Schedule of Benefits

Employer: **Rice University**

MSA: 878783

Issue Date: October 20, 2016
Effective Date: July 1, 2016
Schedule: 3A
Booklet Base: 3

For: Aetna Whole Health[SM] – Memorial Hermann Accountable Care Network – Aetna Select

This is an ERISA plan, and you have certain rights under this plan. Please contact your Employer for additional information.

Aetna Select Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK

Plan Maximum Out of Pocket Limit includes plan **deductible and copayments**.

Individual Maximum Out of Pocket Limit:

- For **network** expenses: $1,500

Family Maximum Out of Pocket Limit:

- For **network** expenses: $3,000

Lifetime Maximum Benefit per person	Unlimited	Not applicable

Payment Percentage listed in the Schedule below reflects the Plan Payment Percentage. This is the amount the Plan pays. You are responsible to pay any deductibles and the remaining payment percentage. You are responsible for full payment of any non-covered expenses you incur.

All Covered Expenses Are Subject To The Plan Year Deductible Unless Otherwise Noted In The Schedule Below.

Maximums for specific covered expenses, including visit, day and dollar maximums are combined maximums between network and out-of-network, unless specifically stated otherwise.

PLAN FEATURES	NETWORK	OUT OF NETWORK
Preventive Care Benefits		
Routine Physical Exams		
Office Visits -	100% per visit. No copay or **deductible** applies.	Not Covered

Covered Persons through age 21: Maximum Age & Visit Limits per 12 consecutive months	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents. *For details, contact your **physician** or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card.*	Not Covered
Covered Persons ages 22 but less than 65: Maximum Visits per 12 consecutive months	1 visit	Not Covered
Covered Persons age 65 and over: Maximum Visits per 12 consecutive months	1 visit	Not Covered.
Preventive Care Immunizations *Performed in a facility or **physician's** office*	100% per visit. No **copay** or **deductible** applies. Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. *For details, contact your **physician** or Member Services by logging onto the Aetna website www.aetna.com, or calling the number on the back of your ID card.*	Not Covered
Screening & Counseling Services ***Office Visits*** ***Obesity and/or Healthy Diet*** ***Misuse of Alcohol and/or Drugs & Use of Tobacco Products*** ***Sexually Transmitted Infections*** ***Genetic Risk for Breast and Ovarian Cancer***	100% per visit No **copay** or **deductible** applies.	Not Covered

Obesity and/or Healthy Diet Maximum Visits per 12 consecutive months *(This maximum applies only to Covered Persons ages 22 & older.)*	26 visits *(however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)**	Not Covered.
Note: *In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.		
Misuse of Alcohol and/or Drugs Maximum Visits per 12 consecutive months	5 visits*	Not Covered.
Note: *In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.		
Use of Tobacco Products Maximum Visits per 12 consecutive months	8 visits*	Not Covered.
Note: *In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.		
Sexually Transmitted Infections Benefit Maximums Maximum Visits per Plan Year	2 visits*	Not Covered
Note: *In figuring the Maximum Visits, each session of up to 30 minutes is equal to one visit.		
Well Woman Preventive Visits Office Visits Subject to any age limits provided for in the comprehensive guidelines supported by the Health and Human Resources Administrations	100% No Plan Year **deductible** applies.	Not Covered
Maximum Visits per Plan Year	1 visit	Not Covered
Hearing Exam	100% No Plan Year **deductible** applies.	Not Covered
Maximum exams per 12 month period	1 exam	Not Covered

Routine Cancer Screening Outpatient	100% per visit No Plan Year **deductible** applies.	Not Covered
Maximums	Subject to any age; family history and frequency guidelines as set forth in the most current: • evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • the comprehensive guidelines supported by the Health Resources and Services Administration. *For details, contact your **physician** or Member Services by logging onto the **Aetna** website www.aetna.com, or calling the number on the back of your ID card.*	Not Covered
Lung Cancer Screening Maximum	One screening every 12 months*	Not Covered
Important Note:** ***Lung cancer screenings in excess of the maximum as shown above are covered under the Outpatient Diagnostic and Preoperative Testing section of your Schedule of Benefits.		
Prenatal Care Office Visits	100% per visit No **copay** or **deductible** applies.	Not Covered
Important Note: Refer to the Physician Services and Pregnancy Expenses sections of the Schedule of Benefits for more information on coverage levels for pregnancy expenses under this Plan, including other prenatal care, delivery and postnatal care office visits.		
Comprehensive Lactation Support and Counseling Services **Lactation Counseling Services** *Facility or Office Visits*	100% per visit No **copay** or **deductible** applies.	Not Covered.
Lactation Counseling Services Maximum Visits either in a group or individual setting	6* visits per 12 months	Not Covered
***Important Note**: Visits in excess of the Lactation Counseling Services Maximum as shown above, are covered under the *Physician Services* office visit section of the *Schedule of Benefits*.		

Breast Pumps & Supplies	100% per item No **copay** or **deductible** applies.	Not Covered
Family Planning - Other Voluntary Termination of Pregnancy Outpatient	100% per visit No **deductible** applies.	Not Covered.
Voluntary Sterilization for Males		
Outpatient	100% per visit No **deductible** applies.	Not Covered.
Family Planning Services Female Contraceptive Counseling Services -Office Visits.	100% per visit No Plan Year **deductible** applies.	Not Covered.
Contraceptive Counseling Services - Maximum Visits either in a group or individual setting	2* visits per 12 months	Not Covered.
*Important Note: Visits in excess of the Contraceptive Counseling Services Maximum as shown above, are covered under the *Physician Services* office visit section of the *Schedule of Benefits*.		

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Female Contraceptive Generic **Prescription Drugs** and Devices provided, administered, or removed, by a **Physician** during an Office Visits.	100% per item No **copay** or **deductible** applies.	Not Covered.
Family Planning - Female Voluntary Sterilization ***Inpatient***	100% per visit No **copay** or **deductible** applies.	Not Covered
Outpatient	100% per visit No **copay** or **deductible** applies.	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Vision Care		
Eye Examinations (including refraction)	100% No Plan Year **deductible** applies.	Not Covered
Maximum Benefit per 12 consecutive month period	1 exam	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Physician Services		
Office Visits to Primary Care Physician Office visits (non-surgical) to non-**specialist**	$25 visit **copay** then the plan pays 100% No Plan Year **deductible** applies.	Not Covered
Specialist Office Visits	$35 visit **copay** then the plan pays 100% No Plan Year **deductible** applies.	Not Covered
Walk-In Clinic Visit (Non-Emergency) ***Preventive Care Services****		
Immunizations	100% per visit No **copay** or **deductible** applies. For details, contact your **physician**, log onto the **Aetna** website www.aetna.com, or call the number on the back of your ID card.	Not Covered
Individual Screening and Counseling Services for Tobacco Use	100% per visit No **copay** or **deductible** applies.	Not Covered
Maximum Benefit per visit - Individual Screening and Counseling Services for Tobacco Use	Refer to the *Preventive Care Benefit* section earlier in this Schedule of Benefits for maximums that may apply to these types of services	Not Applicable
Individual Screening and Counseling Services for Obesity	100% per visit No **copay** or **deductible** applies.	Not Covered
Maximum Benefit per visit - Individual Screening and Counseling Services for Obesity	Refer to the *Preventive Care Benefit* section earlier in this Schedule of Benefits for maximums that may apply to these types of services	Not Applicable

***Important Note**:
Not all preventive care services are available at all **Walk-In Clinics**. The types of services offered will vary by the provider and location of the clinic. These services may also be obtained from your **physician**.

All Other Services	$25 visit **copay** then the plan pays 100% No Plan Year **deductible** applies.	Not Covered
Physician Office Visits - Surgery		
Physician	$25 per visit **copay** then the plan pays 100% No Plan Year **deductible** applies.	Not Covered
Specialist	$35 per visit **copay** then the plan pays 100% No Plan Year **deductible** applies.	Not Covered
Physician Services for Inpatient Facility and Hospital Visits	100% per visit No Plan Year **deductible** applies.	Not Covered
Administration of Anesthesia	100% No Plan Year **deductible** applies.	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Emergency Medical Services		
Hospital Emergency Facility and Physician	$200 **copay** per visit then the plan pays 100% No Plan Year **deductible** applies.	Paid the same as the Network level of benefits. **See Important note below*

*__Important Note__: Please note that as these providers are not Network Providers and do not have a contract with **Aetna**, the provider may not accept payment of your cost share as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this Plan. If the Emergency Room Facility or **physician** bills you for an amount above your cost share, you are not responsible for paying that amount. Please send **Aetna** the bill at the address listed on the back of your member ID card and **Aetna** will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.

Non-Emergency Care in a Hospital Emergency Room	Not Covered	Not Covered

Important Notice:
A separate **hospital** emergency room **deductible** or **copay** applies for each visit to an emergency room for

emergency care. If you are admitted to a **hospital** as an inpatient immediately following a visit to an emergency room, your **deductible** or **copay** is waived.

Covered expenses that are applied to the emergency room **copay** cannot be applied to any other **copay** under your plan. Likewise, **covered expenses** that are applied to any of your plan's other **copay** cannot be applied to the emergency room **copay**.

Urgent Care Services		
Urgent Medical Care *(at a non-hospital free standing facility)*	$50 **copay** per visit then the plan pays 100% No Plan Year **deductible** applies.	Not Applicable
Urgent Medical Care *(from other than a non-hospital free standing facility)*	Refer to *Emergency Medical Services* and *Physician Services* above.	Refer to *Emergency Medical Services* and *Physician Services* above.
Non-Urgent Use of Urgent Care Provider *(at an Emergency Room or a non-hospital free standing facility)*	Not Covered	Not Covered

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Outpatient Diagnostic and Preoperative Testing		
Complex Imaging Services		
Complex Imaging	$30 per visit **copay** then the plan pays 100% No Plan Year **deductible** applies.	Not Covered
Diagnostic Laboratory Testing		
	100% per procedure No Plan Year **deductible** applies.	Not Covered
Diagnostic X-Rays		
Diagnostic X-Rays (except Complex Imaging Services)	$30 per visit **copay** then the plan pays 100% No Plan Year **deductible** applies.	Not Covered

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Outpatient Surgery		
Performed in a Physician's Office	100% per visit No Plan Year **deductible** applies.	Not Covered
Performed at a Hospital	$100 per visit **copay** then the plan	Not Covered

Outpatient Facility	pays 100% No Plan Year **deductible** applies.	
Performed at any other Facility	$100 per visit **copay** then the plan pays 100% No Plan Year **deductible** applies.	Not Covered

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Inpatient Facility Expenses		
Birthing Center	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Hospital Facility Expenses		
Room and Board (including maternity)	$250 per admission **copay** then the plan pays 100% No Plan Year **deductible** applies.	Not Covered
Other than Room and Board	100% per admission No Plan Year **deductible** applies.	Not Covered
Skilled Nursing Inpatient Facility	$250 per admission **copay** then the plan pays 100%	Not Covered

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Specialty Benefits		
Home Health Care(Outpatient)	100% per visit No Plan Year **deductible** applies.	Not Covered
Skilled Nursing Care (Outpatient)	100% per visit No Plan Year **deductible** applies.	Not Covered
Private Duty Nursing (Outpatient)	100% per visit No Plan Year **deductible** applies.	Not Covered

Maximum Visit Limit per Plan Year	70 Private Duty Nursing Shifts. Up to 8 hours will be deemed to be one private duty nursing shift.	Not Covered

Hospice Benefits		
Hospice Care –Facility Expenses (Room & Board)	100% per admission No Plan Year **deductible** applies.	Not Covered
Hospice Care – Other Expenses during a stay	100% per admission No Plan Year **deductible** applies.	Not Covered
Maximum Benefit per lifetime	Unlimited days	Not Covered
Hospice Outpatient Visits	100% per visit No Plan Year **deductible** applies.	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Infertility Treatment		
Basic Infertility Expenses Coverage is for the diagnosis and treatment of the underlying medical condition causing the infertility only.	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Treatment of Mental Disorders		
MENTAL DISORDERS		
Hospital Facility Expenses		
Room and Board	$250 per admission **copay** then the plan pays 100% No Plan Year **deductible** applies.	Not Covered
Other than Room and Board	100% per admission No Plan Year **deductible** applies.	Not Covered
Physician Services	100% per admission No Plan Year **deductible** applies.	Not Covered
Inpatient Residential Treatment Facility Expenses	$250 per admission **copay** then the plan pays 100% No Plan Year **deductible** applies.	Not Covered
Inpatient Residential Treatment Facility Expenses Physician Services	100% per visit No Plan Year **deductible** applies.	Not Covered

Outpatient Treatment Of Mental Disorders		
Outpatient Services	$35 per visit **copay** then the plan pays 100% No Plan Year **deductible** applies.	Not Covered

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Inpatient Treatment of Substance Abuse		
Hospital Facility Expenses		
Room and Board	$250 per admission **copay** then the plan pays 100% No Plan Year **deductible** applies.	Not Covered
Other than Room and Board	100% per admission No Plan Year **deductible** applies.	Not Covered
Physician Services	100% per admission No Plan Year **deductible** applies.	Not Covered
Inpatient Residential Treatment Facility Expenses	$250 per admission **copay** then the plan pays 100% No Plan Year **deductible** applies.	Not Covered
Inpatient Residential Treatment Facility Expenses Physician Services	100% per visit No Plan Year **deductible** applies.	Not Covered
Outpatient Treatment of Substance Abuse		
Outpatient Services	$35 per visit **copay** then the plan pays 100% No Plan Year **deductible** applies.	Not Covered

PLAN FEATURES	**NETWORK (IOE Facility)**	**NETWORK (Non-IOE Facility)**	**OUT-OF-NETWORK**
Transplant Services Facility and Non-Facility Expenses			
Transplant Facility Expenses	$250 per admission **copay**, then the plan pays 100%	Not Covered	Not Covered
Transplant Physician (including office visits)	Payable in accordance with the type of expense incurred and the place where service is provided	Not Covered	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Other Covered Health Expenses		
Acupuncture in lieu of anesthesia	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Ground, Air or Water Ambulance	100%	Not Covered
Durable Medical and Surgical Equipment	100% per item No Plan Year **deductible** applies.	Not Covered
Clinical Trial Therapies (Experimental or Investigational Treatment)	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered.
Routine Patient Costs	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered.

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Prosthetic Devices	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Therapies		
Chemotherapy	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Infusion Therapy	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered

Radiation Therapy	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Short Term Outpatient Rehabilitation Therapies		
Outpatient Physical and Occupational Therapy only	$35 per visit **copay** then the plan pays 100% No Plan Year **deductible** applies.	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Short Term Outpatient Rehabilitation Therapies		
Speech Therapy only	$35 per visit **copay** then the plan pays 100% No Plan Year **deductible** applies.	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Spinal Manipulation		
	$35 per visit **copay** then the plan pays 100% No Plan Year **deductible** applies.	Not Covered

Spinal Manipulation Maximum visits per Plan Year	20 visits	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Autism Spectrum Disorder		
Autism - Applied Behavior Analysis	$35 per visit **copay** then the plan pays 100% No Plan Year **deductible** applies.	Not Covered

Expense Provisions

The following provisions apply to your health expense plan.
This section describes cost sharing features, benefit maximums and other important provisions that apply to your Plan. The specific cost sharing features and the applicable dollar amounts or benefit percentages are contained in the attached health expense sections of this *Schedule of Benefits*.

This *Schedule of Benefits* replaces any *Schedule of Benefits* previously in effect under your plan of health benefits.

KEEP THIS SCHEDULE OF BENEFITS WITH YOUR BOOKLET.

Covered expenses that are subject to the **deductibles** include covered expenses provided under the Medical or **Prescription drug** Plans, as applicable. Integration is with the Rx third party vendor.

Copayments and Benefit Deductible Provisions

Copayment, Copay
This is a specified dollar amount or percentage of the **negotiated charge** required to be paid by you at the time you receive a covered service from a **network provider**. It represents a portion of the applicable expense.

Per Admission Copayment
A Per Admission **Copayment** is an amount you are required to pay when you or a covered dependent have a **stay** in an inpatient facility. A **copayment** is a specified dollar amount or percentage of the **negotiated charge** required to be paid by you at the time you receive a covered service from a **network provider**. It represents a portion of the applicable expense.

Separate **copayments** may apply per facility. These **copayments** are in addition to any other **copayments** applicable under this plan. They may apply to each **stay** or they may apply on a per day basis up to a per admission maximum amount.

Covered expenses applied to the per admission **copayment** cannot be applied to any other **copayment** required in your plan. Likewise, **covered expenses** applied to your plan's other **copayments** cannot be applied to meet the per admission **copayment**.

Payment Provisions

Payment Percentage
This is the percentage of your **covered expenses** that the plan pays and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as the "Plan Payment Percentage". Once applicable **deductibles** have been met, your plan will pay a percentage of the **covered expenses**, and you will be responsible for the rest of the costs. The payment percentage may vary by the type of expense. Refer to your *Schedule of Benefits* for payment percentage amounts for each covered benefit.

Maximum Out-of-Pocket Limit
The **Maximum Out-of-Pocket Limit** is the maximum amount you are responsible to pay for **covered expenses** during the Plan Year. This Plan has an individual **Maximum Out-of-Pocket Limit**. As to the individual **Maximum Out-of-Pocket Limit**, each of you must meet your **Maximum Out-of-Pocket Limit** separately and they cannot be combined and applied towards one limit.

Certain **covered expenses** do not apply toward the **Maximum Out-of-Pocket Limit**. See list below.

Network Provider Maximum Out-of-Pocket Limit

Individual
Once the amount of eligible **network provider** expenses you or your covered dependents have paid during the Plan Year meets the individual **Maximum Out-of-Pocket Limit**, this Plan will pay 100% of such **covered expenses** that apply toward the limit for the remainder of the Plan Year for that person.

Family Maximum Out-of-Pocket Limit
When you and each of your covered dependents incur **covered expenses** that apply towards the individual Plan Year **network provider Maximum Out-of-Pocket Limit**, these expenses will also count toward a family **network provider Maximum Out-of-Pocket Limit**.

To satisfy this family **network provider Maximum Out-of-Pocket Limit** for the rest of the Plan Year, the following must happen:

> The family **Maximum Out-of-Pocket Limit** is a cumulative **Maximum Out-of-Pocket Limit** for all family members. The family **network provider Maximum Out-of-Pocket Limit** can be met by a combination of family members with no single individual within the family contributing more than the individual **network provider Maximum Out-of-Pocket Limit** amount in a Plan Year.

Covered expenses that are subject to the **Maximum Out-of-Pocket Limit** include **prescription drug** expenses provided under the Medical or **Prescription drug** Plans, as applicable. Integration is with the Rx third party vendor.

Expenses That Do Not Apply to Your Out-of-Pocket Limit
Certain covered expenses do not apply toward your plan **out-of-pocket** limit. These include:

- Non-covered expenses;
- Expenses for non-emergency use of the emergency room;
- Expenses incurred for non-urgent use of an **urgent care provider**; and
- Expenses that are not paid, or **precertification** benefit reductions because a required **precertification** for the service(s) or supply was not obtained from **Aetna**.

General

This Schedule of Benefits replaces any similar Schedule of Benefits previously in effect under your plan of benefits. Requests for coverage other than that to which you are entitled in accordance with this Schedule of Benefits cannot be accepted. This Schedule is part of your Booklet and should be kept with your Booklet.