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# Member handbook and other important information about your health benefits

**For the Aetna HMO plan**

**Aetna Health Inc.  
Consumer Disclosure and Member Handbook**



**[www.aetna.com](http://www.aetna.com)**

Aetna Health Inc. is licensed by the Texas Department of Insurance to operate as a Health Maintenance Organization (HMO) within an approved service area.

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# Getting help

## Contact us

For more information, including information about participating health care providers, you may call **1-888-982-3862** or write to **Aetna, P.O. Box 569441, Dallas, TX, 75356-9441**.

Member Services can help with your questions. To contact Member Services, call the toll-free number on your ID card. You can also send Member Services an e-mail. Just go to your secure Aetna Navigator® member website at **www.aetna.com**. Click on “Contact Us” after you log on.

- Understand how your plan works or what you will pay
- Get information about how to file a claim
- Get a referral
- Find care outside your area
- File a complaint or appeal
- Get copies of your plan documents
- Connect to behavioral health services (if included in your plan)
- Find specific health information
- Learn more about our Quality Management program
- And more

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## Help for those who speak another language and for the hearing impaired

Do you need help in another language? Member Services representatives can connect you to a special line where you can talk to someone in your own language. You can also get interpretation assistance for registering a complaint or appeal.

*Language hotline – 1-888-982-3862 (140 languages are available. You must ask for an interpreter.)*

*TDD 1-800-628-3323 (hearing impaired only)*

## Ayuda para las personas que hablan otro idioma y para personas con impedimentos auditivos

¿Necesita ayuda en otro idioma? Los representantes de Servicios al Miembro le pueden conectar a una línea especial donde puede hablar con alguien en su propio idioma. También puede obtener asistencia de un intérprete para presentar una queja o apelación.

*Línea directa – 1-888-982-3862 (Tenemos 140 idiomas disponibles. Debe pedir un intérprete.)*

*TDD 1-800-628-3323 (sólo para personas con impedimentos auditivos)*

# Information about specific benefits

## Medically necessary covered benefits

As an Aetna HMO member, you will be entitled to the medically necessary covered benefits as listed in the Certificate of Coverage. You'll receive this document after you enroll.

This plan does not provide coverage for all health care expenses and includes exclusions and limitations. These exclusions and limitations are outlined in your Certificate of Coverage. Read your Certificate of Coverage carefully to determine which health care services are covered benefits and to what extent.

You'll also find a summary of exclusions and limitations within this document. To find out before you enroll whether your Certificate of Coverage contains exclusions and limitations different from those listed in this document, contact your employer's benefits manager. You may also request a sample copy of the Aetna Certificate of Coverage by calling us, toll free, at **1-888-982-3862**.

In order for benefits to be covered, they must be "medically necessary" and, in some cases, must also be preauthorized by Aetna. Refer to the "We check if it's medically necessary" and "Preauthorization" sections of this document for more about those topics.

For the purpose of coverage, except for certain specialist benefits (referred to as "direct access" benefits) or in a medical emergency or an urgent care situation outside the service area, you must access the following benefits through your primary care physician (PCP) either directly or with a PCP referral. Although listed as covered below, benefits are subject to the exclusions and limitations as listed in the Certificate of Coverage. You are also responsible for cost-sharing as outlined in your Certificate of Coverage.

- Primary care physician and specialist physician (upon referral) outpatient and inpatient visits
- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF)
- Routine adult physical examinations (including immunizations, routine vision and hearing screenings)
- Routine well-child care (including immunizations)
- Routine cancer screenings (which include screening mammograms; prostate specific antigen (PSA) tests; digital-rectal exams (DRE); fecal occult blood tests (FOBT); sigmoidoscopies; double contrast barium enemas (DCBE) and colonoscopies)
- Routine gynecological exams, including routine Pap smears
- Routine vision, speech and hearing screenings (including newborns)
- Injections, including allergy desensitization injections
- Diagnostic, laboratory, X-ray services
- Cancer chemotherapy and cancer hormone treatments and services that have been approved by the United States Food and Drug Administration for general use in treatment of cancer
- Diagnosis and treatment of gynecological or infertility problems by participating gynecologists or participating infertility specialists. Benefits for infertility treatment are

limited and you should call **1-800-575-5999** for more information about coverage under your specific health plan.

- Outpatient and inpatient pre-natal and postpartum care and obstetrical services
- Inpatient hospital & skilled nursing facility benefits.
- Except in an emergency, all services are subject to preauthorization by Aetna. Coverage for skilled nursing facility benefits is subject to the maximum number of days, if any, listed in your specific health plan.
- Transplants that are nonexperimental or noninvestigational. Covered transplants must be approved by an Aetna medical director before the surgery. The transplant must be performed at a hospital specifically approved and designated by Aetna to perform these procedures. If we deny coverage of a transplant based on lack of medical necessity, the member may request a review by an independent review organization (IRO). More information can be found in the "Complaints, Appeals and Independent Review" section of the plan documents.
- Outpatient surgical services and supplies in connection with a covered surgical procedure. Nonemergency services and supplies are subject to preauthorization by Aetna.
- Chemical dependency/substance abuse benefits. There is a lifetime maximum of 3 treatment episodes for inpatient hospital, inpatient treatment facility, partial hospitalization and outpatient treatment combined.
- Outpatient and inpatient care benefits are covered for detoxification.
- Outpatient rehabilitation visits are covered to a participating behavioral health provider upon referral by the PCP for diagnostic, medical or therapeutic rehabilitation services for chemical dependency.
- Inpatient rehabilitation benefits are covered for medical, nursing, counseling or therapeutic rehabilitation services in an appropriately licensed participating facility upon referral by the member's participating behavioral health provider for chemical dependency.
- Mental health benefits. A member is covered for services for the treatment of mental or behavioral conditions provided through participating behavioral health providers.
- Up to 20 outpatient visits are covered for short-term, outpatient evaluative and crisis intervention or home health mental health services.
- Serious mental illness: diagnosis and medical treatment of a serious mental illness. Serious mental illness means the following psychiatric illnesses (as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM)III-R): schizophrenia; paranoid and other psychotic disorders; bipolar disorders (hypomanic; mixed, manic and depressive); major depressive disorders (single episode or recurrent); schizoaffective disorders (bipolar or depressive); pervasive developmental disorders; obsessive-compulsive disorders and depression in childhood and adolescence.
- Inpatient benefits are provided for a maximum of 45 days per calendar year.
- Outpatient benefits are provided for a maximum of 60 visits per calendar year.
- Emergency medical services, including screening/evaluation to determine whether an emergency medical condition exists,

and for emergency medical transportation. See the “Emergency and urgent care and care after office hours” section for more information. As a reminder, a referral from your PCP is not required for this service.

- Urgent, nonemergent care services obtained from a licensed physician or facility outside the service area if (i) the service is a covered benefit; (ii) the service is medically necessary and immediately required because of unforeseen illness, injury, or condition; and (iii) it was not reasonable, given the circumstances, for the member to return to the Aetna HMO service area for treatment. As a reminder, a referral from your PCP is not required for this service. Inpatient and outpatient physical, occupational and speech rehabilitation services when they are medically necessary and meet or exceed the treatment goals established for the patient.
- We will not exclude coverage for cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing or treatment, neurofeedback therapy, remediation, postacute transition services, or community reintegration services necessary as a result of and related to an acquired brain injury.
- Cardiac rehabilitation benefits following an inpatient hospital stay. A limited course of outpatient cardiac rehabilitation is covered following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction.
- Home health benefits rendered by a participating home health care agency. Preauthorization must be obtained from the member’s attending participating physician. Home health benefits are not covered if Aetna determines the treatment setting is not appropriate or if there is a more cost-effective setting in which to provide appropriate care.
- Hospice care medical benefits when preauthorized.
- Initial provision of prosthetic appliances. Covered prosthetic appliances generally include those items covered by Medicare unless otherwise excluded under your specific health plan.
- Certain injectable medications when an oral alternative drug is not available and when preauthorized, unless excluded under your specific health plan
- Mastectomy-related services including reconstructive breast surgery, prostheses and lymph edema, as described in your specific health plan
- Voluntary sterilizations
- Administration, processing of blood, processing fees, and fees related to autologous blood donations only
- Diagnostic and surgical treatment of the temporomandibular joint that is medically necessary as a result of an accident, a trauma, a congenital defect, a developmental defect or a pathology
- Diabetic outpatient self-management training and education (including medical nutrition therapy for the treatment of diabetes), equipment and supplies (including blood glucose monitors and monitor-related supplies including test strips and lancets; injection aids; syringes and needles; insulin infusion devices; and insulin and other pharmacological agents for controlling blood sugar)
- Certain infertility services. Refer to the “Covered Benefits” section of the Certificate of Coverage for detailed information. Benefits

for infertility treatment are limited. Call **1-800-575-5999** for more information about coverage under your specific health plan.

- Coverage is provided for formulas necessary for the treatment of phenylketonuria or other heritable diseases to the same extent as for drugs available only on the orders of a physician

*Note: Consumer Choice health benefits plans issued pursuant to the Texas Consumer Choice of Benefits Health Insurance Plan Act do not include all state mandated health insurance benefits. Benefits provided under a Consumer Choice Benefits plan are provided at a reduced level from what is mandated or are excluded completely from the plan. The covered benefits listed below may not be available under a Consumer Choice health benefits plan.*

See also Exclusions and limitations on page 6.

## Prescription drug benefit

### Some plans encourage generic drugs over brand- name drugs

A generic drug is the same as a brand-name drug in dose, use and form. They are FDA approved and safe to use.

Generic drugs usually sell for less; so many plans give you incentives to use generics. That doesn’t mean you can’t use a brand-name drug, but you’ll pay more for them. You’ll not only pay your normal share of the cost, you’ll also pay the difference in the two prices.

### We may also encourage you to use certain drugs

Some plans encourage you to buy certain prescription drugs over others. The plan may even pay a larger share for those drugs. We list those drugs in the Aetna Preferred Drug Guide (also known as a “drug formulary”). This list shows which prescription drugs are covered on a preferred basis. It also explains how we choose medications to be on the list.

When you get a drug that is not on the preferred drug list, your share of the cost will usually be more. Check your plan documents to see how much you will pay. If your plan has an “open formulary,” that means you can use those drugs, but you’ll pay the highest copay under the plan. If your plan has a “closed formulary,” those drugs are not covered.

### Drug Manufacturer Rebates

Drug manufacturers may give us rebates when our members buy certain drugs. While rebates apply mostly to drugs on the preferred drug list, they may apply to nonpreferred drugs as well. However, your share of the cost (copay, deductible, coinsurance) is based on the price of the drug before any rebate.

### What does that mean to you?

If you pay a flat cost for your prescriptions in your plan there is no difference. Some plans members pay a percentage of the drug cost. If you pay a percentage of the cost, your cost for a drug on the preferred drug list could be more than the cost for a nonpreferred drug because the price of the drug is not reduced by any rebate.

### Mail-order and specialty-drug services are from Aetna-owned pharmacies

Aetna Rx Home Delivery® and Aetna Specialty Pharmacy® are pharmacies that Aetna owns. These pharmacies are for-profit entities.

### **You might not have to stick to the list**

If it is medically necessary for you to use a drug that's not on your plan's preferred drug list, you or your doctor (or pharmacist in the case of antibiotics and pain medicines) can ask us to make an exception. Check your plan documents for details.

### **You may have to try one drug before you can try another**

Step therapy means you have to try one or more "prerequisite" drugs before a "step-therapy" drug will be covered. The preferred drug list includes step-therapy drugs. Your doctor might want you to skip one of these drugs for medical reasons. If so, you or your doctor (or pharmacist in the case of antibiotics and pain medicines) can ask for a medical exception.

### **Some drugs are not covered at all**

Prescription drug plans do not cover drugs that don't need a prescription. Your plan documents might also list specific drugs that are not covered. You cannot get a medical exception for these drugs.

### **New drugs may not be covered**

Your plan may not cover drugs that we haven't reviewed yet. You or your doctor may have to get our approval to use one of these new drugs.

### **Get a copy of the preferred drug list**

The Aetna Preferred Drug Guide is posted to our website at [www.aetna.com/formulary/](http://www.aetna.com/formulary/). If you don't use the Internet you can ask for a printed copy. Just call Member Services at the toll-free number on your Aetna ID card. We are constantly adding new drugs to the list. Look online or call Member Services for the latest updates.

### **Have questions? Get answers.**

Ask your doctor about specific medications. Call Member Services (at the number on your ID card) to ask about how your plan pays for them. Your plan documents also spell out what's covered and what is not.

## **Emergency and urgent care and care after office hours**

An emergency medical condition means your symptoms are sudden and severe. If you don't get help right away, an average person with average medical knowledge will expect that you could die or risk your health. For a pregnant woman, that includes her unborn child.

Emergency care is covered anytime, anywhere in the world. If you need emergency care, follow these guidelines:

- Call 911 or go to the nearest emergency room or freestanding emergency medical care facility. If a delay would not risk your health, call your doctor or PCP.
- Tell your doctor or PCP as soon as possible afterward. A friend or family member may call on your behalf.
- Emergency care services do not require preauthorization.

### **What to do outside your Aetna service area**

You are covered for emergency and urgently needed care when you're traveling. That includes students who are away at school. When you need care right away, go to any doctor, walk-in clinic,

urgent care center or hospital emergency facility or freestanding emergency medical care facility.

We'll review the information when the claim comes in. If we think the situation was not urgent, we might ask you for more information and may send you a form to fill out. Please complete the form, or call Member Services to give us the information over the phone.

If you receive emergency care outside your Aetna service area, your health care provider may not accept payment of your cost share (copay/coinsurance) as payment in full. If the provider bills you for an amount above your cost share, you are not responsible for paying the amount. You should send the bill to the address listed on your member ID card and we will resolve any payment dispute with the provider.

### **Follow-up care for plans that require a PCP**

You may need to follow up with a doctor after your emergency. For example, you'll need a doctor to take out stitches, remove a cast or take another set of X-rays to see if you've healed. Your PCP should coordinate all follow-up care. You will need a referral for follow-up care that is not performed by your PCP. You may also need to preauthorize the services if you go outside the network.

### **After-hours care — available 24/7**

Call your doctor anytime if you have medical questions or concerns. Your doctor should have an answering service if you call after the office closes. You can also go to an urgent care center, which may have limited hours. To find a center near you, log on to [www.aetna.com](http://www.aetna.com) and search our list of doctors and other health care providers. Check your plan documents to see how much you must pay for urgent care services.

## **Costs and rules for using your plan**

### **Your costs when you go outside the network**

This plan provides out-of-network benefits only for emergency care and when medically necessary covered services are not available within the network. Otherwise, the plan covers health care services only when provided by a doctor who participates in the Aetna network. If you receive services from an out-of-network doctor or other health care provider (unless for emergency or if medically necessary services are not available in the network), you will have to pay all of the costs for the services.

When you have no choice (such as emergency and non-available in-network services), we will pay the bill as if you got care in network. You pay your plan's copayments, coinsurance and deductibles for your in-network level of benefits. Under federal health care reform (Affordable Care Act), the government will allow some plans an exception to this rule. Contact Aetna if your provider asks you to pay more. We will help you determine if you need to pay that bill.

### **Your financial responsibility**

You are responsible for all applicable copayments and premiums under your particular plan. This information is included, with specific amounts, in your enrollment kit. You are also financially responsible for all noncovered services and, in some cases, out-of-area expenses. (Out-of-area hospital emergency facility,

freestanding emergency medical care facility or, urgent care expenses are reimbursed by the health plan. Also covered are medically necessary services outside the network when otherwise not available within the network.)

All doctors and other health care providers who participate in the Aetna HMO network have agreed to file claims with Aetna on your behalf. Providers have agreed to look to Aetna, not to enrollees, for payment of covered services. If you receive a bill for covered services, please contact us at the number on your ID card or at **1-888-982-3862**.

## What you pay

You will share in the cost of your health care. These are called “out-of-pocket” costs. Your plan documents show the amounts that apply to your specific plan. Those costs may include:

- Copay – A fixed amount (for example, \$15) you pay for covered health care services. You usually pay this when you receive the service. The amount can vary by the type of service. For example, the copay for your primary doctor’s office visit may be different than a specialist’s office visit.
  - Inpatient Hospital Copay – This copay applies when you are a patient in a hospital.
  - Emergency Room or Freestanding Emergency Medical Care Facility Copay – This is the amount you pay when you go to the emergency room or a freestanding emergency medical care facility. If you are admitted to the hospital within 24 hours, you won’t have to pay it.
- Coinsurance – Your share of the costs of a covered service. Coinsurance is calculated as a percent — such as 20% — of the allowed amount for the service. For example, if the health plan’s allowed amount for an office visit is \$100 and you’ve met your deductible, your coinsurance payment of 20% would be \$20. The health plan pays the rest of the allowed amount.
- Deductible – Some plans include a deductible. This is the amount you owe for health care services before your health plan begins to pay. For example, if your deductible is \$1,000, your plan won’t pay anything until you have paid \$1,000 for any covered health care services that are subject to the deductible. The deductible may not apply to all services.

## Exclusions and limitations

The following is a summary of services that are not covered unless your employer has included them in your plan or purchased a separate, optional rider. You are responsible for all costs. Other exclusions and limitations may apply to your specific plan so be sure to consult your Certificate of Coverage for more detail.

### Expenses for these health care services and supplies are not covered:

- Acupuncture and acupuncture therapy, except when performed by a participating physician as a form of anesthesia in connection with covered surgery
- Ambulance or medical transportation services for nonemergency transportation
- Bereavement counseling, funeral arrangements, pastoral counseling, financial or legal counseling, homemaker or caretaker services, respite care, and any service not solely

related to the care of the member, including but not limited to, sitter or companion services for the member or other members of the family, transportation, house cleaning, and maintenance of the house

- Biofeedback
- Blood and blood plasma, including provision of blood, blood plasma, blood derivatives, synthetic blood or blood products other than blood-derived clotting factors, the collection or storage of blood plasma, the cost of receiving the services of professional blood donors, apheresis (removal of the plasma) or plasmapheresis (cleaning and filtering of the plasma). Only administration, processing of blood, processing fees, and fees related to autologous blood donations are covered.
- Care for conditions that state or local law requires to be treated in a public facility, including but not limited to mental illness commitments
- Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury. Examples include asbestos removal, air filtration, and special ramps or doorways.
- Cosmetic surgery, or treatment relating to the consequences of, or as a result of, cosmetic surgery, including but not limited to surgery to correct gynecomastia, breast augmentation, and otoplasties. This exclusion does not apply to (i) surgery to restore normal bodily functions, including but not limited to, cleft lip and cleft palate or as a continuation of a staged reconstruction procedure, or congenital defects; (ii) breast reconstruction following a mastectomy, including the breast on which mastectomy surgery has been performed and the breast on which mastectomy surgery has not been performed; and (iii) reconstructive surgery performed on a member who is less than 18 years of age to improve the function of or to attempt to create a normal appearance of a craniofacial abnormality.
- Costs for court-ordered services, or those required by court order as a condition of parole or probation
- Custodial care
- Dental services, including false teeth. This exclusion does not apply to: the removal of bone fractures, tumors, and orthodontogenic cysts; diagnostic and medical/surgical treatment of the temporomandibular joint disorder; or medical services required when the dental services cannot be safely provided in a dentist’s office due to the member’s physical, mental or medical condition.
- Durable medical equipment and household equipment, including but not limited to crutches, braces, the purchase or rental of exercise cycles, water purifiers, hypo-allergenic pillows, mattresses or waterbeds, whirlpool or swimming pools, exercise and massage equipment, central or unit air conditioners, air purifiers, humidifiers, dehumidifiers, escalators, elevators, ramps, stair glides, emergency alert equipment, handrails, heat appliances, improvements made to a member’s house or place of business and adjustments made to vehicles
- Educational services and treatment of behavioral disorders and services for remedial education including evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, behavioral training, and cognitive rehabilitation. This includes services, treatment or educational testing and training related to behavioral (conduct)

problems, learning disabilities, or developmental delays. Special education, including lessons in sign language to instruct a member, whose ability to speak has been lost or impaired, to function without that ability, are not covered.

- Experimental or investigational procedures or ineffective surgical, medical, psychiatric or dental treatments or procedures, research studies, or other experimental or investigational health care procedures or pharmacological regimes as determined by Aetna, unless preauthorized by Aetna. This exclusion will not apply to drugs: (i) that have been granted treatment investigational new drug (IND) or Group c/treatment IND status; (ii) that are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; or (iii) when we have determined that available scientific evidence demonstrates that the drug is effective or the drug shows promise of being effective for the disease.
- Hair analysis
- Health services, including those related to pregnancy, rendered before the effective date or after the termination of the member's coverage
- Hearing aids
- Home births
- Home uterine activity monitor
- Hypnotherapy
- Infertility services not otherwise covered, including injectable infertility drugs, charges for the freezing and storage of cryopreserved embryos, charges for storage of sperm, and donor costs, including but not limited to: the cost of donor eggs and donor sperm, ovulation predictor kits, and donor egg program or gestational carriers, ZIFT, GIFT or in-vitro fertilization. Call **1-800-575-5999** for more information about exclusions.
- Injectable drugs as follows: experimental drugs or medications, or drugs or medications that have not been proven safe and effective for a specific disease or approved for a mode of treatment by the Food and Drug Administration (FDA) and the National Institutes of Health (NIH); needles, syringes and other injectable aids (except for diabetic supplies.); drugs related to the treatment of non-covered services; and drugs related to contraception (unless covered by a prescription drug rider), the treatment of infertility, and performance enhancing steroids
- Inpatient care for serious mental illness that is not provided in a hospital or mental health treatment facility; non-medical ancillary services and rehabilitation services in excess of the number of days described in the Schedule of Benefits for serious mental illness
- Inpatient treatment for mental or behavioral conditions, except for serious mental illness (unless covered by a rider to your plan)
- Military service-related diseases, disabilities or injuries for which the member is legally entitled to receive treatment at government facilities and which facilities are reasonably available to the member
- Missed appointment charges
- Non-diagnostic and non-medical/surgical treatment of temporomandibular joint disorder (TMJ)
- Oral or topical drugs used for sexual dysfunction or performance
- Orthoptic therapy (vision exercises)
- Outpatient medical consumable or disposable supplies such as syringes, incontinence pads, elastic stockings, and reagent strips. This exclusion does not apply to diabetic supplies
- Performance, athletic performance or lifestyle enhancement drugs and supplies
- Personal comfort or convenience items
- Prescription or nonprescription drugs and medicines, except as provided on an inpatient basis (unless covered by a prescription drug rider). This exclusion does not apply to diabetes supplies, including but not limited to insulin.
- Private duty or special nursing care (unless medically necessary and pre-authorized by Aetna)
- Recreational, educational, and sleep therapy, including any related diagnostic testing
- Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling, and sex therapy
- Reversal of voluntary sterilizations
- Routine foot/hand care
- Services for which a member is not legally obligated to pay in the absence of this coverage
- Services for the treatment of sexual dysfunctions or inadequacies, including therapy, supplies, or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis
- **The following services or supplies:**
  1. Those that do not require the technical skills of a medical, mental health or a dental professional
  2. Those furnished mainly for the personal comfort or convenience of the member, or any person who cares for the member, or any person who is part of the member's family, or any provider
  3. Those furnished solely because the member is an inpatient on any day in which the member's disease or injury could safely and effectively be diagnosed or treated while the member is not an inpatient
  4. Those furnished in a particular setting that could safely and effectively be furnished in a physician's or a dentist's office or other less costly setting consistent with the applicable standard of care
- Services performed by a relative of a member for which, in the absence of any health benefits coverage, no charge would be made
- Services rendered for the treatment of delays in speech development, unless resulting from disease, injury, or congenital defects
- Services required by third parties, including but not limited to, physical examinations, diagnostic services and immunizations in connection with obtaining or continuing employment, insurance, travel, school admissions or attendance, including examinations required to participate in athletics, except when such examinations are considered to be part of an appropriate schedule of wellness services
- Specific non-standard allergy services and supplies, including but not limited to, skin titration (wrinkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine auto-injections

- Special medical reports, including those not directly related to treatment of the member (i.e., reports prepared in connection with litigation)
- Spinal manipulation for subluxation
- Surgical operations, procedures or treatment of obesity
- Therapy or rehabilitation as follows: primal therapy (intense non-verbal expression of emotion expected to result in improvement or cure of psychological symptoms), chelation therapy (removal of excessive heavy metal ions from the body), rolfing, psychodrama, megavitamin therapy, purging, bio-energetic therapy, vision perception training, carbon dioxide and other therapy or rehabilitation not supported by medical and scientific evidence. This exclusion does not apply to rehabilitative services such as physical, speech and occupational therapy.
- Transsexual surgery, sex change or transformation, including any procedure or treatment or related service designed to alter a member's physical characteristics from the member's biologically determined sex to those of another sex, regardless of any diagnosis of gender role or psychosexual orientation problems
- Treatment in a federal, state, or governmental entity, including care and treatment provided in a nonparticipating hospital owned or operated by any federal, state or other governmental entity, except to the extent required by applicable laws
- Treatment of mental retardation, defects, and deficiencies
- Treatment of occupational injuries and occupational diseases
- Unauthorized services, including any nonemergency service obtained by or on behalf of a member without prior referral by the member's PCP or certification by Aetna
- Vision care services and supplies, including orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision) and radial keratotomy, including related procedures designed to surgically correct refractive errors
- Weight reduction programs or dietary supplements

## Preauthorization: Getting approvals for services

Sometimes we will pay for care only if we have given an approval before you get it. We call that "preauthorization."

Preauthorization is usually limited to more serious care like surgery or being admitted to a hospital or skilled nursing facility. Your plan documents list all the services that require preauthorization. When you get care from a doctor in the Aetna network, your doctor takes care of preauthorization. But if you get your care outside our network, you must call us for preauthorization when that's required. Your plan documents list all the services that require you to get preauthorization. If you don't, you will have to pay for all or a larger share of the cost of the service. Even with preauthorization, if you receive services from an out-of-network provider, you will usually pay more.

Call the number shown on your Aetna ID card to begin the process. You must get the approval before you receive the care.

Preauthorization is not required for emergency services.

## What happens if your doctor leaves the health plan

If your doctor or other health care provider leaves the plan, you may be able to continue to see that doctor during a transitional period. For information on continuing your care in these situations, please refer to your Certificate of Coverage or call Member Services at the toll-free number on your ID card.

## What to do if you disagree with us

### Complaints, appeals and external review

We are interested in hearing all comments, questions, complaints or appeals from customers, members and doctors. Aetna is prohibited from retaliation against any of those individuals or groups for initiating a complaint or appeal.

The complaint and appeal processes can be different depending on your plan and where you live. Some states have laws that include their own processes. But these state laws don't apply to many plans we administer. So it's best to check your plan documents or talk to someone in Member Services to see how it works for you.

**Call Member Services to file a verbal complaint or to ask for the appropriate address to mail a written complaint.** The phone number is on your Aetna ID card. You can also e-mail Member Services through the secure member website at [www.aetna.com](http://www.aetna.com), or write to:

Aetna  
P.O. Box 14586  
Lexington, KY 40512-1486

If you're not satisfied after talking to a Member Services representative, you can ask that your issue be sent to the appropriate department.

### If you don't agree with a denied claim, you can file an appeal.

To file an appeal, follow the directions in the letter or explanation of benefits statement that explains that your claim was denied. The letter also tells you what we need from you and how soon we will respond. We will send an acknowledgement when we receive your request. This notice will explain the appeals process and what to expect next.

Appeals of medical necessity denials will be reviewed by a Texas-licensed physician who was not involved in the original decision.

For more information about your right to an appeal, contact the Texas Department of Insurance. The website for the Texas Department of Insurance is [www.tdi.texas.gov](http://www.tdi.texas.gov). Their toll-free telephone number is **1-800-578-4677**.

### A "rush" review may be possible

If your doctor thinks you cannot wait 30 days, ask for an "expedited review." Examples include denials for emergency care and for continued hospital stays. We will respond as soon as is practicable, but not later than within 1 working day.



## Get a review from someone outside Aetna

If we determine that a service or supply is not medically necessary, or if it is experimental or investigational, you (or a person acting on your behalf, or your doctor/health care provider) may appeal to the Texas independent review organization (IRO) orally or in writing, after exhausting the internal review process. If you have a life-threatening condition (that is, a disease or condition in which death is probable unless the course of the disease or condition is interrupted), you may appeal a medical necessity, experimental or investigational denial immediately to an IRO, as described below, without first exhausting this internal appeal process. We will follow the external reviewer's decision. We will also pay the cost of the review.

## Binding Arbitration

Most of our plans contain the following binding arbitration provision. Check your plan documents to see if it applies to you.

*"Aetna, Contract Holder and you may agree to binding arbitration to resolve any controversy, dispute or claim between them arising out of or relating to this Certificate, whether stated in tort, contract, statute, claim for benefits, bad faith, professional liability or otherwise ("Claim"). Said binding arbitration shall be administered pursuant to the Texas Arbitration Act before a sole arbitrator ("Arbitrator"). Judgment on the award rendered by the Arbitrator ("Award") may be entered by any court having jurisdiction thereof. If administrator declines to oversee the case and the parties do not agree on an alternative administrator, a sole neutral Arbitrator shall be appointed upon petition to a court having jurisdiction.*

*If the parties agree to resolve their controversy, dispute or claim through binding arbitration, said arbitration shall be held in lieu of any and all other legal remedies and rights that the parties may have regarding their controversy, dispute or claim, unless otherwise required by law. If the parties do not agree to binding arbitration, nothing herein shall limit any legal right or remedy that the parties may otherwise have."*

## Doctors and other health care providers

### Search our network for doctors, hospitals and other health care providers

It's important to know which doctors are in our network. That's because this plan generally covers services provided by doctors, hospitals and other health care providers, such as labs, if they are in our network. Exceptions include emergency care and medically necessary services provided out of network when those services are otherwise not available within the network.

Here's how you can find out if your health care provider is in our network.

- Log on to your secure Aetna Navigator member website at [www.aetna.com](http://www.aetna.com). Follow the path to find a doctor and enter your doctor's name in the search field.
- Call us at the toll-free number on your Aetna ID card. If you don't have your card, you can call us at **1-888-87-AETNA (1-888-872-3862)**.

For up-to-date information about how to find inpatient and outpatient services, partial hospitalization and other behavioral health care services, please follow the instructions above. If you do not have Internet access and would like a printed list of

providers, please contact Member Services at the toll-free number on your Aetna ID card to ask for a copy.

Our online directory is more than just a list of doctor's names and addresses. It also includes information about where the physician attended medical school, board certification status, language spoken, gender and more. You can even get driving directions to the office. If you don't have Internet access, you can call Member Services to ask about this information.

### Information about doctors who participate in the Aetna network

Participating doctors, specialists and other health care providers are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. We cannot guarantee that any particular provider will be available or is accepting new patients. Our network of doctors may change without notice.

Although we have identified providers who were not accepting patients as known to us at the time we added that provider to our network listing, the status of a provider's practice may have changed. For the most current information, please contact the selected physician or Member Services at the toll-free number on your ID card.

Your PCP may be part of a practice group or association of health professionals (often referred to as a "limited provider network") who work together to provide a full range of health care services. That means when you choose your PCP, in some cases, you are also choosing a limited provider network. In most instances, you will not be allowed to receive services from any physician or provider who is not also part of your PCP's limited provider network. You will not be able to select any physician or provider outside of your PCP's limited provider network, even though that physician or provider appears in the directory.

To the extent it is available, your care will be provided or arranged for within your PCP's limited provider network, so make sure your PCP's limited provider network includes the specialists and hospitals you prefer. PCPs who are part of a limited provider network will have that designation shown in the directory immediately following their name (for example, Dr. John Smith, XYZ IPA). If you have questions about whether a PCP is a member of a limited provider network, please call the Member Services toll-free telephone number on your ID card.

### Provider networks help to improve care while lowering costs

Members who receive care from providers from value-based arrangements are participating in a network designed to improve care while lowering costs. These networks may be set up in different ways, but all include primary care doctors and specialists. They also typically include at least one hospital.

Like most plans, we usually pay doctors and hospitals on a fee-for-service basis. This means your doctor or hospital still gets paid for each visit. However, the value-based network's mission is to better coordinate patient care to improve efficiency, quality and patient satisfaction.

We agree with the network on certain goals,\* such as:


- Clinical performance goals, like completing enough screenings for cancer, diabetes and cholesterol

- Cost-efficiency goals, such as reducing avoidable ER visits, short-term hospital stays, repetitive tests and the overall cost of care.

We pay these value-based networks more when they meet certain goals. The amount of these payments depends on how well the network meets their goals. The network may also have to make payments to us if they fail to meet their goals.

In most of our arrangements we will reward the network financially for both efficient care and higher quality of care. This helps encourage savings that are tied to value and better health outcomes for our members.

Doctors and hospitals that are members of a value-based (accountable care) network may have their own financial arrangements through the network itself. Ask your doctor for details.

Choose a doctor the fast and easy way with the DocFind® directory. Simply log on to your secure Aetna Navigator® website at [www.aetna.com](http://www.aetna.com) and select “Find a Doctor, Pharmacy or Facility”. After entering your search criteria, look for the Accountable Care Collaboration logo . If you need a printed directory instead, call the Member Services phone number on your member ID card.

\*The specific goals will vary from network to network.

## Choose a primary care physician (PCP)

You must pick a primary care physician, or “PCP” who can get to know your health care needs and help you better manage your health care. You can designate any primary care provider who participates in the Aetna network and who is available to accept you or your family members. If you do not pick a PCP, your benefits may be limited or we may select a PCP for you.

A PCP is the doctor you go to when you need health care. If it’s an emergency, you don’t have to call your PCP first. This one doctor can coordinate all your care. Your PCP will perform physical exams, order tests and screenings and help you when you’re sick. Your PCP will also refer you to a specialist when needed.

A female member may choose an Ob/Gyn as her PCP. You may also choose a pediatrician for your child(ren)’s PCP. Your OB/Gyn acting as your PCP will provide the same services and follow the same guidelines as any other PCP. They will issue referrals to other doctors (if your plan requires referrals), and they will get all required approvals and comply with any preapproved treatment plans. See the sections about referrals and preauthorization for more about those requirements.

### Tell us who you choose to be your PCP

You may choose a different PCP from the Aetna network for each member of your family. Enter the name of the PCP you have chosen on your enrollment form. Or, call Member Services after you enroll to tell us your selection.

The name of your PCP will appear on your Aetna ID card. You may change your selected PCP at any time. If you change your PCP, you will receive a new ID card.

### If you are admitted to a hospital

Your PCP does not have to oversee your care if you are admitted to a hospital. You may have a doctor who works in the hospital direct your care. These doctors are called “hospitalists.” The

choice is between you and your PCP. This is also true for a skilled nursing facility or other inpatient facility.

## Referrals: Your PCP will refer you to a specialist when needed

If you need specialty care, your PCP will give you a referral to a specialist who participates in the Aetna network. A “referral” is a written request for you to see another doctor. Some doctors can send the referral electronically to your specialist. There’s no paper involved!

Talk to your doctor to understand why you need to see a specialist. And remember to always get the referral before you receive the care.

### Remember these points about referrals:

- You do not need a referral for emergency care.
- If you do not get a referral when required, you may have to pay the bill yourself. If your plan lets you go outside the network, the plan will pay it as an out-of-network benefit.
- Your specialist might recommend treatment or tests that were not on the original referral. In that case, you may need to get another referral from your PCP for those services.
- Women can go to an Ob/Gyn without a referral. See “PCP and referral rules for Ob/Gyns” below.
- Referrals are valid for one year as long as you are still a member of the plan. Your first visit must be within 90 days of the referral issue date.
- In plans that do not let you go outside the network, you can get a special referral if a network specialist is not available.

### Referrals within physician groups

Some PCPs are part of a larger group of doctors. These PCPs will usually refer you to another doctor within that same group. If this group cannot meet your medical needs, you can ask us for a coverage exception to go outside this group. You may also need to preauthorize these services. And you may need permission from the physician group as well.

If medically necessary covered services are not available within the Aetna network or within your PCP’s limited provider network, you have the right to a referral to a specialist or provider outside the Aetna network of physicians or providers, and outside the limited provider network to which your PCP belongs.

If medically necessary covered services you wish to receive are available through your limited provider network, but you want to receive these services from an Aetna network provider who is not within your PCP’s limited provider network, you may change your PCP in order to select a PCP within the same limited provider network from which you want to receive medically necessary covered services.

### Female members

In selecting a PCP, remember that your PCP’s limited provider network affects your choice of an Ob/Gyn. You have the right to designate an Ob/Gyn to whom you have access without first obtaining referral from a PCP. However, the designated Ob/Gyn must belong to the same limited provider network as your PCP. This is another reason to be sure your PCP’s limited provider network includes the specialist (particularly the Ob/Gyn) and

hospitals you prefer. You do not have to designate an Ob/Gyn; instead, you may elect to receive Ob/Gyn services from your PCP.

## PCP and referral rules for Ob/Gyns

A female member can choose an Ob/Gyn as her PCP. Women can also go to any obstetrician or gynecologist who participates in the Aetna network without a referral or prior authorization. Visits can be for checkups, including breast exams, mammograms and Pap smears, and for obstetric or gynecologic problems.

Also, an Ob/Gyn can give referrals for covered obstetric or gynecologic services just like a PCP. Just follow your plan's normal rules. Your Ob/Gyn might be part of a larger physician's group. If so, any referral will be to a specialist in that larger group. Check with the Ob/Gyn to see if the group has different referral policies.

## Where to find information about your specific plan

Your "plan documents" list all the details for the plan you chose. Such as, what's covered, what's not covered and the specific amounts that you will pay for services. Plan document names vary. They may include a Schedule of Benefits, Certificate of Coverage, Group Agreement, Group Insurance Certificate, Group Insurance Policy and/or any riders and updates that come with them.

If you can't find your plan documents, call Member Services to ask for a copy. Use the toll-free number on your Aetna ID card.

## If you receive a bill

Two of the advantages of being an Aetna HMO member are:

1. You generally do not have to submit claim forms
2. You should not receive any bills for covered services. However, if you receive a bill for covered services, send the itemized bill with your Aetna ID number clearly written on it to us at the address on your ID card. Be sure to keep a copy for your records.

### We will not pay your bill if:

- You receive treatment from a physician (other than your PCP) or facility in a nonemergency situation without a prior referral from your PCP, except for a direct-access benefit, urgently needed care, emergency care and certain other specific services as described in your plan documents.
- You go directly to an emergency facility for treatment in your service area when it is not an emergency. Except in certain areas where we are required to pay for screening fees, you will be responsible for the entire bill (see your Certificate of Coverage).
- You receive post emergency follow-up treatment from a nonparticipating physician without a referral, except where payment is required by applicable state law. You receive services that are not covered by your health plan. (See Limitations and Exclusions in your plan documents.)

## Where to find information about your specific plan

Your "plan documents" list all the details for the plan you chose. Such as, what's covered, what's not covered and the specific amounts that you will pay for services. Plan document names vary. They may include a Schedule of Benefits, Certificate of Coverage, Group Agreement, Group Insurance Certificate, Group Insurance Policy and/or any riders and updates that come with them.

If you can't find your plan documents, call Member Services to ask for a copy. Use the toll-free number on your Aetna ID card.

## Other covered benefits

### Behavioral health and substance abuse benefits

You must use behavioral health professionals who are in the Aetna network.

Here's how to get behavioral health services

- Emergency services – call 911.
- Call the toll-free Behavioral Health number on your Aetna ID card.
- If no other number is listed, call Member Services.
- If you're using your employer's or school's EAP program, the EAP professional can help you find a behavioral health specialist.

### Read about behavioral health provider safety

We want you to feel good about using the Aetna network for behavioral health services. Visit [www.aetna.com/docfind](http://www.aetna.com/docfind) and click the "Get info on Patient Safety and Quality" link. No Internet? Call Member Services instead. Use the toll-free number on your Aetna ID card to ask for a printed copy.

### Behavioral health programs to help prevent depression

Aetna Behavioral Health offers two prevention programs for our members: Perinatal Depression Education, Screening and Treatment Referral Program, also known as Beginning Right<sup>®</sup> Depression Program, and Identification and Referral of Substance Abuse Screening for Adolescents with Depression and/or Anxiety Prevention Program (SASDA). For more information on either of these prevention programs and how to use the programs, ask Member Services for the phone number of your local Care Management Center.

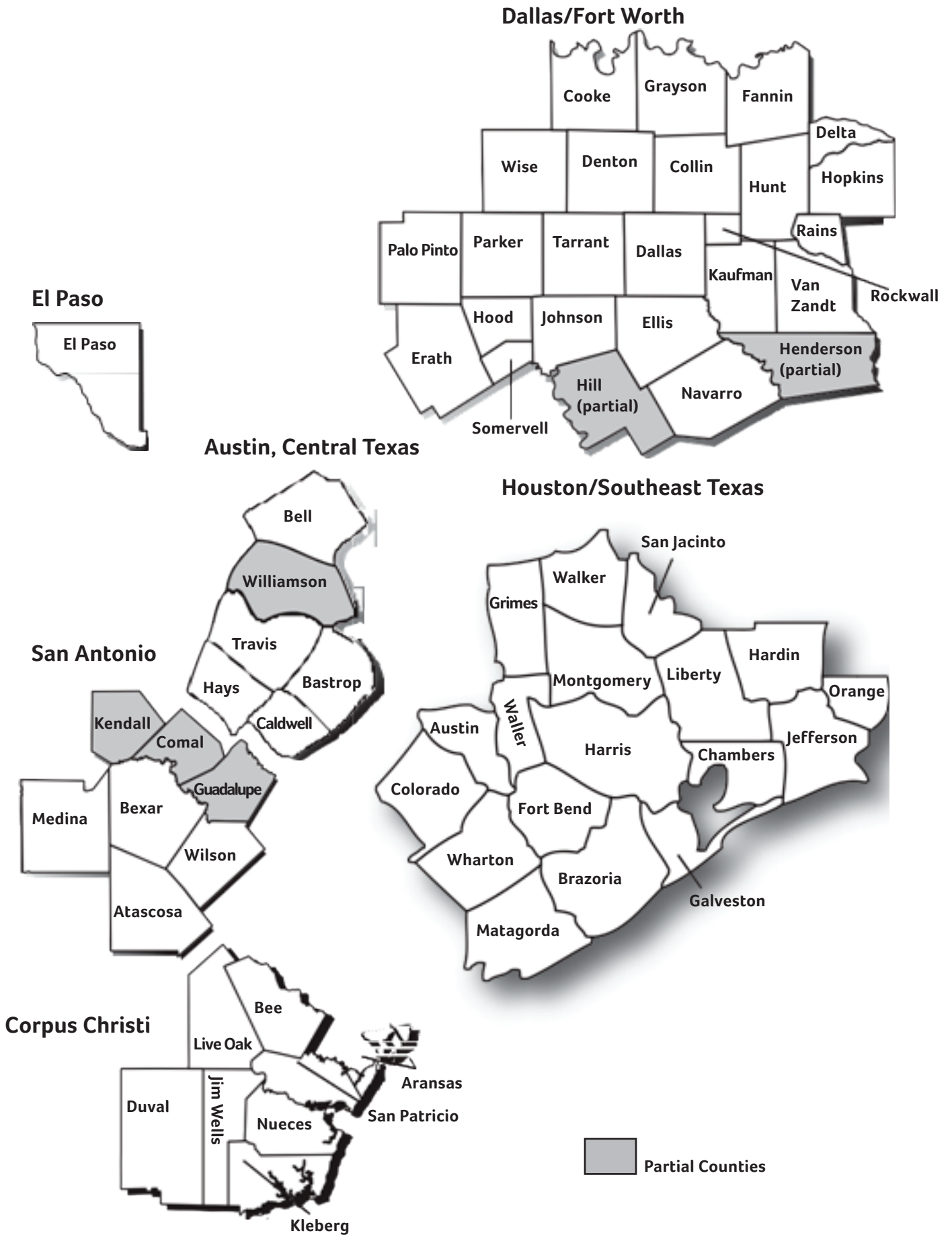
## Breast reconstruction benefits

### Notice regarding Women's Health and Cancer Rights Act

Under this health plan, as required by the Women's Health and Cancer Rights Act of 1998, coverage will be provided to a person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy for:

- All stages of reconstruction of the breast on which a mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and

# Aetna HMO service areas



- Treatment of physical complications of all stages of mastectomy, including lymph edemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be provided in accordance with the plan design, limitations, copays, deductibles, and referral requirements, if any, as outlined in your plan documents.

If you have any questions about our coverage of mastectomies and reconstructive surgery, please contact the Member Services number on your ID card.

For more information, you can visit this U.S. Department of Health and Human Services website, [www.cms.hhs.gov/HealthInsReformforConsumer/06\\_TheWomen'sHealthandCancerRightsAct.asp](http://www.cms.hhs.gov/HealthInsReformforConsumer/06_TheWomen'sHealthandCancerRightsAct.asp) and the U.S. Department of Labor at: [www.dol.gov/ebsa/consumer\\_info\\_health.html](http://www.dol.gov/ebsa/consumer_info_health.html).

## Transplants and other complex conditions

Our National Medical Excellence Program® (NME) is for members who need a transplant or have a condition that can only be treated at a certain hospital. You usually need to use an Aetna Institutes of Excellence™ hospital to get coverage for the treatment. Some plans won't cover the service if you don't. We choose hospitals for the NME program based on their expertise and experience with these services. We also follow any state rules when choosing these hospitals.

## Benefits that are mandated by Texas law

These benefits are provided by your contract with Aetna. If you have any questions, please call us at the Member Services number on your ID card, or write to us at: **Aetna Patient Management, P.O. Box 569440, Dallas, Texas 75356-9440.**

### Coverage of Tests for Detection of Human Papillomavirus and Cervical Cancer

Coverage is provided, for each woman enrolled in the plan who is 18 years of age or older, for expenses incurred for an annual medically recognized diagnostic examination for the early detection of cervical cancer. Coverage required under this section includes at a minimum a conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the U.S. Food and Drug Administration (FDA), alone or in combination with a test approved by the U.S. FDA for the detection of the human papillomavirus.

Form Number LHL391 Human Papillomavirus and Cervical Cancer Screening

### Coverage for tests for detection of colorectal cancer

Benefits are provided, for each person enrolled in the plan who is 50 years of age or older and at normal risk for developing colon cancer, for expenses incurred in conducting a medically recognized screening examination for the detection of colorectal cancer. Benefits include the covered person's choice of: (a) a fecal occult blood test performed annually and a flexible sigmoidoscopy performed every five years, or (b) a colonoscopy performed every 10 years.

Form Number 1467 Colorectal Cancer Screening

### Prostate cancer screening

Benefits are provided for each covered male for an annual medically recognized diagnostic examination for the detection of prostate cancer. Benefits include a: (a) Physical examination

for the detection of prostate cancer (b) Prostate-specific antigen test for each covered male who is at least: (1) 50 years of age (2) 40 years of age with a family history of prostate cancer or other prostate cancer risk factor.

Form Number 258 Prostate

### Inpatient stay following birth of a child

For each person covered for maternity/childbirth benefits, we will provide inpatient care for the mother and her newborn child in a health care facility for a minimum of:

- (a) 48 hours following an uncomplicated vaginal delivery.
- (b) 96 hours following an uncomplicated delivery by cesarean section.

This benefit does not require a covered female who is eligible for maternity/childbirth benefits to (a) give birth in a hospital or other health care facility or (b) remain in a hospital or other health care facility for the minimum number of hours following birth of the child. If a covered mother or her newborn child is discharged before the 48 or 96 hours has expired, we will provide coverage for post-delivery care. Post-delivery care includes parent education, assistance and training in breast-feeding and bottle-feeding and the performance of any necessary and appropriate clinical tests. Care will be provided by a physician, registered nurse or other appropriate licensed health care provider, and the mother will have the option of receiving the care at her home, the health care provider's office or a health care facility.

Because we provide coverage for in-home post-delivery care, we are not required to provide coverage for the minimum number of hours outlined above unless (a) the mother's or child's physician determines the inpatient care is medically necessary or (b) the mother requests the inpatient stay.

Prohibitions: We may not (a) modify the terms of this coverage based on any covered person requesting less than the minimum coverage required; (b) offer the mother financial incentives or other compensation for waiver of the minimum number of hours required; (c) refuse to accept a physician's recommendation for a specified period of inpatient care made in consultation with the mother if the period recommended by the physician does not exceed guidelines for prenatal care developed by nationally recognized professional associations of obstetricians and gynecologists or pediatricians; (d) reduce payments or reimbursements below the usual and customary rate; or (e) penalize a physician for recommending inpatient care for the mother or the newborn child.

Form Number 102 Maternity

### Breast reconstruction

Coverage and/or benefits are provided to each covered person for reconstructive surgery after mastectomy, including:

- All stages of the reconstruction of the breast on which mastectomy has been performed.
- Surgery and reconstruction of the other breast to achieve a symmetrical appearance.
- Prostheses and treatment of physical complications, including lymph edemas, at all stages of mastectomy.

The coverage and/or benefits must be provided in a manner to be appropriate in consultation with the covered person and the attending physician.

Prohibitions: We may not (a) offer the covered person a financial incentive to forego breast reconstruction or waive the coverage and/or benefits shown above; (b) condition, limit, or deny any covered person's eligibility or continued eligibility to enroll in the plan or fail to renew this plan solely to avoid providing the coverage and/or benefits shown above; or (c) reduce or limit the amount paid to the physician or provider, nor otherwise penalize, or provide a financial incentive to induce the physician or provider to provide care to a covered person in a manner inconsistent with the coverage and/or benefits shown above.

Form Number 1764 Reconstructive Surgery After Mastectomy – Enrollment

### **Mastectomy or lymph node dissection minimum inpatient stay**

If due to treatment of breast cancer, any person covered by this plan has either a mastectomy or a lymph node dissection, this plan will provide coverage for inpatient care for a minimum of:

- 48 hours following a mastectomy, and
- 24 hours following a lymph node dissection.

The minimum number of inpatient hours is not required if the individual receiving the treatment and the attending physician determine that a shorter period of inpatient care is appropriate.

Prohibitions: We may not (a) deny any covered person eligibility or continued eligibility or fail to renew this plan solely to avoid providing the minimum inpatient hours;

(b) provide money payments or rebates to encourage any covered person to accept less than the minimum inpatient hours; (c) reduce or limit the amount paid to the attending physician, or otherwise penalize the physician, because the physician required a covered person to receive the minimum inpatient hours; or (d) provide financial or other incentives to the attending physician to encourage the physician to provide care that is less than the minimum hours.

Form Number 349 Mastectomy

### **Early Detection of Cardiovascular Disease**

The plan includes coverage for certain tests for the early detection of cardiovascular disease for any member who is:

- Male, between the ages of 45 and 76 years; or
- Female, between the ages of 55 and 76 years; and who:
- Is diabetic; or
- Has a risk of developing coronary heart disease, based on a score of intermediate or higher derived using the Framingham Heart Study coronary prediction algorithm.

If performed by a laboratory certified by a national organization recognized by Texas for the purposes of this section, coverage will be provided for up to \$200 to \$1,000 every five years for one of the following noninvasive screening tests for atherosclerosis and abnormal artery structure and function:

- Computed tomography (CT) scanning measuring coronary artery calcification; or
- Ultrasonography measuring carotid intima-media thickness and plaque.

### **Orthotic and Prosthetic Devices**

The plan includes coverage for orthotic and prosthetic devices including custom-fitted or custom-fabricated medical devices that are applied to a part of the human body to correct a deformity, improve function, or relieve symptoms of a disease.

Coverage includes professional services related to the fitting and use of the devices, as well as repair and replacement, unless due to misuse by the member.

Coverage is limited to the most appropriate model orthotic device that adequately meets the medical needs of the covered person as determined by the treating physician, podiatrist or orthotist, and the member, as applicable.

### **Clinical Trials**

The plan includes coverage for routine patient care costs in connection with a phase I, phase II, phase III, or phase IV clinical trial, if the clinical trial is conducted in relation to the prevention, detection, or treatment of a life-threatening disease or condition and is approved by any one of the following:

- The Centers for Disease Control and Prevention of the United States Department of Health and Human Services
- The National Institutes of Health
- The United States Food and Drug Administration
- The United States Department of Defense
- The United States Department of Veterans Affairs
- A review board of an institution in this state that has an agreement with the Office for Human Research Protections of the United States Department of Health and Human Services.

“Routine patient care costs” means the costs of any medically necessary covered benefit that would have been covered under the plan even if the member had not been participating in a clinical trial. Routine patient care costs do not include:

- The cost of an investigational new drug or device that is not approved for any indication by the United States Food and Drug Administration, including a drug or device that is the subject of the clinical trial
- The cost of a service or supply that is not a medically necessary covered benefit, regardless of whether the service or supply is required in connection with participation in a clinical trial
- The cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis
- A cost associated with managing a clinical trial
- The cost of a service or supply that is specifically excluded from coverage under the plan

All plan deductibles, coinsurance and copayments that typically apply for routine patient care costs will apply when this care is received during the course of a clinical trial.

Limitations:

1. The plan is not required to reimburse the research institution conducting the clinical trial for the cost of routine patient care provided through the research institution unless the research institution, and each health care professional providing routine patient care through the research institution, agrees to accept reimbursement under the plan at either the negotiated charge or the recognized charge, as appropriate for the particular provider, as payment in full for the routine patient care provided in connection with the clinical trial.
2. The plan will not provide coverage for services and supplies that are a part of the subject matter of the clinical trial and

that are customarily paid for by the research institution conducting the clinical trial.

3. The plan will not provide coverage for routine patient care provided outside the Aetna network unless the plan otherwise covers out-of-network care.
4. The plan will not provide coverage for services and supplies provided outside of Texas.

## How doctors are paid

If you have any question about how your doctor or other health care providers are compensated, call Member Services at the toll-free number on your ID card. We encourage you to discuss this issue with your doctor.

One of the goals of managed care is to reduce and control the costs of health care. We offer financial incentives in compensation arrangements with doctors in an attempt to reduce and control the costs of health care.

Appropriate financial incentives are intended to:

- Reduce waste in the application of medical resources
- Eliminate inefficiencies that can lead to artificial inflation of health care costs
- Encourage doctors to practice preventive medicine and focus on improving the long-term health of patients.
- Direct attention to patient satisfaction
- Improve the efficient delivery of quality health care services without compromising the quality and integrity of the physician-patient relationship

Only appropriate financial incentives will be used to compensate physicians and providers treating Aetna members.

Capitation is an example of a financial incentive arrangement that we may use to compensate your doctors. Under capitation, a physician, physician group, independent practice association, or other health care provider is paid a predetermined set amount to cover all costs of providing certain medically necessary benefits to members whether or not the actual costs of providing those medically necessary covered benefits is greater or less than the amount we pay. In our capitation arrangements with an individual doctor, we provide capitation payments only for those services the doctor provides to you. However, in a capitation arrangement with a group of physicians or providers, also known as a “delegated entity,” we may provide capitation payments for other health care services such as hospitalization, use of specialists, tests and prescription drugs. Under either capitation arrangement, your doctor has a financial incentive to reduce and control the costs of providing medical care.

Texas law prohibits financial incentives that act directly or indirectly as an inducement to limit medically necessary services. An improperly used incentive may encourage a doctor to provide a patient with a less effective treatment because it is less expensive. We will not improperly use incentives to compensate doctors for treatments and services provided to Aetna members.

If you are considering enrolling in our plan, you are entitled to ask if the plan, or any provider group serving Aetna members, has compensation arrangements with participating doctors that

can create a financial incentive to reduce or control the costs of providing medically necessary covered services. Upon request, we will send you a summary of the compensation arrangements known to us relating to a particular doctor. To request this summary, call the Member Services telephone number on your ID card. Or, you may contact the provider group directly to find out about compensation arrangements between the provider group and any participating doctor. You may also wish to ask your doctor about what financial incentive arrangements are included in his or her compensation.

## How we determine what is covered

You can avoid receiving an unexpected bill with a simple call to Member Services. You can find out if your preventive care service, diagnostic test or other treatment is a covered benefit — before you receive care — just by calling the toll-free number on your ID card.

Here are some of the ways we determine what is covered:

### We check if it’s “medically necessary”

Medical necessity is more than being ordered by a doctor. “Medically necessary” means your doctor ordered a product or service for an important medical reason. It might be to help prevent a disease or condition. Or to check if you have one. Or it might be to treat an injury or illness.

The product or service:

- Must meet a normal standard for doctors
- Must be the right type in the right amount for the right length of time and for the right body part. It also has to be known to help the particular symptom.
- Cannot be for the member’s or the doctor’s convenience
- Cannot cost more than another service or product that is just as effective

Only medical professionals can deny coverage if the reason is medical necessity. We do not give financial incentives or otherwise to Aetna employees for denying coverage.

Sometimes the review of medical necessity is handled by a physicians’ group. Those groups might use different resources than we do. If we deny coverage, we’ll send you and your doctor a letter. The letter will explain how to appeal the denial. You have the same right to appeal if a physician’s group denied coverage for medical necessity. You can call Member Services to ask for a free copy of the criteria we use to make coverage decisions. Or visit

[www.aetna.com/about/cov\\_det\\_policies.html](http://www.aetna.com/about/cov_det_policies.html) to read our policies. Doctors can write or call our Patient Management department with questions. Contact Member Services either online or at the phone number on your Aetna ID card for the appropriate address and phone number.

“Medically necessary” services are those hospital or medical services and supplies that, under the applicable standard of care, are appropriate: (a) to improve or preserve health, life or function; or (b) to slow the deterioration of health, life or function; or (c) for the early screening, prevention, evaluation, diagnosis or treatment of a disease, condition, illness or injury. Determinations that we make of whether care is medically

necessary under this definition also include determinations of whether the services and supplies are cost-effective, timely, and sufficient in quality, quantity and frequency, consistent with the applicable standard of care.

For purposes of this definition, “cost-effective” means the least expensive medically necessary treatment selected from two or more treatments that are equally effective. That means the care can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects, in achieving a desired health outcome for that particular member. Medical necessity, when used in relation to services, has the same meaning as medically necessary services. This definition applies only to our determination of whether health care services are medically necessary covered benefits under your Certificate of Coverage.

The determination of medically necessary care is an analytical process applied on a case-by-case basis by qualified professionals who have the appropriate training, education, and experience and who possess the clinical judgment and case-specific information necessary to make these decisions. The determination of whether proposed care is a covered benefit is independent of, and should not be confused with, the determination of whether proposed care is medically necessary.

We will not use any decision-making process that operates to deny medically necessary care that is a covered benefit under your certificate. Since we have authority to determine medical necessity for purposes of the plan, a determination under the plan that a proposed course of treatment, health care service or supply is not medically necessary may be made by Texas-licensed physicians other than the your own doctor.

This means that, even if your doctor determines in his or her clinical judgment that a treatment, service or supply is medically necessary for you, our Texas-licensed physician may determine that it is not medically necessary under this plan. If we determine that a service or supply is not medically necessary, you (or your authorized representative) may appeal to the Texas independent review organization, as described in the section entitled “What to do if you disagree with us.”

## **We study the latest medical technology**

To help us decide what is medically necessary, we may look at scientific evidence published in medical journals. This is the same information doctors use. We also make sure the product or service is in line with how doctors, who usually treat the illness or injury, use it. Our doctors may use nationally recognized resources like The Milliman Care Guidelines.

We also review the latest medical technology, including drugs, equipment — even mental health treatments. Plus, we look at new ways to use old technologies. To make decisions, we may:

- Read medical journals to see the research. We want to know how safe and effective it is.
- See what other medical and government groups say about it. That includes the federal Agency for Health Care Research and Quality.
- Ask experts.
- Check how often and how successfully it has been used.

We publish our decisions in our Clinical Policy Bulletins.

## **We post our findings on [www.aetna.com](http://www.aetna.com)**

After we decide if a product or service is medically necessary, we write a report about it. We call the report a Clinical Policy Bulletin (CPB).

CPBs tell if we view a product or service as medically necessary. They also help us decide whether to approve a coverage request. But your plan may not cover everything that our CPBs say is medically necessary. Each plan is different, so check your plan documents.

CPBs are not meant to advise you or your doctor on your care. Only your doctor can give you advice and treatment. Talk to your doctor about any CPB related to your coverage or condition.

You and your doctor can read our CPBs on our website at [www.aetna.com](http://www.aetna.com) under “Individuals & Families.” No Internet? Call Member Services at the toll-free number on your ID card. Ask for a copy of a CPB for any particular product or service.

## **We can help when more serious care is suitable**

In certain cases, we review a request for coverage to be sure the service or supply is consistent with established guidelines. Then we follow up. We call this “utilization management review.”

It’s a three step process:

First, we begin this process if your hospital stay lasts longer than what was approved. We verify that it is necessary for you to still be in the hospital. We look at the level and quality of care you are getting.

Second, we begin planning your discharge. This process can begin at any time. We look to see if you may benefit from any of our programs. We might have a nurse case manager follow your progress. Or we might recommend that you try a wellness program after you get back home.

Third, after you are home, we may review your case. We may look over your medical records and claims from your doctors and the hospital. We look to see that you got appropriate care. We also look for waste or unnecessary costs.

We follow specific rules to help us make your health a top concern:

- Aetna employees are not compensated based on denials of coverage.
- We do not encourage denials of coverage. In fact, our utilization review staff is trained to focus on the risks of members not adequately using certain services.

Where such use is appropriate, our Utilization Review/Patient Management staff uses nationally recognized guidelines and resources, such as The Milliman Care Guidelines® to guide these processes. When provider groups, such as independent practice associations, are responsible for these steps, they may use other criteria that they deem appropriate. Utilization Review/Patient Management policies may vary as a result of state laws.

In Texas, Med Solutions performs utilization review for certain high-tech radiology procedures including, but not limited to, MRIs, CTs and PET scans.



# Member rights & responsibilities

## Know your rights as a member

You have many legal rights as a member of a health plan. You also have many responsibilities. You have the right to suggest changes in our policies and procedures, including our Member Rights and Responsibilities.

Below are just some of your rights. We also publish a list of rights and responsibilities on our website. Visit [www.aetna.com/individuals-families-health-insurance/member-guidelines/member-rights.html](http://www.aetna.com/individuals-families-health-insurance/member-guidelines/member-rights.html) to view the list. You can also call Member Services at the number on your ID card to ask for a printed copy.

## Making medical decisions before your procedure

An “advance directive” tells your family and doctors what to do when you can’t tell them yourself. You don’t need an advance directive to receive care. But you have the right to create one. Hospitals may ask if you have an advance directive when you are admitted.

There are three types of advance directives:

- Durable power of attorney – name the person you want to make medical decisions for you.
- Living will – spells out the type and extent of care you want to receive.
- Do-not-resuscitate order – states that you don’t want CPR if your heart stops or a breathing tube if you stop breathing.

You can create an advance directive in several ways:

- Ask your doctor for an advance directive form.
- Pick up a form at state or local offices on aging, bar associations, legal service programs, or your local health department.
- Work with a lawyer to write an advance directive.
- Create an advance directive using computer software designed for this purpose.

Source: American Academy of Family Physicians. Advanced Directives and Do Not Resuscitate Orders. January 2012. Available at <http://familydoctor.org/familydoctor/en/healthcare-management/end-of-life-issues/advance-directives-and-do-not-resuscitate-orders.html>. Accessed April 2, 2013.

## Learn about our quality management programs

We make sure your doctor provides quality care for you and your family. To learn more about these programs, go to our website at [www.aetna.com/members/health\\_coverage/quality/quality.html](http://www.aetna.com/members/health_coverage/quality/quality.html). You can also call Member Services to ask for a printed copy. See “Contact Us” on page 2.

## We protect your privacy

We consider your personal information to be private. Our policies help us protect your privacy. By “personal information,” we mean information about your physical condition, the health care you receive and what your health care costs. Personal information does not include what is available to the public. For example, anyone can find out what your health plan covers or how it works. It also does not include summarized reports that do not identify you.

Below is a summary of our privacy policy. For a copy of our actual policy, go to [www.aetna.com](http://www.aetna.com). You’ll find the “Privacy Notices” link at the bottom of the page. You can also write to:

Aetna Legal Support Services Department  
151 Farmington Avenue, W121  
Hartford, CT 06156

## Summary of the Aetna privacy policy

We have policies and procedures in place to protect your personal information from unlawful use and disclosure. We may share your information to help with your care or treatment and administer our health plans and programs. We use your information internally, share it with our affiliates, and we may disclose it to:

- Your doctors, dentists, pharmacies, hospitals and other caregivers
- Those who pay for your health care services. That can include health care provider organizations and employers who fund their own health plans or who share the costs.
- Other insurers
- Third-party administrators
- Vendors
- Consultants
- Government authorities and their respective agents These parties must also keep your information private.

Network doctors must allow you to see your medical records within a reasonable time after you ask for it. We use your personal information for:

- Paying claims
- Making decisions about what to cover
- Coordinating payments with other insurers
- Preventive health, early detection, and disease and case management

We consider these activities key for the operation of our health plans. We usually will not ask if it’s okay to share your information unless the law requires us to. We will ask your permission to disclose personal information if it is for marketing purposes. Our policies address how we get your permission if you are unable to give consent.

## Anyone can get health care

We do not consider your race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age or national origin when giving you access to care. Network providers are contractually obligated to the same.

We must comply with these laws:

- Title VI of the Civil Rights Act of 1964
- Age Discrimination Act of 1975
- Americans with Disabilities Act
- Laws that apply to those who receive federal funds
- Other laws that protect your rights to receive care

## **How we use information about your race, ethnicity and the language you speak**

You choose if you want to tell us your race/ethnicity and preferred language. We'll keep that information private. We use it to help us improve your access to health care. We also use it to help serve you better. See "We protect your privacy" and "Anyone can get health care" for more information.

## **Your rights to enroll later if you decide not to enroll now**

### **When you lose your other coverage**

You might choose not to enroll now because you already have health insurance. You may be able to enroll later if you lose that other coverage or if your employer stops contributing to the cost. This includes enrolling your spouse or children and other dependents. If that happens, you must apply within 31 days after your coverage ends (or after the employer stops paying for coverage).

### **When you have a new dependent**

Getting married? Having a baby? A new dependent changes everything. If you chose not to enroll during the normal open enrollment period, you can enroll within 31 days after a life event. That includes marriage, birth, adoption or placement for adoption. Talk to your benefits administrator to request special enrollment or for more information.

### **Getting proof that you had previous coverage**

Sometimes when you apply for health coverage, the insurer may ask for proof that you were covered before. This helps determine if you are eligible for their plan. Your plan sponsor may have contracted with us to issue a certificate. Ask us for a Certificate of Prior Health Coverage anytime you want to check the status of your coverage. If you lost your coverage, you have 24 months to make this request. Just call Member Services at the toll-free number on your ID card.

# Notes

Aetna is committed to Accreditation by the National Committee for Quality Assurance (NCQA) as a means of demonstrating a commitment to continuous quality improvement and meeting customer expectations. A complete listing of health plans and their NCQA status can be found on the NCQA website located at [reportcard.ncqa.org](http://reportcard.ncqa.org).

To refine your search, we suggest you search these areas: Managed Behavioral Healthcare Organizations – for behavioral health accreditation; Credentials Verification Organizations – for credentialing certification; Health Insurance Plans – for HMO and PPO health plans; Physician and Physician Practices – for physicians recognized by NCQA in the areas of heart/stroke care, diabetes care, back pain and medical home. Providers who have been duly recognized by the NCQA Recognition Programs are annotated in the provider listings section of the Aetna provider directory.

Providers, in all settings, achieve recognition by submitting data that demonstrates they are providing quality care. The program constantly assesses key measures that were carefully defined and tested for their relationship to improved care; therefore, NCQA provider recognition is subject to change.

Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice.

Aetna does not provide care or guarantee access to health services. For up-to-date information, please visit our DocFind® directory at [www.aetna.com](http://www.aetna.com) or, if applicable, visit the NCQA's new top-level recognition listing at [recognition.ncqa.org](http://recognition.ncqa.org).

**If you need this material translated into another language, please call Member Services at 1-800-323-9930.**

**Si usted necesita este material en otro lenguaje, por favor llame a Servicios al Miembro al 1-800-323-9930.**

[www.aetna.com](http://www.aetna.com)

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