calendar year*)	Not Covered Except for Diabetic Supplies	
PHARMACY		
Pharmacy Deductible per Individual (does not apply to generic)*	Not Applicable	Not Applicable
Generic (Oral Contraceptives Included)	Not Covered**	Not Covered**
Preferred Brand/Non-Preferred Brand (Oral Contraceptives Included)	Not Covered**	Not Covered**
Calendar Year Maximum per Individual*	Not Covered**	Not Covered**

* Maximum applies to combined in and out of network benefits.
** Aetna Discount Available.
\+ 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.

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

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