

	TEHP Low Utilizer Plan	TEHP HD Plan	TEHP Mid Utilizer Plan	TEHP High Utilizer Plan	TEHP Select Plan This plan not accepting new enrollees. Only available to current Select Plan holders.
<b>Plan Features</b>					
Type of Coverage	Point of Service	Point of Service	Point of Service	Point of Service	Point of Service
Network	CHOICE - PHCS/Multiplan and Multiple Texas Hospital and Provider Systems	CHOICE - PHCS/Multiplan and Multiple Texas Hospital and Provider Systems	CHOICE - PHCS/Multiplan and Multiple Texas Hospital and Provider Systems	CHOICE - PHCS/Multiplan and Multiple Texas Hospital and Provider Systems	CHOICE - PHCS/Multiplan and Multiple Texas Hospital and Provider Systems
PCP Requirement	No	No	No	No	No
Individual/ Family Deductible	\$6000/ \$12000	\$3000/ \$6000	\$3000/ \$6000	\$1500/ \$3000	\$1500/ \$3000
Coinsurance	70% after Deductible	70% after Deductible	70% after Deductible	70% after Deductible	70% after Deductible
Individual/ Family Out of Pocket Maximum	\$7500/ \$15000	\$7,500/ \$15,000	\$7,500/ \$15,000	\$7,500/ \$15,000	\$7,500/ \$15,000
<b>PHYSICIAN SERVICES</b>					
Primary Care Office Visit	\$30 Copay	30% after deductible	\$30 Copay	\$30 Copay	\$30 Copay
Specialist Office Visit	\$70 Copay	30% after deductible	\$70 Copay	\$70 Copay	\$70 Copay
Services provided in a Physicians Office	30% after deductible	30% after deductible	30% after deductible	30% after deductible	30% after deductible
Urgent Care	\$50 Copay	30% after deductible	\$50 Copay	\$50 Copay	\$50 Copay
Telemedicine Services	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay
<b>PREVENTIVE &amp; WELLNESS SERVICES</b>					
Preventive Health Services	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay
<b>HOSPITAL/FACILITY SERVICES</b>					
Inpatient Hospitalization (Prior Auth Required)	30% after deductible	30% after deductible	30% after deductible	30% after deductible	30% after deductible
Inpatient Visits - Physician	30% after deductible	30% after deductible	30% after deductible	30% after deductible	30% after deductible
Inpatient Surgery (Prior Auth Required/ Second surgical opinion may be required)	30% after deductible	30% after deductible	30% after deductible	30% after deductible	30% after deductible
Outpatient Hospital Free Standing Facility Services and Surgery (Prior Auth Required)	30% after deductible	30% after deductible	30% after deductible	30% after deductible	30% after deductible
Anesthesia	30% after deductible	30% after deductible	30% after deductible	30% after deductible	30% after deductible
Emergency Room Services (Life threatening Services)	30% after deductible	30% after deductible	30% after deductible	30% after deductible	30% after deductible
Emergency Room Services (Non-Emergent Care)	Not Covered / 100% paid by Member	Not Covered / 100% paid by Member	Not Covered / 100% paid by Member	Not Covered / 100% paid by Member	Not Covered / 100% paid by Member
<b>DIAGNOSTIC SERVICES</b>					
Laboratory Services	30% after deductible	30% after deductible	30% after deductible	30% after deductible	\$70 Copay
Radiology (x-ray, ultrasound)	30% after deductible	30% after deductible	30% after deductible	30% after deductible	\$70 Copay
CT / MRI / MRA / PET Scan (Prior Auth Required)	30% after deductible	30% after deductible	30% after deductible	30% after deductible	\$500 Copay
<b>PREGNANCY BENEFITS</b>					
Physician Visits	\$30 Copay	30% after deductible	\$30 Copay	\$30 Copay	\$30 Copay
Childbirth/Delivery	30% after deductible	30% after deductible	30% after deductible	30% after deductible	30% after deductible

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<b>OTHER SERVICES</b>						
<b>Allergy Office visits</b> (The copay applies for the office visit only)		\$100 Copay	30% after deductible	\$100 Copay	\$100 Copay	\$100 Copay
<b>Allergy Services</b> Testing / injections (Prior Auth Required)		30% after deductible	30% after deductible	30% after deductible	30% after deductible	30% after deductible
<b>Second Surgical Opinion</b> (may be required)		\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay	\$0 Copay
<b>Home Health Care</b> (Limited to 30 visits per plan year) (Prior Auth Required)		30% after deductible	30% after deductible	\$30 Copay	\$30 Copay	\$30 Copay
<b>Hospice Care</b> (Prior Auth Required)		30% after deductible	30% after deductible	\$30 copay	\$30 copay	\$30 copay
<b>Treatment for Chemical Abuse &amp; Dependency</b> (Prior Auth Required)	<b>(In-Patient)</b>	30% after deductible	30% after deductible	30% after deductible	30% after deductible	30% after deductible
<b>Treatment for Chemical Abuse &amp; Dependency</b> (Prior Auth Required)	<b>(Out-Patient)</b>	\$30 Copay	30% after deductible	\$30 Copay	\$30 Copay	\$30 Copay
<b>Rehabilitation/Habilitation Services</b> (limited to 30 visits per plan year)		30% after deductible	30% after deductible	\$30 Copay	\$30 Copay	\$30 Copay
<b>Emergency Medical Transportation</b>		30% after deductible	30% after deductible	30% after deductible	30% after deductible	30% after deductible

\* Deductible represents Maximum out of pocket expense for members of Aetna Low, Mid, and High balance covered by embedded GAP coverage.

<b>PHARMACY BENEFITS</b>						
<b>Preventive Prescriptions</b>						
<b>Pharmacy Retail – up to a 30 day supply</b>	Generic - \$0 Copay (Limited to Preventive Generic)	Generic - \$0 Copay No deductible (Limited to Preventive Generic)	Generic - \$0 Copay (Limited to Preventive Generic)	Generic - \$0 Copay (Limited to Preventive Generic)	Generic - \$0 Copay (Limited to Preventive Generic)	Generic - \$0 Copay (Limited to Preventive Generic)
<b>Pharmacy Mail Order – up to a 90 day supply</b>	Generic - \$0 Copay (Limited to Preventive Generic)	Generic - \$0 Copay No deductible (Limited to Preventive Generic)	Generic - \$0 Copay (Limited to Preventive Generic)	Generic - \$0 Copay (Limited to Preventive Generic)	Generic - \$0 Copay (Limited to Preventive Generic)	Generic - \$0 Copay (Limited to Preventive Generic)
<b>Non-Preventive Prescriptions</b>						
<b>Pharmacy Retail – up to a 30 day supply</b>	Generic – \$10 Copay	Generic – 20% after deductible	Generic – \$10 Copay	Generic – \$10 Copay	Generic – \$10 Copay	Generic – \$10 Copay
<b>Pharmacy Mail Order – 90 day supply</b>	Generic – \$25 Copay	Generic – 20% after deductible	Generic – \$25 Copay	Generic – \$25 Copay	Generic – \$25 Copay	Generic – \$25 Copay
<b>Pharmacy Retail – up to a 30 day supply</b>	Preferred Brand – \$35 Copay	Preferred Brand – 20% after deductible	Preferred Brand – \$35 Copay	Preferred Brand – \$35 Copay	Preferred Brand – \$35 Copay	Preferred Brand – \$35 Copay
<b>Pharmacy Mail Order – 90 day supply</b>	Preferred Brand – \$87.50 Copay	Preferred Brand – 20% after deductible	Preferred Brand – \$87.50 Copay	Preferred Brand – \$87.50 Copay	Preferred Brand – \$87.50 Copay	Preferred Brand – \$87.50 Copay
<b>Non Preferred Brand</b>	Not Covered / 100% paid by Member	20% after deductible	Not Covered / 100% paid by Member	Not Covered / 100% paid by Member	Not Covered / 100% paid by Member	Not Covered / 100% paid by Member
<b>Specialty Drugs / Infusion Therapy (pre-certification required)</b>	* \$0 copay if qualified under the RX Contain Program, otherwise subject to deductible then 50% to a max copay of \$500	50% after deductible Max \$500	* \$0 copay if qualified under the RX Contain Program, otherwise subject to deductible then 50% to a max copay of \$500	* \$0 copay if qualified under the RX Contain Program, otherwise subject to deductible then 50% to a max copay of \$500	* \$0 copay if qualified under the RX Contain Program, otherwise subject to deductible then 50% to a max copay of \$500	* \$0 copay if qualified under the RX Contain Program, otherwise subject to deductible then 50% to a max copay of \$500

# MONTHLY PREMIUM

	TEHP LOW UTILIZER PLAN	TEHP HD PLAN	TEHP MID UTILIZER PLAN	TEHP HIGH UTILIZER PLAN	TEHP SELECT PLAN
Employee Only	\$401.30	\$431.30	\$446.02	\$566.19	\$644.10
Employee and Spouse	\$1,096.40	\$1,151.00	\$1,167.72	\$1,329.98	\$1,359.65
Employee and Children	\$688.83	\$728.44	\$753.30	\$905.57	\$1,072.77
Employee and Family	\$1,351.52	\$1,414.40	\$1,445.36	\$1,709.40	\$1,958.40