Important information about your health benefits
– Arizona

For: small and large group Aetna Open Access® HMO, Aetna Choice® POS, Health Network Only and Health Network Option plans.

This disclosure booklet contains important information you should know before you enroll. It is only a summary. Your official “plan documents” list all the details for the plan you choose. Such as, what’s covered, what’s not covered and the specific amounts that you will pay for services. Plan documents 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.

Understanding your plan of benefits

Aetna® health benefits plans cover most types of health care from a doctor or hospital. But they do not cover everything. The plan covers recommended preventive care and care you need for medical reasons. It does not cover services you may just want to have, like plastic surgery. It also does not cover treatment that is not yet widely accepted. You should also be aware that some services may have limits. For example, a plan may allow only one eye exam per year.

Not all of the information in this booklet applies to your specific plan

Most of the information in this booklet applies to all plans. But some does not. For example, not all plans have deductibles or prescription drug benefits. Information about those topics will only apply if the plan includes those rules.

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Getting help

Contact us

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.

Member Services can help you:
• 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

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)

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 health plan only lets you visit doctors, hospitals and other health care providers, such as labs, if they are in our network.

Here’s how you can find out if your health care provider is in our network.
• Refer to the Physician Directory for a list of Aetna doctors, each physician’s degree, practice specialty, and year first licensed to practice medicine and, if different, the year initially licensed to practice in Arizona. If you don’t have a copy of the printed Physician Directory, you can call the number on your Aetna ID card to ask for one. If you don’t have your card, you can call us at 1-888-872-3862.
• Search for doctors using our online DocFind® directory. If you’re not yet a member, you can access this at www.aetna.com. After you become a member, you can simplify your search by logging on to your secure Aetna Navigator® member website at www.aetna.com. Follow the path to find a doctor and enter your doctor’s name in the search field.
• Call Member Services at the toll-free number on your Aetna ID card to ask for help finding a doctor in your area or to send you a printed directory.

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 doctors’ 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.

Provider networks 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 – completing enough screenings for cancer, diabetes and cholesterol
• Cost-efficiency goals – 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 DocFind®. Simply log on to your secure Aetna Navigator® website at www.aetna.com and select “Find a Doctor, Pharmacy or Facility.” After entering your search criteria, look for the ACO 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.
 Costs and rules for using your plan

What you pay

Your premium and factors that affect it
Your plan sponsor will provide information about your monthly premium cost for the plan. Your portion of the premium will depend on how much your employer contributes. We may also adjust the premium rates and/or the manner of calculating premiums. This will only occur on the premium due date and only after we provide 60 days prior written notice to your employer. We will not make any such adjustments during the initial term except as required by law, or to adjust accordingly where a law impacts what is covered.

The premium may also include an experience factor. If claims are more than expected, the employer may owe additional premium. If claims are less than expected, the employer may receive a refund. This feature applies only to contracts that are retrospectively rated, not fully insured contracts.

The initial medical rates quoted for your group are subject to adjustment at the beginning of each rating period based on the current new business rates for groups of similar size and demographic characteristics that have purchased similar benefits. Demographic characteristics of a group include age, gender and group size. They may not include claims experience, health status, industry or duration of coverage.

The rates for your group may be adjusted at the beginning of any rating period based on your group’s claims experience, health status, industry or duration since issue. The actual adjustment will be determined by comparing your group’s claim experience to the claim experience of other groups of similar size and demographic characteristics. This information is subject to change based on future changes to your state’s insurance law or other regulatory requirements, as well as future changes to rating practices. We will communicate any such changes to your employer.

Contribution requirements: For small groups, employers must contribute a minimum of 50% of the employee-only rate. For large groups, employer must contribute a minimum of 50% of the total plan or 75% of the employee-only rate.

Participation requirements: Less than four eligible employees require a minimum of 100% participation, excluding valid benefit waivers. Four or more employees require a minimum of 75% participation, excluding valid benefit waivers.

Your share of the cost of health care services
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 set amount (for example, $15) you pay for covered health care service. 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.

• Coinsurance – Your share of the costs of a covered service. Coinsurance is calculated as a percent (for example, 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. Other deductibles may apply at the same time.
  - Inpatient Hospital Deductible – This deductible applies when you are a patient in a hospital.
  - Emergency Room Deductible – This is the amount you pay when you go to the emergency room. If you are admitted to the hospital within 24 hours, you won’t have to pay it.

The Inpatient Hospital and Emergency Room Deductibles are separate from your general deductible. For example, your plan may have an overall $1,000 deductible and also has a $250 Emergency Room Deductible. This means that you pay the first $1,000 before the plan pays anything. Once the plan starts to pay, if you go to the emergency room you will pay the first $250 of that bill.

How we pay health care providers based on certain goals
Our provider compensation programs do not require providers to comply with any specified numbers, targeted averages, or maximum durations of patient visits.

Your costs when you go outside the network

Network-only plans
Open Access HMO and Health Network Only plans are network-only plans. That means 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, you will have to pay all of the costs for the services.

Plans that cover out-of-network services
With Open Choice, Health Network Option, Open Access Managed Choice and Aetna Choice POS plan, You may choose a doctor in our network. You may choose to visit an out-of-network doctor. We cover the cost of care based on if the provider, such as a doctor or hospital, is “in network” or “out of network.” We want to help you understand how much we will pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this care.

The following are examples for when you see a doctor:
“In network” means we have a contract with that doctor. Doctors agree to how much they will charge you for covered services. That amount is often less than what they would charge you if they were not in our network. Most of the time, it costs you less to use doctors in our network. Doctors also agree to not bill you for any amount over their contract rate. All you have to pay is your coinsurance or copayments, along with any deductible. Your network doctor will handle any precertification required by your plan.

“Out of network” means we do not have a contract with that doctor. We don’t know exactly what an out-of-network doctor will charge you. If you choose a doctor who is out of network, your Aetna health plan may pay some of that doctor’s bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor.

Your out-of-network doctor or hospital sets the rate to charge you. It may be much higher than what your Aetna plan “recognizes” or “allows.” Your doctor may bill you for the dollar amount that your plan doesn’t “recognize.” You must also pay any copayments, coinsurance and deductibles that apply. No dollar amount above the “recognized charge” counts toward your deductible or out-of-pocket limits.

This means you are fully responsible for paying everything above the amount we allow for a service or procedure.

How we pay doctors who are not in our network

When you choose to see an out-of-network doctor, hospital or other health care provider, we pay for your care using a “prevailing” or “reasonable” charge obtained from an industry database; a rate based on what Medicare would pay for that service; or a local market fee set by Aetna. Your plan will state which method is used.

This way of paying out-of-network doctors and hospitals applies whenever you choose to get care out of network. See “Emergency and urgent care and care after office hours” for more.

Going in network just makes sense.

• We have negotiated discounted rates for you.
• In-network doctors and hospitals won’t bill you for costs above our rates for covered services.
• You are in great hands with access to quality care from our national network.

Precertification: Getting approvals for services

Sometimes we will pay for care only if we have given an approval before you get it. We call that “precertification.” Precertification is usually limited to more serious care like surgery or being admitted to a nursing home. When you get care from a doctor in the Aetna network, your doctor takes care of precertification. But if you get your care outside our network, you must call us for precertification when that’s required. Your plan documents list all the services that require you to get precertification. If you don’t, you will have to pay for all or a larger share of the cost of the service. Even with precertification, you will usually pay more if you receive services from an out-of-network provider.

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

We will not retroactively deny covered nonemergency treatment that had prior authorization under our written policies. Precertification is not required for emergency services.

We do not give financial incentives or otherwise to Aetna employees for denying coverage.

What we look for when reviewing a precertification request

First, we check to see that you are still a member. And we make sure the service is considered medically necessary for your condition. We also check that the service and place requested to perform the service is cost effective. If we know of a treatment or place of service that is just as effective but costs less, we may talk to you or your doctor about it. We also look to see if you qualify for one of our case management programs. If so, one of our nurses may call to tell you about it and help you understand your upcoming procedure.

Precertification does not verify if you have reached any plan dollar limits or visit maximums for the service requested. So, even if you get approval, the service may not be covered.

Continuing care if your doctor is not in the Aetna network or later leaves the network

If you are a new member undergoing an active course of treatment with a doctor who is not in the Aetna network, you may request to continue seeing that doctor at the highest level of benefits, as follows:

• For a member with a life-threatening disease or condition on their effective date, the transitional period is 30 days after the member’s effective date of coverage.
• For a member who has entered the third trimester of pregnancy on their effective date, the transitional period includes the delivery and any care up to 6 weeks after the delivery that is related to the delivery.

If you are already a member and your participating doctor leaves the network for reasons other than medical incompetence or unprofessional conduct, you may request to continue the highest level of benefits coverage for an active, ongoing course of treatment with that doctor after the termination date as follows:

• For a member with a life-threatening disease or condition, the transitional period is 30 days after the date of the participating provider’s termination date.
• For a member who has entered the third trimester of pregnancy on the participating provider’s termination date, the transitional period includes the delivery and any care up to six weeks after the delivery that is related to the delivery.

We will authorize the highest level of benefits coverage for the transitional period only if the health care provider agrees to the following in writing:

1. To accept our normal reimbursement rates for similar services;
2. To adhere to our quality standards and to provide medical information related to such care; and
To adhere to our policies and procedures. This provision only applies to benefits that are covered under the plan as outlined in your plan documents.

To request continuation of coverage, contact Member Services at the number on your Aetna ID card, or contact your plan administrator if you do not yet have an ID card.

Information about specific benefits

What's covered

Description of Benefits

1. Covered Benefits
   A. Primary Care Physician Benefits
      1. Office visits during office hours
      2. Home visits/After hours
      3. Hospital visits
   B. Diagnostic Services Benefits Services include the following:
      1. Diagnostic, laboratory and X-ray services
      2. Mammograms
         Screening mammogram benefits for female members are provided as follows:
         • age 35 through 39, one baseline mammogram;
         • age 40 and older, 1 routine mammogram every year; or
         • when medically necessary.
   C. Specialist Physician Benefits, including outpatient and inpatient services
   D. Direct Access Specialist Benefits
      The following services are covered without a referral when rendered by a participating provider:
      • Routine gynecological examination(s)
      • Routine eye examinations
      • Preventive dental care for members under the age of 12. See your Summary of Benefits for plan applicability.
   E. Maternity Care and Related Newborn Care Benefits
   F. Inpatient Hospital and Skilled Nursing Facility Benefits
   G. Transplants Benefits
   H. Outpatient Surgery Benefits
   I. Substance Abuse Benefits (inpatient/outpatient services for detoxification)
   J. Mental Health Benefits
   K. Emergency Care/Urgent Care Benefits
   L. Outpatient Rehabilitation Benefits
   M. Home Health Benefits
   N. Hospice Benefits
   O. Prosthetic Appliances Benefits
   P. Injectable Medications Benefits
   Q. Basic Infertility Services Benefits
   R. Diabetes Services
   S. Blood and Blood Plasma
   T. Reconstructive Breast Surgery Services
   U. Chiropractic Benefits

Depending on your employer’s chosen plan of benefits, there may be other benefits added to your plan as riders.

2. See your attached Summary of Benefits for copayment information.

3. Services are covered outside the plan in the event of an emergency. See Emergency Care.

What’s not covered

Exclusions and Limitations that Apply to Services and Benefits

A. Exclusions

This section lists some, but not all, benefits and services that are not covered services under the COC. Members are advised to carefully review the entire COC, including the covered benefits section, and any applicable riders, to determine the extent of a particular benefit’s coverage. The following are some, but not all, examples of limitations and excluded services and supplies for which a member is not covered under the COC:

• Ambulance services, for routine transportation to receive outpatient or inpatient services
• Beam neurologic testing
• Biofeedback, except as preauthorized by Aetna
• 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 or plasmapheresis. Only administration, processing of blood, processing fees and fees related to autologous blood donations are covered.
• Care for conditions that state or local laws require to be treated in a public facility, including 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
• Cosmetic surgery, or treatment relating to the consequences of, or as a result of, cosmetic surgery, other than medically necessary services. This exclusion includes surgery to correct gynecomastia and breast augmentation procedures, and otoplasties. Reduction mammoplasty, except when determined to be medically necessary by an Aetna medical director, is not covered. This exclusion does not apply to surgery to correct the results of injuries causing the impairment, or as a continuation of a staged reconstruction procedure, or congenital defects necessary to restore normal bodily functions, including cleft lip and cleft palate, and postmastectomy reconstruction.
• Costs for services resulting from the commission of or attempt to commit a felony by the member
• Court ordered services or those required by court order as a condition of parole or probation
• Custodial care
• Dental services, including services related to the care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth, dental services related to the gums, apicectomy (dental root resection), orthodontics, root canal treatment, soft tissue impactions, alveoectomy, augmentation and vestibuloplasty treatment of periodontal disease, false teeth, prosthetic restoration of dental implants, and dental implants. This exclusion does not include removal of bony impacted teeth, bone fractures, removal of tumors and orthodontogenic cysts.
• Educational services and treatment of behavioral disorders, together with 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, is 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 regimens as determined by Aetna, unless preauthorized by Aetna.
• This exclusion will not apply with respect to drugs:
   1. That have been granted treatment investigational new drug (IND) or Group c/treatment IND status;
   2. That are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; or
   3. That we have determined available scientific evidence demonstrates that the drug is effective or the drug shows promise of being effective for the disease.
This exclusion will also not apply to the following:
(Note: We will provide coverage for all medically necessary routine patient care costs incurred as a result of a treatment being provided in accordance with a cancer clinical trial in which a member participates voluntarily, except to the extent that the expenses are paid by the government, biotechnical, pharmaceutical or medical device industry sources.)
All of the following apply to a course of treatment for a cancer clinical trial:
1. The treatment is part of a scientific study of a new therapy or intervention that is being conducted at an institution in Arizona for the treatment, palliation or prevention of cancer in humans
2. The treatment is provided as part of a study being conducted in a phase I, phase II, phase III or phase IV cancer clinical trial
3. The treatment is provided as part of a study being conducted in accordance with a clinical trial approved by at least one of the following:
   a. One of the National Institutes of Health (NIH)
   b. An NIH cooperative group or center
   c. The U.S. Food and Drug Administration (FDA) in the form of an investigational new drug application
   d. The U.S. Departments of Defense and Veterans Affairs
   e. A panel of qualified recognized experts in clinical research within academic health institutions in Arizona
   f. A qualified research entity that meets the criteria established by the NIH for grant eligibility
4. The proposed treatment or study has been reviewed and approved by an institutional review board of an institution in Arizona
5. The personnel providing the treatment or conducting the study are doing so within their scope of practice, experience and training and are capable of providing the treatment because of their experience, training and volume of patients treated to maintain expertise
6. There is no clearly superior, noninvestigational treatment alternative
7. The available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as effective as any noninvestigational alternative
• Hair analysis
• Hearing aids
• Home births
• Home uterine activity monitoring
• Household equipment, including the purchase or rental of exercise cycles, water purifiers, hypoallergenic 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
• Hypnotherapy, except when preauthorized by Aetna
• Implantable drugs
• The treatment of male or female Infertility including:
  1. The purchase of donor sperm and any charges for
     the storage of sperm
  2. The purchase of donor eggs and any charges
     associated with care of the donor required for donor
     egg retrievals or transfers or gestational carriers
  3. Charges associated with cryopreservation or
     storage of cryopreserved embryos (for example,
     office, hospital, ultrasounds, laboratory tests)
  4. Home ovulation prediction kits
  5. Injectable infertility medications, including
     menotropins, hCG, GnRH agonists, and IVIG
  6. Artificial insemination, in vitro fertilization (IVF),
     gamete intrafallopian tube transfer (GIFT), zygote
     intrafallopian tube transfer (ZIFT), and
     intracytoplasmic sperm injection (ICSI), and any
     other advanced reproductive technology (ART)
     procedures or services related to such procedures
  7. Any charges associated with care required for ART
     (for example office, hospital, ultrasounds,
     laboratory tests)
  8. Donor egg retrieval or fees associated with donor
     egg programs, including fees for laboratory tests
  9. Any charges associated with a frozen embryo
     transfer, including thawing charges
 10. Reversal of sterilization surgery
 11. Any charges associated with obtaining sperm for
     any ART procedures
• 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
• Nonmedically necessary services, including those services
  and supplies:
  1. That are not medically necessary, as determined
     by Aetna, for the diagnosis and treatment of
     illness, injury, restoration of physiological
     functions or covered preventive services
  2. That do not require the technical skills of a
     medical, mental health or dental professional
  3. 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
  4. Furnished solely because the member is an
     inpatient on any day in which the member’s
     disease or injury could safely and adequately be
     diagnosed or treated while not confined
  5. Furnished solely because of the setting if the
     service or supply could safely and adequately be
     furnished in a physician’s or a dentist’s office or
     other less costly setting
• Orthotics except when applied to diabetes-related care, supplies and treatment
• Outpatient supplies, including outpatient medical
  consumable or disposable supplies such as syringes,
  incontinence pads, elastic stockings and reagent strips. This
  exclusion does not apply to diabetes-related care, supplies and treatment.
• Payment for that portion of the benefit for which Medicare
  or another party is the primary payer
• Personal comfort or convenience items, including those
  services and supplies not directly related to medical care,
  such as guest meals and accommodations, barber services,
  telephone charges, radio and television rentals, homemaker
  services, travel expenses, take-home supplies and other like
  items and services
• Prescription or nonprescription drugs and medicines, except
  when applied to diabetes related care, supplies and treatment
• Private duty or special nursing care, unless preauthorized
  by Aetna
• Recreational, educational and sleep therapy, including any
  related diagnostic testing
• Rehabilitation services, for substance abuse, including
  treatment of chronic alcoholism or drug addiction
• Religious, marital and sex counseling, including services and
  treatment related to religious counseling, marital/
  relationship counseling and sex therapy
• Reversal of voluntary sterilizations, including related
  follow-up care and treatment of complications of such
  procedures
• Routine foot/hand care, including routine reduction of nails,
  calluses and corns
• 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
• Services, including those related to pregnancy, rendered
  before the effective date or after the termination of the
  member’s coverage, unless coverage is continued under the
  Continuation and Conversion section of the COC
• Services performed by a relative of a member for which, in the
  absence of any health benefits coverage, no charge would be
  made
• Services required by third parties, including physical
  examinations and immunizations, except when medically
  necessary or indicated, and diagnostic procedures in
  connection with:
  1. Obtaining or continuing employment;
  2. Securing insurance coverage; or
  3. School admissions or attendance, including
     examinations required to participate in athletics,
     except when such examinations are considered to
• Services that are not a covered benefit under the COC, even when a prior referral has been issued by a PCP
• Specific nonstandard allergy services and supplies, including skin titration (wrinkle method), cytotoxicity testing (Bryan’s Test), treatment of nonspecific candida sensitivity and urine autoinjections
• Specific injectable drugs, except when applied to diabetes-related care, supplies and treatment, including:
  1. 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 FDA and the NIH;
  2. Needles, syringes and other injectable aids;
  3. Drugs related to the treatment of noncovered services; and
• Special medical reports, including those not directly related to treatment of the member, (for example, employment or insurance physicals, and reports prepared in connection with litigation)
• Surgical operations, procedures or treatment of obesity, except when preauthorized by Aetna
• Therapy or rehabilitation, including primal therapy, chelation therapy, rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, vision perception training and carbon dioxide
• Thermograms and thermography
• 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. This exclusion does not apply to mental health services or to medical treatment of mentally retarded members in accordance with the benefits provided in the Covered Benefits section of the COC.
• Treatment of occupational injuries and occupational diseases, including those injuries that arise out of (or in the course of) any work for pay or profit, or in any way results from a disease or injury that does. If a member is covered under a Workers’ Compensation law or similar law, and submits proof that the member is not covered for a particular disease or injury under such law, that disease or injury will be considered “nonoccupational” regardless of cause.
• Unauthorized services, including any service obtained by or on behalf of a member without a referral issued by the member’s PCP or preauthorized by Aetna. This exclusion does not apply in a medical emergency, in an urgent care situation or when it is a direct access benefit.
• Vision care services and supplies except as provided in the Description of Benefits
• Weight reduction programs, or dietary supplements
• Acupuncture and acupuncture therapy, except when performed by a participating physician as a form of anesthesia in connection with covered surgery
• Durable Medical Equipment, except when applied to diabetes-related care, supplies and treatment
• Family planning services
• Temporomandibular joint disorder treatment (TMJ), including treatment performed by prosthesis placed directly on the teeth, surgical and nonsurgical medical and dental services, and diagnostic or therapeutics services related to TMJ

B. Limitations
• In the event there are two or more alternative medical services that, in the sole judgment of Aetna, are equivalent in quality of care, we reserve the right to provide coverage only for the least costly medical service, as determined by us, provided that we preauthorize the medical service or treatment
• Determinations regarding eligibility for benefits, coverage for services, benefit denials and all other terms of the COC are at the sole discretion of Aetna, subject to the terms of the COC.

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. 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 precertification.

How we cover out-of-network emergency care
You are covered for emergency and urgently needed care. You have this coverage while you are traveling or if you are near your home. 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 emergency room.

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.

Your plan pays out-of-network benefits when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident), we will
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 for urgent care services.

Drug manufacturer rebates

Drug manufacturers may give us rebates when our members buy certain drugs. We may share those rebates with your employer. While those rebates for the most part apply to drugs on the Preferred Drug List, they may also apply to drugs not on the Preferred Drug List. But, in any case, in plans where you pay a percent of the cost, your share of the cost is based on the price of the drug before any rebate is received by Aetna. In plans where you pay a percent of the cost instead of a flat dollar amount, you may pay more for a drug on the Preferred Drug List than for a drug not on the list.

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 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, someone helping you or your doctor can ask for a medical exception. Your pharmacist can also ask for an exception for antibiotics and pain medicines.

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/. 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.

Mental health and addiction benefits

Here’s how to get mental 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 mental health specialist.

Read about mental health provider safety

We want you to feel good about using the Aetna network for mental health services. Visit 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.
Mental health programs to help prevent depression
Aetna Behavioral Health offers two prevention programs for our members:

• **Beginning Right**™ Depression Program: Perinatal Depression Education, Screening and Treatment Referral and
• **SASDA**: Identification and Referral of Substance Abuse Screening for Adolescents with Depression and/or Anxiety Prevention

For more information on either of these prevention programs and how to enroll in the programs, ask Member Services for the phone number of your local Care Management Center.

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.

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:

1. all stages of reconstruction of the breast on which a mastectomy has been performed;
2. surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. prostheses; and
4. 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 Aetna ID card.


Knowing 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.

**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
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 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.

How we determine whether to pay a claim
A claim occurs whenever you, your doctor or your authorized representative requests one of the following:

• Preauthorization (precertification) for a service that requires prior approval
• Payment for services or treatment received

As an Aetna member, you are not required to submit claims for in-network services. However, if you receive a bill for covered benefits, please submit the bill to us for payment. Send the bill with your Aetna member identification number clearly marked to the address shown on your ID card. We will make a decision on the claim.

For urgent care claims and preservice claims, we will send you written notification of our determination whether to pay the claim or not. For other types of claims, we may only notify you if we determine not to pay the claim, or reduce the claimed amount.

“Adverse benefit determinations” are decisions that result in denial, reduction or termination of a benefit or the amount paid for it. It also means a decision not to provide a benefit or

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<th>Time frames for notifying you that we denied a claim</th>
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<td><strong>Type of Claim</strong></td>
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<tr>
<td><strong>Urgent care claim.</strong> A claim for medical care or treatment where delay could seriously jeopardize the life or health of the member, the ability of the member to regain maximum function; or subject the member to severe pain that cannot be adequately managed without the requested care or treatment.</td>
</tr>
<tr>
<td><strong>Preservice claim.</strong> A claim for a benefit that requires preauthorization of the benefit before you receive the medical care.</td>
</tr>
<tr>
<td><strong>Concurrent care claim extension.</strong> A request to extend a course of treatment that we previously authorized.</td>
</tr>
<tr>
<td><strong>Concurrent care claim reduction or termination.</strong> Decision to reduce or terminate a course of treatment that we previously authorized.</td>
</tr>
<tr>
<td><strong>Postservice claim.</strong> A claim for a benefit that is not a preservice claim.</td>
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service. Adverse benefit determinations can be made for one or more of the following reasons:

- **Utilization Review.** We determine that the service or supply is not medically necessary or is an experimental or investigational procedure.
- **No Coverage.** We determine that a service or supply is not covered by the plan. A service or supply is not covered if it is not included in the list of covered benefits or otherwise excluded from coverage.
- **A plan limitation has been reached.**
- **Eligibility.** We determine that the subscriber or subscriber’s covered dependents are not eligible to be covered by Aetna.

Written notice of an adverse benefit determination will be provided to the member within the time frames in the chart on the previous page. Under certain circumstances, these time frames may be extended. The notice will provide important information that will help you appeal the adverse benefit determination if you wish to do so. Please see the Arizona Appeals Packet, which accompanies this booklet, for more information about appealing an adverse benefit determination.

### What to do if you disagree with us

#### Complaints, appeals and external review

Please tell us if you are not satisfied with a response you received from us or with how we do business.

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 email Member Services through the secure member website. 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.

#### Get a review from someone outside Aetna

If the denial is based on a medical judgment, you may be able to get an outside review if you’re not satisfied with your appeal. Follow the instructions on our response to your appeal. Call Member Services to ask for an External Review Form or log in to [www.aetna.com/individualsfamilies-health-insurance/member-guidelines/ext_review.html](http://www.aetna.com/individualsfamilies-health-insurance/member-guidelines/ext_review.html).

Most claims are allowed to go to external review. An exception would be if you are denied because you’re no longer eligible for the plan.

If your case qualifies, an Independent Review Organization (IRO) will assign it to an outside expert. The expert will be a doctor or other professional who specializes in that area or type of dispute. You should have a decision within 45 calendar days of the request.

The outside reviewer’s decision is final and binding; we will follow the external reviewer’s decision. We will also pay the cost of the review.

### A “rush” review may be possible

If your doctor thinks you cannot wait 45 days, ask for an “expedited review.” That means we will make our decision more quickly.

#### 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/individualsfamilies-healthinsurance/member-guidelines/member-rights.html](http://www.aetna.com/individualsfamilies-healthinsurance/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 “advanced directive” tells your family and doctors what to do when you can’t tell them yourself. You don’t need an advanced directive to receive care. But you have the right to create one. Hospitals may ask if you have an advanced directive when you are admitted.

There are three types of advanced 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 advanced directive in several ways:

- **Ask your doctor for an advanced 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 advanced directive.**
- **Create an advanced directive using computer software designed for this purpose.**


#### 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/individualsfamilies-health-insurance/member-guidelines/healthcare-quality.html](http://www.aetna.com/individualsfamilies-health-insurance/member-guidelines/healthcare-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. 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. Doctors in the Aetna network must allow you to see your medical records within a reasonable time after you ask for them.

Some of the ways we use your personal information include:

• 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 include how to handle requests for your information 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
• All other laws that protect your rights to receive health 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” to learn more about how we use and protect your private information. See also “Anyone can get health care.”

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 contributing to the other coverage).

When you have a new dependent
Getting married? Having a baby? A new dependent changes everything. And you can change your mind. 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 for more information, 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.
This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.[insert] or by calling 1-800-[insert].

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<th>Important Questions</th>
<th>Answers</th>
<th>Why this Matters</th>
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<tr>
<td>What is the overall deductible?</td>
<td>$500 person / $1,000 family</td>
<td>You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>Yes. $300 for prescription drug coverage. There are no other specific deductibles.</td>
<td>You must pay all the costs for these services up to the specific deductible amount before this plan begins to pay for these services.</td>
</tr>
<tr>
<td>Is there an out-of-pocket limit on my expenses?</td>
<td>Yes. For participating providers $2,500 person / $5,000 family. For non-participating providers $4,000 person / $8,000 family.</td>
<td>The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billed charges, and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Is there an overall annual limit on what the plan pays?</td>
<td>No.</td>
<td>The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.</td>
</tr>
<tr>
<td>Does this plan use a network of providers?</td>
<td>Yes. See <a href="http://www.%5Binsert">www.[insert</a>] or call 1-800-[insert] for a list of participating providers.</td>
<td>If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.</td>
</tr>
<tr>
<td>Do I need a referral to see a specialist?</td>
<td>No. You don’t need a referral to see a specialist.</td>
<td>You can see the specialist you choose without permission from this plan.</td>
</tr>
<tr>
<td>Are there services this plan doesn’t cover?</td>
<td>Yes.</td>
<td>Some of the services this plan doesn’t cover are listed on page 4. See your policy or plan document for additional information about excluded services.</td>
</tr>
</tbody>
</table>

Questions: Call 1-800-[insert] or visit us at www.[insert], or visit us at www.[insert] or call 1-800-[insert] to request a copy.

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Copayments are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.

Coinsurance is your share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan’s allowed amount for an overnight hospital stay is $1,000, your coinsurance payment of 20% would be $200. This may change if you haven’t met your deductible.

The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)

This plan may encourage you to use participating providers by charging you lower deductibles, copayments and coinsurance amounts.

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<th>Common Medical Event</th>
<th>Services You May Need</th>
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<th>Your Cost If You Use a Non-Participating Provider</th>
<th>Limitations &amp; Exceptions</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>Your Cost if You Use a Participating Provider</td>
<td>Your Cost if You Use a Non-Participating Provider</td>
<td>Limitations &amp; Exceptions</td>
</tr>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$35 copay/visit</td>
<td>40% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$50 copay/visit</td>
<td>40% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>20% coinsurance for chiropractor and acupuncture</td>
<td>40% coinsurance for chiropractor and acupuncture</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>40% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>$10 copay/test</td>
<td>40% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$50 copay/test</td>
<td>40% coinsurance</td>
<td>none</td>
</tr>
</tbody>
</table>

Questions: Call 1-800-[insert] or visit us at www.[insert], or visit us at www.[insert] or call 1-800-[insert] to request a copy.
# Summary of Benefits and Coverage: What this Plan Covers & What it Costs

## Insurance Company 1: Plan Option 1
**Coverage Period:** 01/01/2014 – 12/31/2014

### Plan Option 1 Coverage Period: 01/01/2014 – 12/31/2014

**Summary of Benefits and Coverage:**

**What this Plan Covers & What it Costs**

**Coverage for:** Individual + Spouse  
**Plan Type:** PPO

### Questions:
Call 1-800-[insert] or visit us at [www.[insert]] to request a copy.

If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.[insert]] or call 1-800-[insert] to request a copy.

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### Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>Your Cost If You Use a Participating Provider</th>
<th>Your Cost If You Use a Non-Participating Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>More information about prescription drug coverage is available at [<a href="http://www.%5Binsert">www.[insert</a>]].</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic drugs</td>
<td>$10 copay/prescription (retail and mail order)</td>
<td>40% coinsurance</td>
<td>Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)</td>
</tr>
<tr>
<td>Preferred brand drugs</td>
<td>20% coinsurance (retail and mail order)</td>
<td>40% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td>Non-preferred brand drugs</td>
<td>40% coinsurance (retail and mail order)</td>
<td>60% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td>Specialty drugs</td>
<td>50% coinsurance</td>
<td>70% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Emergency medical transportation</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td>Urgent care</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>none</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
</tr>
<tr>
<td>Physician/surgeon fee</td>
<td>20% coinsurance</td>
<td>40% coinsurance</td>
<td>none</td>
</tr>
</tbody>
</table>

### If you need drugs to treat your illness or condition

- **Generic drugs**:
  - $10 copay/prescription (retail and mail order)
  - 40% coinsurance
  - Covers up to a 30-day supply (retail prescription); 31-90 day supply (mail order prescription)

- **Preferred brand drugs**:
  - 20% coinsurance (retail and mail order)
  - 40% coinsurance

- **Non-preferred brand drugs**:
  - 40% coinsurance (retail and mail order)
  - 60% coinsurance

- **Specialty drugs**:
  - 50% coinsurance
  - 70% coinsurance

### If you have outpatient surgery

- **Facility fee (e.g., ambulatory surgery center)**
  - 20% coinsurance
  - 40% coinsurance

### If you need immediate medical attention

- **Emergency room services**
  - 20% coinsurance
  - 20% coinsurance

- **Emergency medical transportation**
  - 20% coinsurance
  - 20% coinsurance

- **Urgent care**
  - 20% coinsurance
  - 40% coinsurance

### If you have a hospital stay

- **Facility fee (e.g., hospital room)**
  - 20% coinsurance
  - 40% coinsurance

### If you need help recovering or have other special health needs

- **Mental/Behavioral health outpatient services**
  - $35 copay/office visit and 20% coinsurance other outpatient services
  - 40% coinsurance

- **Mental/Behavioral health inpatient services**
  - 20% coinsurance
  - 40% coinsurance

- **Substance use disorder outpatient services**
  - 20% coinsurance
  - 40% coinsurance

- **Substance use disorder inpatient services**
  - 20% coinsurance
  - 40% coinsurance

### If you are pregnant

- **Prenatal and postnatal care**
  - 20% coinsurance
  - 40% coinsurance

### If you need help recovering or have other special health needs

- **Home health care**
  - 20% coinsurance
  - 40% coinsurance

- **Rehabilitation services**
  - 20% coinsurance
  - 40% coinsurance

- **Habilitation services**
  - 20% coinsurance
  - 40% coinsurance

- **Skilled nursing care**
  - 20% coinsurance
  - 40% coinsurance

- **Durable medical equipment**
  - 20% coinsurance
  - 40% coinsurance

- **Hospice service**
  - 20% coinsurance
  - 40% coinsurance

### If your child needs dental or eye care

- **Eye exam**
  - $35 copay/visit
  - Not Covered

- **Glasses**
  - 20% coinsurance
  - Not Covered

- **Dental check-up**
  - No Charge
  - Covers up to $50 per year

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Questions: Call 1-800-[insert] or visit us at [www.[insert]]. If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.[insert]] or call 1-800-[insert] to request a copy.
Excluded Services & Other Covered Services:

<table>
<thead>
<tr>
<th>Services Your Plan Does NOT Cover</th>
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<th>Services Your Plan Does NOT Cover</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Cosmetic surgery</td>
<td>• Long-term care</td>
<td>• Routine eye care (Adult)</td>
</tr>
<tr>
<td>• Dental care (Adult)</td>
<td>• Non-emergency care when traveling outside the U.S.</td>
<td>• Routine foot care</td>
</tr>
<tr>
<td>• Infertility treatment</td>
<td>• Private-duty nursing</td>
<td></td>
</tr>
</tbody>
</table>

Other Covered Services (This isn’t a complete list. Check your policy or plan document for other covered services.)

<table>
<thead>
<tr>
<th>Services Your Plan Does NOT Cover</th>
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</tr>
</thead>
<tbody>
<tr>
<td>• Acupuncture (if prescribed for rehabilitation purposes)</td>
<td>• Chiropractic care</td>
<td>• Most coverage provided outside the United States. See [insert].</td>
</tr>
<tr>
<td>• Bariatric surgery</td>
<td>• Hearing aids</td>
<td>• Weight loss programs</td>
</tr>
</tbody>
</table>

Questions: Call 1-800-[insert] or visit us at www.[insert]. If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.[insert] or call 1-800-[insert] to request a copy.

Your Rights to Continue Coverage:

** Individual health insurance sample –

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your premium. There are exceptions, however, such as if:

• You commit fraud
• The insurer stops offering services in the State
• You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at [contact number]. You may also contact your state insurance department at [insert applicable State Department of Insurance contact information].

** Group health coverage sample –

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at [contact number]. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: [insert applicable contact information from instructions].

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan or policy [does/does not] provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage [does/does not] meet the minimum value standard for the benefits it provides.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.
Insurance Company 1: Plan Option 1
Coverage Examples

Coverage Period: 1/1/2014 – 12/31/2014
Coverage for: Individual + Spouse | Plan Type: PPO

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Questions:
Call 1-800-[insert] or visit us at www.[insert].
If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.[insert] or call 1-800-[insert] to request a copy.

Insurance Company 1: Plan Option 1
Coverage Examples

Coverage Period: 1/1/2014 – 12/31/2014
Coverage for: Individual + Spouse | Plan Type: PPO

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don’t include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren’t specific to a particular geographic area or health plan.
- The patient’s condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn’t covered or payment is limited.

Does the Coverage Example predict my own care needs?

No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor’s advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

No. Coverage Examples are not cost estimators. You can’t use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

Yes. When you look at the Summary of Benefits and Coverage for other plans, you’ll find the same Coverage Examples. When you compare plans, check the “Patient Pays” box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you’ll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions:
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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.

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 this 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 or, if applicable, visit the NCQA’s new top-level recognition listing at 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.

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