RICE UNIVERSITY
Effective Date: 07-01-2019
Aetna Select℠

PLAN DESIGN & BENEFITS
ADMINISTERED BY AETNA HEALTH INSURANCE COMPANY - SELF-FUNDED

PLAN FEATURES	IN-NETWORK DESIGNATED PROVIDERS
Benefit Limitations - For any service or supply that is subject to a maximum visit, day, or dollar limitation on a per year basis, the benefit year begins on the effective date of the plan unless otherwise mandated. Refer to your plan documents for more information.	
Deductible (per plan year)	None Individual None Family
Member Coinsurance	Covered 100%
Applies to all expenses unless otherwise stated.	
Payment Limit (per plan year)	$1,500 Individual $3,000 Family
Certain member cost sharing elements may not apply toward the Payment Limit. Pharmacy expenses do not 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.	
Primary Care Physician Selection	Required
Referral Requirement	Required
Network Designations- In order to be covered at the preferred in-network benefit level you must use a designated provider for care. If you receive care from a non-designated provider your care may be paid at the out-of-network benefit level or may not be covered at all.	
PREVENTIVE CARE	**IN-NETWORK DESIGNATED PROVIDERS**
Routine Adult Physical Exams/ Immunizations	Covered 100%
1 exam every 12 months up to age 65, 1 exam every 12 months age 65 and older	
Routine Well Child Exams	Covered 100%
7 exams first 12 months, 3 exams 13th - 24th months, 3 exams 25th - 36th months, 1 exam per 12 months thereafter to age 22.	
Routine Gynecological Care Exams	Covered 100%
1 exam and pap smear per year, includes related fees.	
Routine Mammograms	Covered 100%
One baseline mammogram for females age 35 - 39; and one annual mammogram for females age 40 and over.	
Women's Health	Covered 100%
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	Covered 100%
Recommended: For covered males age 40 and over.	
Prostate-specific Antigen Test	Covered 100%
Recommended: For covered males age 40 and over.	
Colorectal Cancer Screening	Covered 100%
Recommended: For all members age 45 and over.	
Routine Eye Exams	Not Covered
Routine Hearing Screening	Covered 100%

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Medications	Certain over-the-counter preventive medications covered 100% in network.
PHYSICIAN SERVICES	**IN-NETWORK**
Primary Care Physician Visits	$30 copay
Specialist Office Visits	$40 copay
Hearing Exams 1 routine exam per 12 months.	Covered 100%
Pre-Natal Maternity	Covered 100%
Walk-in Clinics	$30 copay
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.	
Allergy Testing	Your cost sharing is based on the type of service and where it is performed
Allergy Injections	Your cost sharing is based on the type of service and where it is performed. Covered 100% when an office visit charge is not applicable.
DIAGNOSTIC PROCEDURES	**IN-NETWORK**
Diagnostic X-ray	$40 copay
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 Laboratory	Covered 100%
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 Complex Imaging	$40 copay
EMERGENCY MEDICAL CARE	**IN-NETWORK DESIGNATED PROVIDERS**
Urgent Care Provider	$50 copay
Non-Urgent Use of Urgent Care Provider	Not Covered
Emergency Room Copay waived if admitted	$200 copay
Non-Emergency Care in an Emergency Room	Not Covered
Emergency Use of Ambulance	Covered 100%
Non-Emergency Use of Ambulance	Not Covered
HOSPITAL CARE	**IN-NETWORK DESIGNATED PROVIDERS**
Inpatient Coverage	$300 copay
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Inpatient Maternity Coverage (includes delivery and postpartum care)	$300 copay
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Outpatient Hospital	Covered 100%
The member cost sharing applies to all covered benefits incurred during a member's outpatient stay.	
Outpatient Surgery - Hospital	$100 copay
The member cost sharing applies to all covered benefits incurred during a member's outpatient stay.	
Outpatient Surgery - Freestanding Facility	$100 copay
The member cost sharing applies to all covered benefits incurred during a member's outpatient stay.	

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MENTAL HEALTH SERVICES	IN-NETWORK DESIGNATED PROVIDERS
Inpatient	$300 copay
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Outpatient	$40 copay
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
Other Mental Health Services	Covered 100%
SUBSTANCE ABUSE	**IN-NETWORK DESIGNATED PROVIDERS**
Inpatient	$300 copay
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Residential Treatment Facility	$300 copay
Substance Abuse Office Visits	$40 copay
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
Other Substance Abuse Services	Covered 100%
OTHER SERVICES	**IN-NETWORK DESIGNATED PROVIDERS**
Skilled Nursing Facility	$300 copay
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Home Health Care	Covered 100%
Limited to 3 intermittent visits per day by a participating home health care agency; 1 visit equals a period of 4 hrs or less.	
Hospice Care - Inpatient	Covered 100%
Your cost sharing applies to all covered benefits incurred during your inpatient stay.	
Hospice Care - Outpatient	Covered 100%
Your cost sharing applies to all covered benefits incurred during your outpatient visit.	
Private Duty Nursing	Covered 100%
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	$40 copay
Includes speech, physical, occupational therapy	
Spinal Manipulation Therapy	$40 copay
Limited to 20 visits per year	
Habilitative Physical Therapy	Not Covered
Habilitative Occupational Therapy	Not Covered
Habilitative Speech Therapy	Not Covered
Autism Behavioral Therapy	Refer to MBH Outpatient Mental Health
Combined with outpatient mental health visits	
Autism Applied Behavior Analysis	Covered 100%
Autism Physical Therapy	$40 copay
Autism Occupational Therapy	$40 copay
Autism Speech Therapy	$40 copay
Durable Medical Equipment	Covered 100%
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.
Affordable Care Act mandated Women's Contraceptives	Covered 100%; deductible waived
Women's Contraceptive drugs and devices not obtainable at a pharmacy	Covered 100%; deductible waived

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Infusion Therapy Administered in the home or physician's office	Your cost sharing is based on the type of service and where it is performed
Infusion Therapy Administered in an outpatient hospital department or freestanding facility	Your cost sharing is based on the type of service and where it is performed
Transplants	$300 copay Preferred coverage is provided at an IOE contracted facility only.
Bariatric Surgery	$300 copay Preferred coverage is provided at an IOQ contracted facility only.
FAMILY PLANNING	**IN-NETWORK DESIGNATED PROVIDERS**
Infertility Treatment	Applicable cost sharing based on the type of service performed and place of service where rendered
Diagnosis and treatment of the underlying medical condition only.	
Comprehensive Infertility Services Artificial insemination and ovulation induction	Not Covered
Advanced Reproductive Technology (ART)	Not Covered
In-vitro fertilization (IVF), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI), or ovum microsurgery	
Vasectomy	Covered 100%
Tubal Ligation	Covered 100%
PHARMACY	**IN-NETWORK**
Pharmacy coverage is provided by Express Scripts, Inc.	
GENERAL PROVISIONS	
Dependents Eligibility - Spouse, children from birth to age 26 regardless of student status.	

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 Health Inc. 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. 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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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
• 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.
• 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/enhancement, including therapy, supplies or counseling or prescription drugs.
• Special duty nursing.
• Therapy or rehabilitation other than those listed as covered.
• 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.

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

Translation of this material into another language may be available. Please call Member Services at the number on the back of your ID card.

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.**

Aetna and MinuteClinic, LLC (which either operates or provides certain management support services to MinuteClinic-branded walk-in clinics) are both within the CVS Health family.