Consumer Disclosure and Member Handbook — Texas

This is an Exclusive Provider Organization (EPO) plan, which only provides benefits for services received from a doctor, hospital or other health care provider that participates in the plan’s network. It does not cover services received from health care providers who do not participate in the network. Some exceptions apply. They are described in your policy and this booklet.

For Aetna Leap℠ health insurance plans and these networks:

- Memorial Hermann
- Austin Yellow Rose
- Austin Redbud
- Tyler Yellow Rose
- Tyler Redbud
- Houston Yellow Rose
- JPS Hospital
- Medical Center Hospital
- Odessa Regional Medical Center
- Parkland Hospital
- San Antonio Yellow Rose
- San Antonio Redbud
- Texas Health

These health insurance plans are underwritten by Aetna Life Insurance Company — a licensed insurer in Texas.

https://myaetna.com

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Get plan information online and by phone

If you are new to this plan and have not yet enrolled
For help understanding how a particular medical plan works, or to request a sample copy of your policy for the plan you’re interested in. You may also contact us at:
Aetna
PO Box 569441
Dallas, TX 75356-9441
1-844-269-3751

If you’re already enrolled in an Aetna health plan
You have two ways to get plan information:
1. Log in to your secure member website at https://myaetna.com. You can get coverage information for your plan online. You can also get details about any programs, tools and other services that come with your plan. Just register once to create a user name and password.

Visit https://myaetna.com and click “Sign Up.” Follow the prompts to complete the one-time registration. Then you can log in any time to:
• Access your digital member ID card
• Verify who’s covered and what’s covered
• Access your “plan documents”
• Track claims or view past copies of Explanation of Benefits statements
• Use the provider search tool to find in-network care
• Learn more about and access any wellness programs that come with your plan

2. Call the toll-free number on your digital member ID card.
You can speak with a representative to:
• Understand how your plan works and your share of costs
• Get information about how to file a claim
• Find care outside your area
• File a complaint or appeal
• Get copies of your plan documents
• Connect to behavioral health services
• Find specific health information
• Learn more about our Quality Management program

Help for those who speak another language and for the hearing impaired
If you require language assistance, please call the number on your digital member ID card, and an Aetna representative will connect you with an interpreter. You can also get interpretation assistance for utilization management issues or for registering a complaint or appeal. If you’re deaf or hard of hearing, use your TTY and dial 711 for the Telecommunications Relay Service. Once connected, please enter or provide the Aetna telephone number you’re calling.

Ayuda para las personas que hablan otro idioma y para personas con impedimentos auditivos
Si usted necesita asistencia lingüística, por favor llame al número que aparece en su tarjeta de identificación digital para el miembro, y un representante de Aetna le conectará con un intérprete. También puede recibir asistencia de interpretación para asuntos de administración de la utilización o para registrar una queja o apelación. Si usted es sordo o tiene problemas de audición, use su TTY y marque 711 para el Servicio de Retransmisión de Telecomunicaciones (TRS). Una vez conectado, por favor entrar o proporcionar el número de teléfono de Aetna que está llamando.

Covered services and benefits
As an Open Access Elect Choice member, you will be entitled to the medically necessary covered benefits as listed in your Policy under “Eligible health services under your policy.” Your plan provides medically necessary covered benefits from providers who have a contract with Aetna (network or “preferred” providers). The plan does not cover services from providers who do not have a contract with Aetna (out-of-network or “nonpreferred” providers) except in certain situations described in this handbook and your policy.

This plan does not cover all health care expenses. See also the Exclusions section for information about what’s not covered. Limitations may also apply to covered services, but vary by plan. Refer to your plan documents for details. If you have questions about the exclusions and limitations before you enroll, or to request a sample copy of the Policy or Schedule of Benefits, call us toll free at 1-844-269-3751.

Medically necessary covered services
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.

Although listed as covered below, benefits are subject to the exclusions and limitations as listed in the Policy and Schedule of benefits. You are also responsible for cost sharing as
outlined in your Policy and Schedule of Benefits. See the “What you pay” section for more information.

Medically necessary covered services include:

- **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 physical examinations for children under age 18 (including immunizations, hearing and vision screening for all children to determine the need for hearing and vision correction, and hearing screening for all newborns)**
- **Pediatric vision care services and supplies as listed in the policy**
- **Certain tests for the early detection of cardiovascular disease**
- **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 physical exams for women, including:**
  - Routine gynecological exams, including routine Pap smears or liquid-based cytology methods for detection of human papillomavirus and cervical cancer
  - For women age 18 and older, annual examination for ovarian cancer including at a minimum a CA 125 blood test
- **Osteoporosis: Medically accepted bone mass measurement to detect low bone mass and to determine the person’s risk of osteoporosis and fractures associated with osteoporosis**
- **Injections, including allergy desensitization injections**
- **Diagnostic, laboratory, X-ray services**
- **Hearing aids**
- **Cancer chemotherapy, oral cancer drugs and cancer hormone treatments and services that have been approved by the United States Food and Drug Administration (FDA) 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 prenatal and postpartum care and obstetrical services, including Inpatient care for a minimum of 48 hours after an uncomplicated vaginal delivery or for 96 hours after a uncomplicated delivery by cesarean section**
- **Complications of pregnancy:**
  - Conditions, requiring hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and
  - Non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible.
- **Contraceptive drugs and devices**
- **Voluntary sterilizations**
- **Inpatient hospital & skilled nursing facility benefits, including inpatient physician care. 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**
- **Outpatient and inpatient care benefits are covered for detoxification**
• Outpatient rehabilitation visits are covered to a participating behavioral health provider 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 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.
• 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); obsessive-compulsive disorders and depression in childhood and adolescence.
• Autism spectrum disorders: a neurological disorder that includes autism, Asperger’s syndrome, or Pervasive Development Disorder.
• Services by a physician to diagnose Alzheimer’s disease.
• 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.
• 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.
• 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.
• Cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neuropsychological, neuropsychological, and psychophysiological testing or treatment, neurofeedback therapy, remediation, postacute transition services, or community reintegration services, including outpatient day treatment services, or other post-acute care treatment 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 lymphedema, as described in your specific health plan.
• Inpatient care for a minimum of 48 hours after a mastectomy or for 24 hours after a lymph node dissection.
• 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.
• Coverage for diabetes includes, but is not limited to: 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).
• 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.
• Coverage is provided for amino-acid based elemental formulas necessary for the diagnosis, treatment or administration of the following to the same extent as for drugs available only on the orders of a physician:
  - Immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins
  - Severe food protein-induced enterocolitis syndrome
  - Eosinophilic disorders, as evidenced by the results of a biopsy
  - Impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length and motility of the gastrointestinal tract
• Orthotic and prosthetic devices
• Routine patient care costs associated with approved clinical trials
• Reconstructive surgery for craniofacial abnormalities for a child who is younger than 18 years of age
• Coverage for telemedicine medical services and telehealth services
• Diagnostic or surgical treatment of conditions affecting the temporomandibular joint (including the jaw and the craniomandibular joint) if the treatment is medically necessary as a result of an accident; a trauma; a congenital defect; a developmental defect; or a pathology

Mental health and addiction benefits
You must use therapists and other mental health professionals who are in the Aetna network. Here’s how to get inpatient and outpatient services, partial hospitalization and other mental health services:
• Call 911 if it’s an emergency.
• Use the online provider search tool at https://myaetna.com.
• Call the toll-free number on your digital member ID card.

Important benefits for women
Women’s Health and Cancer Rights Act of 1998
Your Aetna health plan provides benefits for mastectomy and mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between breasts; prosthesis; and treatment of physical complications of all stages of mastectomy, including lymphedema. Coverage is provided in accordance with your plan design and is subject to plan limitations, copays, deductibles and referral requirements, if any, as outlined in your plan documents.


Transplants and other complex conditions
Our National Medical Excellence Program® is for members who need a transplant or have a condition that can only be treated at a certain hospital.
You may need to visit 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 National Medical Excellence Program based on their expertise and experience with these services. We also follow any state rules when choosing these hospitals.

Prescription drug benefit
You will be responsible for any deductible, copayments or coinsurance shown on your Schedule of Benefits.

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 it. You’ll pay your normal share of the cost, and 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 preferred drug guide (also known as a “drug formulary”). This guide shows which prescription drugs are covered on a preferred basis. It also explains how we choose medications to be in the guide.

When you get a drug that is not in the preferred drug guide, your share of the cost will usually be more. If your plan has a “closed formulary,” those drugs are not covered.

Drug companies may give us rebates when our members buy certain drugs
Rebates usually apply to drugs in the preferred drug guide. They may also apply to drugs not in the guide. In plans where you pay a percent of the cost, your share of the cost is based on the price of the drug before Aetna receives any rebate. Sometimes, in plans where you pay a percent of the cost instead of a flat dollar amount, you may pay more for a drug in the preferred drug guide than for a drug not in the guide.

Get convenient home delivery on refills
Home delivery and specialty drug services are from pharmacies that Aetna owns. Aetna Rx Home Delivery and Aetna Specialty Pharmacy are included in your network and provide convenient options for filling medicine
you take every day or specialty medicines that treat complex conditions.

You might not have to stick to the preferred drug guide
Sometimes your doctor might recommend a drug that’s not in the preferred drug guide. If it is medically necessary for you to use that drug, you, someone helping you or your doctor can ask us to make an exception. Your pharmacist can also ask for an exception for antibiotics and pain medicines. Check your plan documents for details.

You may have to try one drug before you can try another
“Step therapy” means you may have to try one or more less expensive or more common drugs before a drug on the step-therapy list will be covered. 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.

You may request an exception for some drugs that are not covered
Your plan documents might list specific drugs that are not covered. Your plan may also not cover drugs that we haven’t reviewed yet. You, someone helping you or your doctor may have to get our approval (a medical exception) to use one of these drugs.

Find out what drugs your plan covers
You can find covered drugs on your secure member website. Or, you can call the toll-free number on your digital member ID card to ask for a printed copy of the covered drug list. We may sometimes change the drugs we cover. Look online or call the toll-free number on your digital member ID card for the latest updates.

Have questions? Get answers.
Ask your doctor about specific medications. Call the number on your digital member 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.
• Tell your doctor as soon as possible afterward. A friend or family member may call on your behalf.
• You do not have to get approval for emergency services.

You are covered for emergency care
You have this coverage while you are traveling or if you are near your home. That includes students who are away at school.
Sometimes you don’t have a choice about where you go for care. Like if you go to the emergency room for chest pain or a car accident. When you need care right away, go to any doctor, walk-in clinic, urgent care center or emergency room. When you have no choice, we will pay the bill as if you got care in the network. You pay your plan’s copayments, coinsurance, and deductibles for your in-network level of benefits.

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.

After-hours care — available 24/7
Call your doctor when 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 in at https://myaetna.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.

Out-of-area services and benefits
If you are away from home, your plan pays for emergency care and urgent care.

Your financial responsibility
Besides paying your health insurance premium, you will share in the cost of your health care. These are called “out-of-pocket” costs. Out-of-pocket costs vary by plan and your plan may not include all of them. Your plan documents show which amounts apply to your specific plan. Those costs may include:

Copay — A set amount (for example, $25) you pay for covered health care service. You usually pay this when you get the service. The amount can vary by the type of service. For example, you may pay a different amount to see a specialist than you would pay to see your family doctor.
Other copays may apply at the same time:

- **Inpatient Hospital Copay** — This copay applies when you are a patient in a hospital.

- **Emergency Room Copay** — 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.

**Deductible** — The amount you owe for health care services before your health plan begins to pay. For example, if your deductible is $1,000, you have to pay the first $1,000 for covered services before the plan begins to pay. You may not have to pay a deductible for some services.

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

Services and supplies obtained from out-of-network providers are not covered under the plan. Exceptions include care received from an out-of-network provider when a network provider is not reasonably available and emergency care for an emergency medical condition.

In these cases, we will reimburse the out-of-network provider at our usual and customary charge. Please contact Member Services if you receive a bill from the out-of-network provider. We will work to resolve the outstanding balance so that all you pay is the appropriate network deductible, coinsurance, or copayments under your plan.

**Not all hospital doctors are in the network**

Some facility-based physicians and other health care practitioners are not included in the plan’s network, even if the hospital is in the network. For non-emergency care, you can request that doctors attending you during a hospital stay or outpatient procedure are those who participate in the network.

**Doctors outside the network may bill you more**

Network doctors and hospitals agree to accept the plan’s allowed amount as payment in full. Your coinsurance is based on that allowed amount. Health care practitioners that are not in the network may bill you for amounts above the allowed amount. Except for emergency care, you will be responsible for that balance bill.

**Exclusions**

The following is a summary of services that are not covered. You are responsible for all costs. Limitations to medical care products and services as well as prescription drugs may also apply to covered services, but vary by plan. Refer to your plan documents for details.

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

- **Acupuncture, acupressure and acupuncture therapy**, except where described in the Eligible health services section under your policy.

**Ambulance services**

- Ambulance services, for routine transportation to receive outpatient or inpatient services
- Fixed wing air ambulance transportation from an out-of-network provider

**Artificial organs**

- Any device that would perform the function of a body organ

**Autism spectrum disorder**

- Early intensive behavioral interventions (including LEAP, TEACCH, Rutgers, floor time, Lovaas and similar programs) and other intensive educational interventions

**Clinical trial therapies**

**(experimental or investigational)**

- Your policy does not cover clinical trial therapies (experimental or investigational), except where described in the Eligible health services — Clinical trial therapies (experimental or investigational) section under your policy.

**Clinical trial therapies (routine patient costs)**

- Services and supplies related to data collection and record-keeping that is solely needed due to the clinical trial (i.e., protocol-induced costs)
- Services and supplies provided by the trial sponsor without charge to you
- The experimental intervention itself (except medically necessary Category B investigational devices and promising experimental and investigational interventions for terminal illnesses in certain clinical trials in accordance with our claim policies)

**Blood, blood plasma, synthetic blood, blood derivatives or substitutes**

Examples of these are:

- The provision of blood to the hospital, other than blood derived clotting factors
- Any related services including processing, storage or replacement expenses
- The services of blood donors, apheresis or plasmapheresis
- For autologous blood donations, only administration and processing expenses are covered.
Cosmetic services and plastic surgery
• Any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body, whether or not for psychological or emotional reasons. This cosmetic services exclusion does not apply to surgery after an accidental injury when performed as soon as medically feasible. Injuries that occur during medical treatments are not considered accidental injuries, even if unplanned or unexpected.

Counseling
• Marriage, religious, family, career, social adjustment, pastoral, or financial counseling

Court-ordered services and supplies
• Includes those court-ordered services and supplies, or those required as a condition of parole, probation, release or because of any legal proceeding

Custodial care
Examples are:
• Routine patient care such as changing dressings, periodic turning and positioning in bed
• Administering oral medications
• Care of a stable tracheostomy (including intermittent or continuous) feedings
• Care of a stable gastrostomy/jejunostomy/nasogastric tube
• Care of a stable colostomy/ileostomy
• Care of a bladder catheter (including emptying/changing containers and clamping tubing)
• Watching or protecting you
• Respite care, adult (or child) day care, or convalescent care
• Institutional care: includes room and board for rest cures, adult day care and convalescent care
• Help with walking, grooming, bathing, dressing, getting in or out of bed, going to the bathroom, eating or preparing foods
• Any other services that a person without medical or paramedical training could be trained to perform
• Any service performed by a person without any medical or paramedical training

Durable medical equipment (DME)
Examples of these items are:
• Whirlpools
• Portable whirlpool pumps
• Massage table
• Sauna baths
• Message devices (personal voice recorder)
• Over bed tables
• Elevators
• Communication aids
• Vision aids
• Telephone alert systems

Educational services
Examples of those services are:
• Any service or supply for education, training or retraining services or testing. This includes special education, remedial education, job training and job hardening programs
• Evaluation or treatment of learning disabilities, attention deficit disorder, developmental, learning and communication disorders, behavioral disorders or training, regardless of the main cause
• Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and delays in developing skills
• Services such as speech therapy eligible under the Individuals with Disabilities in Education Act (IDEA)

Emergency services and urgent care
• Non-emergency care in a hospital emergency room facility, freestanding emergency medical care facility or comparable emergency facility
• Non-urgent care in an urgent care facility or at a non-hospital freestanding facility

Examinations
Any health or dental examinations needed:
• Because a third party requires the exam. Examples include examinations to get or keep a job, or examinations required under a labor agreement or other contract
• Because a court order requires it
• To buy insurance or to get or keep a license
• To travel
• To go to a school, camp, or sporting event, or to join in a sport or other recreational activity

Experimental or investigational
• Experimental or investigational drugs, devices, treatments or procedures unless otherwise covered under clinical trial therapies (experimental or investigational) or covered under clinical trials (routine patient costs)

Facility charges
For care, services or supplies provided in:
• Rest homes
• Assisted living facilities, except if you have an acquired brain injury. See the Specific therapies and tests section.
• Similar institutions serving as a person’s main residence or providing mainly custodial or rest care
• Health resorts
• Spas or sanitariums
• Infirmaries at schools, colleges, or camps

Family planning services and supplies
Examples of services and supplies that are not covered under the preventive care and wellness benefit include:
• Any contraceptive methods that are only “reviewed” by the FDA and not “approved” by the FDA
• Contraception services during a stay in a hospital or other facility for medical care
• The reversal of voluntary sterilization procedures, including any related follow-up care

**Family planning services — other**
• Reversal of voluntary sterilization procedures including related follow-up care
• Services and supplies provided for an abortion (voluntary termination of pregnancy)
• Charges incurred for family planning services while confined as an inpatient in a hospital or other facility

**Foot care**
• Services and supplies for:
  - The treatment of calluses, bunions, toenails, hammertoes, fallen arches
  - The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes
  - Supplies (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies, except for complications of diabetes. See the **Specific conditions** section of the policy.

**Growth/Height care**
• A treatment, device, drug, service or supply to increase or decrease height or alter the rate of growth
• Surgical procedures, devices and growth hormones to stimulate growth

**Habilitation therapy services**

**Physical, occupational and speech therapy**
• Except for physical therapy, occupational therapy or speech therapy provided for the treatment of autism spectrum disorder, therapies to treat delays in development and/or chronic conditions. Examples of non-covered diagnoses that are considered both developmental and/or chronic in nature are:
  - Autism spectrum disorders
  - Down syndrome
• Any service unless provided in accordance with a specific treatment plan
• Services you get from a home health care agency
• Services not given by a physician (or under the direct supervision of a physician), physical, occupational or speech therapist
• Services for the treatment of delays in development, including speech development, unless as a result of a gross anatomical defect present at birth

**Hearing aids and exams**
The following services or supplies:
• A replacement of:
  - A hearing aid that is lost, stolen or broken
  - A hearing aid installed within the prior 36-month period
• Replacement parts or repairs for a hearing aid
• Batteries or cords
• A hearing aid that does not meet the specifications prescribed for correction of hearing loss
• Any ear or hearing exam performed by a physician who is not certified as an otolaryngologist or otologist
• Any hearing aid furnished or ordered because of a hearing exam that was done before the date you became covered under this policy
• Hearing exams given during a stay in a hospital or other facility, except those provided to newborns as part of the overall hospital stay
• Any tests, appliances and devices to:
  - Improve your hearing: includes hearing aid batteries and auxiliary equipment
  - Enhance other forms of communication to make up for hearing loss or devices that simulate speech

**Home health care**
• Services for infusion therapy (See the **Eligible health services — Outpatient infusion therapy** section under the policy for more information)
• Services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities)
• Transportation
• Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present
• Services are not for applied behavior analysis

**Hospice care**
• Funeral arrangements
• Pastoral counseling
• Financial or legal counseling: includes estate planning and the drafting of a will
• Homemaker or caretaker services, which are not solely related to your care, such as:
  - Sitter or companion services for either you or other family members
  - Transportation
  - Maintenance of the house

**Jaw joint disorder**
• Diagnosis and treatment of Temporomandibular joint disorder (TMJ)
• Temporomandibular joint disorder treatment (TMJ) performed by prosthesis placed directly on the teeth, surgical and non-surgical medical and dental services, and diagnostic or therapeutics services related to TMJ

**Maintenance care**
• Care made up of services and supplies that maintain, rather than improve, a level of physical or mental function except for habilitation therapy services
Medical supplies — outpatient disposable
• Any outpatient disposable supply or device. Examples of these include:
  - Sheaths
  - Bags
  - Elastic garments
  - Support hose
  - Bandages
  - Bedpans
  - Syringes, except for treatment of diabetes
  - Blood or urine testing supplies, except for treatment of diabetes
  - Other home test kits
  - Splints
  - Neck braces
  - Compresses
  - Other devices not intended for reuse by another patient

Mental health treatment
• Mental health services for the following categories (or equivalent terms as listed in the most recent version of the International Classification of Diseases (ICD)):
  - Dementias and amnesias without behavioral disturbances
  - Sexual deviations and disorders except for gender identity disorders
  - Tobacco use disorders
  - Specific disorders of sleep
  - Antisocial or dissociative personality disorder
  - Pathological gambling, kleptomania, pyromania
  - Specific delays in development (learning disorders, academic underachievement)
  - Intellectual disability
  - Wilderness treatment program or any such related or similar program
  - School and/or education service
• Services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities)
• Transportation

• Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present
• Services are not for applied behavior analysis

Nutritional supplements
• Any food item, including infant formulas, nutritional supplements, vitamins, plus prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition, except as covered in the Eligible health services under your policy — Other services section

Obesity (bariatric) surgery
• Weight management treatment or drug intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity, except as covered in the Eligible health services — Other services section and the Preventive care and wellness — Preventive screening and counseling services section under your policy for obesity screening and weight management interventions. This is regardless of the existence of other medical conditions. Examples of these are:
  - Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric surgery
  - Surgical procedures, medical treatments, weight control/loss programs primarily intended to treat, or are related to the treatment of obesity, including morbid obesity
  - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications
  - Hypnosis, or other forms of therapy
  - Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement

Orthotic devices
• Services covered under any other benefit
• Repair and replacement due to loss, misuse, abuse or theft

Outpatient infusion therapy
• Specialty prescription drugs and medicines provided by your employer or through a third party vendor contract with your employer
• Drugs that are included on the list of specialty prescription drugs as covered under your outpatient prescription drug plan
• Enteral nutrition
• Blood transfusions and blood products
• Dialysis

Outpatient prescription drugs
• Abortion drugs
• Allergy serum and extracts
• Any services related to the dispensing, injection or application of a drug
• Biological liquids and fluids
• Brand-name prescription drugs and devices when a generic prescription drug equivalent, biosimilar prescription drug or generic prescription drug alternative is available, unless otherwise covered by medical exception
• Cosmetic drugs
  - Cosmetic drugs, medications or preparations used for cosmetic purposes
• Compound prescriptions containing bulk chemicals that have not been approved by the U.S. Food and Drug Administration (FDA)
• Devices, products and appliances that do not have a National Drug Code (NDC)
• Dietary supplements including medical foods
• Drugs or medications:
  - Administered or entirely consumed at the time and place it is prescribed or dispensed
- Which do not, by federal or state law, require a prescription order (i.e. over-the-counter (OTC) drugs), even if a prescription is written, except where stated in the Eligible health services — Outpatient prescription drugs section under your policy
- That includes the same active ingredient or a modified version of an active ingredient
- That is therapeutically equivalent or a therapeutic alternative to a covered prescription drug unless a medical exception is approved
- That is therapeutically equivalent or a therapeutic alternative to an over-the-counter (OTC) product unless a medical exception is approved
- Provided by, or while the person is an inpatient in, any health care facility, or for any drugs provided on an outpatient basis in any such institution to the extent benefits are payable for it
- Recently approved by the U.S. Food and Drug Administration (FDA), but which have not yet been reviewed by the Aetna Pharmacy and Therapeutics Committee
- That includes vitamins and minerals
- For which the cost is recoverable under any federal, state, or government agency or any medication for which there is no charge made to the recipient
- That are used for the treatment of sexual dysfunction, enhance sexual performance or increase sexual desire, including drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ
- That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature unless there is evidence that the member meets one or more clinical criteria detailed in our preauthorization and clinical policies
- Not approved by the FDA or not proven to be safe and effective
- Duplicative drug therapy (e.g. two antihistamine drugs)
- Genetic care
- Any treatment, device, drug, service or supply to alter the body’s genes, genetic make-up, or the expression of the body’s genes except for the correction of congenital birth defects
- Immunizations related to travel or work
- Immunization or immunological agents. See the Preventive care immunizations section of the policy for covered immunizations.
- Implantable drugs and associated devices except where stated in the Eligible health services under your policy — Preventive care and wellness and Outpatient prescription drugs sections
- Infertility
- Injectable prescription drugs used primarily for the treatment of infertility
- Injectables:
- Any charges for the administration or injection of prescription drugs or injectable insulin and other injectable drugs covered by us. See the Eligible health services under your policy — Diabetic equipment, supplies and education for covered equipment and supplies.
- Injectable drugs dispensed by out-of-network pharmacies
- Needles and syringes, including but not limited to diabetic needles and syringes, except where stated in the Eligible health services under your policy — Diabetic equipment, supplies and education section
- Injectable drugs, unless dispensed through the network specialty pharmacy
- For any refill of a designated specialty prescription drug not dispensed by or obtained through the network specialty pharmacy
- An updated copy of the list of specialty prescription drugs designated by this policy to be refilled by or obtained through the network specialty pharmacy is available upon request or may be accessed by logging onto your secure member website at https://myaetna.com.
- Insulin pumps or tubing or other ancillary equipment and supplies for insulin pumps
- Prescription drugs:
- Dispensed by other than a network retail, home delivery and specialty pharmacies
- Dispensed by an out-of-network home delivery pharmacy, except in a medical emergency or urgent care situation
- For which there is an over-the-counter (OTC) product which has the same active ingredient and strength even if a prescription is written
- Filled prior to the effective date or after the end date of coverage under this policy
- Dispensed by a home delivery pharmacy that includes prescription drugs that cannot be shipped by mail due to state or federal laws or regulations, or when the policy considers shipment through the mail to be unsafe. Examples of these types of drugs include, but are not limited to, narcotics, amphetamines, DEA controlled substances and anticoagulants
- That include an active metabolite, stereoisomer, prodrug (precursor) or altered formulation of another drug and is no clinically superior to that drug as determined by the policy
- That are ordered by a dentist or prescribed by an oral surgeon in relation to the removal of teeth, or prescription drugs for the treatment of a dental condition unless dental benefits are provided under the policy
- That are considered oral dental preparations and fluoride rinses, except pediatric fluoride tablets or drops as specified on the preferred drug guide
- That are non-preferred drugs, unless non-preferred drugs are specifically covered as described in your schedule of benefits. However, a non-preferred drug will be covered if in the judgment of the prescriber there is no equivalent prescription drug in the preferred drug guide or the product in the preferred drug guide is ineffective in treating your disease or condition or has caused or is likely to cause an adverse reaction or harm you
- That are not covered or related to a non-covered service
- That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, the use of or intended use of which would be illegal, unethical, imprudent, abusive, not medically necessary, or otherwise improper and drugs obtained for use by anyone other than the member identified on the ID card

We reserve the right to include only one manufacturer’s product in the preferred drug guide when the same or similar drug (that is, a drug with the same active ingredient), supply or equipment is made by two or more different manufacturers.

We reserve the right to include only one dosage or form of a drug in the preferred drug guide when the same drug (that is, a drug with the same active ingredient) is available in different dosages or forms from the same or different manufacturers. The product in the dosage or form that is listed in our preferred drug guide will be covered at the applicable copayment.

- Progesterone
  - Progesterone for the treatment of premenstrual syndrome (PMS) and compounded natural hormone therapy replacement
- Prophylactic drugs for travel
- Refills
  - Refills dispensed more than one year from the date the latest prescription order was written, or as otherwise permitted by applicable law of the area in which the drug is dispensed
- Replacement of lost or stolen prescriptions
- Tobacco use
  - Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including medications, nicotine patches and gum unless recommended by the United States Preventive Services Task Force (USPSTF). See the Eligible health services under the policy — Outpatient prescription drugs section.
- Test agents except diabetic test agents

**Outpatient surgery**
- The services of any other physician who helps the operating physician
- A stay in a hospital (A hospital stay is an inpatient hospital benefit. See the Eligible health services — Hospital and other facility care section under the policy)
- A separate facility charge for surgery performed in a physician’s office
- Services of another physician for the administration of a local anesthetic

**Dental care for adults**
- Dental services for adults including services related to:
  - The care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth, except for treatment of accidental injury to sound natural teeth
  - Dental services related to the gums
  - Apicoectomy (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
  - Dental implants
  This exclusion does not include removal of bony impacted teeth, bone fractures, removal of tumors, and odontogenic cysts.

**Personal care, comfort or convenience items**
- Any service or supply primarily for your convenience and personal comfort or that of a third party

**Physician surgical services**
- The services of any other physician who helps the operating physician
- A stay in a hospital (See the Eligible health services — Hospital and other facility care section under the policy)
- A separate facility charge for surgery performed in a physician’s office
- Services of another physician for the administration of a local anesthetic

**Private duty nursing**

**Prosthetic devices**
- Services covered under any other benefit
- Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent
complications of diabetes, or if the orthopedic shoe is an integral part of a covered leg brace
• Trusses, corsets, and other support items
• Repair and replacement due to loss, misuse, abuse or theft

Services provided by a family member
• Services provided by a spouse, domestic partner, parent, child, step-child, brother, sister, in-law or any household member

Services, supplies and drugs received outside of the United States
• Non-emergency medical services, outpatient prescription drugs or supplies are not covered when received outside the United States, even if they are covered in the United States under the policy.

Sexual dysfunction and enhancement
• Any treatment, prescription drug, service, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
  - Surgery, prescription drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ
  - Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services

Short-term rehabilitation services

Outpatient cognitive rehabilitation, physical, occupational and speech therapy
• Except for physical therapy, occupational therapy or speech therapy provided for the treatment of autism spectrum disorder, therapies to treat delays in development and/or chronic conditions. Examples of non-covered diagnoses that are considered both developmental and/or chronic in nature are:
  - Down syndrome
  - Cerebral palsy
• Any service unless provided in accordance with a specific treatment plan
• Services you get from a home health care agency
• Services provided by a physician, or treatment covered as part of the spinal manipulation benefit
  - This applies whether or not benefits are paid under the spinal manipulation section
• Services not given by a physician (or under the direct supervision of a physician), physical, occupational or speech therapist
• Services for the treatment of delays in development, including speech development, unless as a result of a gross anatomical defect present at birth

Specialty prescription drugs
• Drugs that are included on the list of specialty prescription drugs as covered under your outpatient prescription drug plan

Strength and performance
• Services, devices and supplies such as drugs or preparations designed primarily to enhance your strength, physical condition, endurance, or physical performance

Substance related disorders treatment
• Except where described in the Eligible health services under the policy — Substance related disorders treatment section, alcoholism or drug abuse rehabilitation treatment on an inpatient or outpatient basis.

Teledmedicine or telehealth
• Any services given by providers that are not contracted with Aetna as telemedicine or telehealth providers
• Any services that are not provided during an internet-based consult or via telephone

Therapies and tests
• Full body CT scans

• Hair analysis
• Hypnosis and hypnotherapy
• Massage therapy, except when used as a physical therapy modality
• Sensory or auditory integration therapy

Tobacco cessation
Except where described in this policy:
• Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including, medications, nicotine patches and gum unless recommended by the United States Preventive Services Task Force (USPSTF). This also includes:
  - Counseling, except where stated in the Eligible health services under the policy — Preventive care and wellness section
  - Hypnosis and other therapies
  - Medications, except where stated in the Eligible health services under the policy — Outpatient prescription drugs section
  - Nicotine patches
  - Gum

Transplant services
• Services and supplies furnished to a donor when the recipient is not a covered person
• Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing illness
• Outpatient drugs including bio-medicals and immunosuppressant not expressly related to an outpatient transplant occurrence
• Home infusion therapy
• Harvesting and/or storage of bone marrow, or hematopoietic stem cells without intending to use them for transplantation within 12 months from harvesting, for an existing illness
Treatment in a federal, state, or governmental entity
• Any care in a hospital or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws

Treatment of infertility
All charges associated with the treatment of infertility, except as described under the Eligible health services — Treatment of infertility — Basic infertility section under the policy. This includes:
• All charges associated with:
  - Surrogacy for you or the surrogate. A surrogate is a female carrying her own genetically related child where the child is conceived with the intention of turning the child over to be raised by others, including the biological father
  - Cryopreservation of eggs, embryos, or sperm
  - Storage of eggs, embryos, or sperm
  - Thawing of cryopreserved eggs, embryos or sperm
  - The care of the donor in a donor egg cycle. This includes, but is not limited to, any payments to the donor, donor screening fees, fees for lab tests, and any charges associated with care of the donor required for donor egg retrievals or transfers
  - The use of a gestational carrier for the female acting as the gestational carrier. A gestational carrier is a female carrying an embryo to which she is not genetically related
• Home ovulation prediction kits or home pregnancy tests
• Injectable infertility medication, including but not limited to menotropins, hCG, and GnRH agonists
• The purchase of donor embryos, donor oocytes, or donor sperm
• Reversal of voluntary sterilizations, including follow-up care
• Any charges associated with obtaining sperm for ART services
• Ovulation induction with menotropins, intrauterine insemination and any related services, products or procedures
• In vitro fertilization (IVF), Zygote intrafallopian transfer (ZIFT), Gamete intrafallopian transfer (GIFT), Cryopreserved embryo transfers and any related services, products or procedures (such as Intracytoplasmic sperm injection (ICSI) or ovum microsurgery)

Vision care
Pediatric vision care
• Eyeglass frames, prescription lenses and prescription contact lenses that are not identified as preferred by a vision provider
• Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes

Adult vision care
• Routine vision exam provided by an ophthalmologist or optometrist including refraction and glaucoma testing and vision care services and supplies

Vision care services and supplies
Your policy does not cover vision care services and supplies, except as described in the Eligible health services — Other services section under the policy.
• Special supplies such as non-prescription sunglasses
• Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes

Wilderness treatment programs
• Wilderness treatment programs (whether or not the program is part of a residential treatment facility or otherwise licensed institution)
• Educational services, schooling or any such related or similar program, including therapeutic programs within a school setting

Work related illness or injuries
• Coverage available to you under workers’ compensation or under a similar program under local, state or federal law for any illness or injury related to employment or self-employment.
• A source of coverage or reimbursement is considered available to you even if you waived your right to payment from that source. You may also be covered under a workers’ compensation law or similar law.
• If you submit proof that you are not covered for a particular illness or injury under such law, then that illness or injury will be considered “non-occupational” regardless of cause.
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.” You usually only need preauthorization for more serious care like surgery or being admitted to a hospital. Your network doctor will get this approval for you. You do not have to get preauthorization for emergency services.

What we look for when reviewing a 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 make sure the service and place requested to perform the service are cost-effective. Our decisions are based entirely on appropriateness of care and service and the existence of coverage, using nationally recognized guidelines and resources. We may suggest a different treatment or place of service that is just as effective but costs less. We also look to see if you qualify for one of our care management programs. If so, one of our nurses may contact you.

Preauthorization 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.

Our review process after preauthorization (Utilization Review/Patient Management)

We have developed a patient management program to help you access appropriate health care and maximize coverage for those health care services. In certain situations, we review your case to be sure the service or supply meets established guidelines and is a covered benefit under your plan. We call this a “utilization review.”

We follow specific rules to help us make your health a top concern during our reviews

• We do not reward Aetna employees for denying coverage.
• We do not encourage denials of coverage. In fact, we train staff to focus on the risks of members not getting proper care. Where such use is appropriate, our staff uses nationally recognized guidelines and resources, such as MCG (formerly Milliman Care Guidelines) to review requests for coverage. Physician groups, such as independent practice associations, may use other resources they deem appropriate.
• We do not encourage utilization decisions that result in underutilization.

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

If you have a chronic condition or an upcoming hospital stay

You may qualify for one of our care management programs. An Aetna nurse can be the extra support you need. After you enroll, just call the number on your ID card to learn more.

What happens if your doctor leaves the health plan

If your doctor leaves the network, you may be able to continue seeing that doctor for a limited time. This will allow you extra time to finish your course of treatment or find a replacement doctor you’re comfortable with. This “continuation of care” provision applies as follows:

<table>
<thead>
<tr>
<th>If you have this condition:</th>
<th>You can be covered with your doctor for an extra</th>
</tr>
</thead>
<tbody>
<tr>
<td>A disability, acute condition, life-threatening illness and special circumstances</td>
<td>90 days, but this may vary based on your condition.</td>
</tr>
<tr>
<td>A terminal illness</td>
<td>Up to nine months, based on the date the provider terminated its participation with Aetna.</td>
</tr>
<tr>
<td>Past the 24th week of pregnancy</td>
<td>Through delivery of the child, immediate postpartum care and follow-up checkup within the first 6 weeks after delivery</td>
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To be eligible, your doctor cannot have left the network for any of these reasons:

• Imminent harm to your health
• Action against the doctor’s professional license
• Provider fraud
• Failure to satisfy credentialing criteria
Complaints, appeals and independent review

Please tell us if you are not satisfied with a response you received from us or with how we do business. We will not retaliate against you or your provider for telling us you are not satisfied. You may file a complaint, appeal or independent review as shown in this section.

Call Member Services to file a verbal complaint or to ask for the address to mail a written complaint.
The phone number is on your digital member ID card. You can also email Member Services through the secure member website or write to us at:

Aetna
PO Box 14586
Lexington, KY 40512-1486

If you’re not satisfied after talking to a Member Services representative, you can ask us to send your issue to the appropriate complaint 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.

Appeals of medical necessity denials will be reviewed by a U.S.-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. Their toll-free telephone number is 1-800-252-3439.

A “rush” review may be possible
If your doctor thinks you cannot wait 30 days, ask for an “expedited review.” Examples include:

• Life-threatening conditions
• Denial of prescription drugs or intravenous infusions you are currently receiving
• Denials for emergency care
• Care after your condition has stabilized (poststabilization)
• Continued hospital stays

We will respond as soon as possible, but not later than within one working day. We will give your provider a notice of denial of coverage for poststabilization care after emergency treatment no later than one hour after the time your physician requests the care. We will also notify you of a denial for continued hospital stay within 24 hours of your request.

Get a review from someone outside Aetna
Independent review is a review done by people in an organization outside of Aetna. We call this an independent review organization (IRO). If we determine that a service or supply is not medically necessary, or is experimental or investigational, you (or a person acting on your behalf, or your doctor/health care provider) may ask us for a review by an IRO. In most situations, you must complete an internal appeal with us before you ask for an independent review. Sometimes you don’t have to complete the internal appeal process before you ask for an immediate independent review. These are when:

• You have an urgent claim or a claim that involves ongoing treatment
• You have a life-threatening condition
• You are receiving prescription drugs or intravenous infusion treatments and we deny them
• We did not follow all of the claim determination and appeal rights of Texas or the Federal Department of Health and Human Services. But, you will not be able to proceed directly to independent review if:

- The rule violation was minor and not likely to influence a decision or harm you
- The violation was for a good cause beyond our control
- The violation was part of an ongoing, good faith exchange between you and us

If a claim is denied as not medically necessary or as experimental investigational (adverse determination) you will receive a denial letter containing the procedures for our complaint and appeal process. The letter will also include notice of your right to appeal an adverse determination to an independent review organization (IRO) and the procedure to obtain that review. If the appeal of the adverse determination is upheld, you will again receive information of your right to seek review of the denial by an IRO and the procedures to do so.

We will follow the independent reviewer’s decision. We will also pay the cost of the review.

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

Use the online provider search tool for the most up-to-date list of health care professionals and facilities. You can get a list of available doctors by ZIP code, or enter a specific doctor’s name in the search field.

Existing members: Log in to your secure member website at https://myaetna.com. Then, select “Doctors & Facilities” from the top menu bar.

Considering enrollment: Visit www.aetnafindadoc.com and answer a few questions. Then use the “Find Participating Providers” bar near the top of the screen to search for providers. You’ll need to select the plan you’re interested in from the drop-down box.
Our online search tool 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
- Hospital affiliations
- Gender
- Driving directions

Get a FREE printed directory

Our provider directories are updated four times each year. To get a free printed list of doctors and hospitals, call the toll-free number on your digital member ID card. If you’re not yet a member, call 1-844-241-0208. You may also write to: Aetna, PO Box 569441, Dallas, TX, 75356-9441.

Our provider directories identify hospitals in which the facility-based physicians are not part of the provider network. Our network hospitals will exercise good faith effort to accommodate your request to use a network doctor. If you are assigned a facility-based physician or physician group at least 48 hours before services are rendered, the hospital will provide, at least 24 hours before services are rendered, enough information for you to determine if the assigned facility-based physician or physician group is a network provider.

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 doctor will be available or is accepting new patients. Our network of doctors may change without notice.

The status of the doctor’s practice may have changed

Although we have identified doctors who were not accepting patients as known to us at the time we added that doctor to our network, the status of the doctor’s practice may have changed. For the most current information, please contact the selected doctor or call Member Services at the toll-free number on your digital member ID card.

We must pay for out-of-network services at network rates if you reasonably relied (within 30 days of the service date) on a statement that a doctor or other health care provider was a network provider as specified in:

- Our provider directory; or
- Provider information on our website

How we pay doctors

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. 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.

Accountable Care Organizations — Physician networks that help to improve care while lowering costs

Accountable care organizations, such as Memorial Hermann, are networks of primary care doctors, specialists and at least one hospital. Their mission is to better coordinate patient care to improve efficiency, quality and patient satisfaction.

Like most plans, we pay these doctors and hospitals on a fee-for-service basis. We pay them more when they meet certain goals. The amount of these payments depends on how well the networks meet goals for efficiency and quality. For example:

- Increase screenings for cancer, diabetes and cholesterol
- Reduce avoidable ER visits, short-term hospital stays, repetitive tests and the overall cost of care

*The specific goals will vary from network to network.
The network may also have to make payments to us if they fail to meet their goals. This helps encourage savings that are tied to value and better health outcomes for our members. Doctors and hospitals that are members of an accountable care network may have their own financial arrangements through the network itself. Ask your doctor for details.

It’s important for doctors to see a complete view of your health care to provide customized treatment plans for your unique needs. For that reason, we may share your health information with the accountable care organization and/or doctors within the network.

You can see which health care providers are part of an accountable care organization when you use our online search tool. See “Search our network for doctors, hospitals and other health care providers” in this booklet for details. After entering your search criteria, look for the specific network logo.

**Service area**

Our service area includes the following counties in Texas:

**A**
Anderson, Andrews, Angelina, Aransas, Archer, Armstrong, Atascosa, Austin

**B**
Bailey, Bandera, Bastrop, Baylor, Bee, Bell, Bexar, Borden, Bowie, Brazoria, Briscoe, Burnet

**C**
Caldwell, Calhoun, Cameron, Camp, Carson, Cass, Castro, Chambers, Cherokee, Childress, Clay, Cochran, Coke, Collin, Collingsworth, Colorado, Comal, Concho, Cooke, Cottle, Crane, Crosby

**D**
Dallam, Dallas, Dawson, Deaf Smith, Delta, Denton, Dickens, Donley, Duval

**E**
Ector, El Paso, Ellis, Erath

**F**
Fannin, Fayette, Fisher, Floyd, Foard, Fort Bend, Franklin, Freestone

**G**
Gaines, Galveston, Garza, Glasscock, Gray, Grayson, Gregg, Grimes, Guadalupe

**H**

**I**
Irion

**J**
Jack, Jackson, Jasper, Jefferson, Jim Wells, Johnson

**K**
Kaufman, Kendall, Kent, King, Kleberg, Knox

**L**
Lamar, Lamb, Lee, Leon, Liberty, Lipscomb, Live Oak, Lubbock, Lynn

**M**
Marion, Martin, Matagorda, McLennan, Medina, Menard, Midland, Mitchell, Montague, Montgomery, Moore, Morris

**N**
Nacogdoches, Navarro, Newton, Nueces

**O**
Ochiltree, Oldham, Orange

**P**
Palo Pinto, Panola, Parker, Parmer, Polk, Potter

**R**
Rains, Randall, Red River, Roberts, Rockwall, Runnels, Rusk

**S**
Sabine, San Augustine, San Jacinto, San Patricio, Schleicher, Scurry, Shackelford, Shelby, Sherman, Smith, Somervell, Starr, Stephens, Sterling, Stonewall, Swisher

**T**
Tarrant, Terry, Throckmorton, Titus, Tom Green, Travis, Trinity, Tyler

**U**
Upshur, Upton

**V**
Van Zandt, Victoria

**W**

**Y**
Yoakum, Young

**Learn about our network demographics and local market access plans**

We annually report health plan data and information to the Texas Department of Insurance (TDI) to assist the TDI in evaluating the adequacy of our networks. If a waiver or a local market access plan applies to facility services or to internal medicine, family or general practice, pediatric practitioner practice, obstetrics and gynecology, anesthesiology, psychiatry, or general surgery services, you may view the plan information on our website at [www.aetna.com/individuals-families-health-insurance/document-library/documents/Texas-Statewide-EPO-2016-Availability-Analysis.pdf](http://www.aetna.com/individuals-families-health-insurance/document-library/documents/Texas-Statewide-EPO-2016-Availability-Analysis.pdf). You can also view the percent of dollars filed with Aetna on behalf of non-contracted providers per facility on our website at [www.aetna.com/docfind/cms/assets/pdf/TX_NonContracted_Prdr_Rprt.pdf](http://www.aetna.com/docfind/cms/assets/pdf/TX_NonContracted_Prdr_Rprt.pdf). If you do not have internet access or prefer a printed copy of the results, contact Member Service.
You have the right to an adequate network of preferred providers

Exclusive Provider Organization Disclosure

Texas Department of Insurance Notice

• An exclusive provider benefit plan provides no benefits for services you receive from out-of-network providers, with specific exceptions as described in your policy and below.
• You have the right to an adequate network of preferred providers (known as “network providers”).
  - If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance.

If your insurer approves a request for out-of-network services because no network provider is available, or if you have received out-of-network emergency care, your insurer must, in most cases, resolve the out-of-network provider’s bill so that you only have to pay any applicable copay and deductible amounts.

You may access a current directory of network providers at the following website: https://myaetna.com or by calling 1-844-241-0208 for assistance in finding available network providers.

If you relied on materially inaccurate directory information, you may be entitled to have an out-of-network claim paid at the network level of benefits.

How we determine what is covered

You can avoid unexpected bills. Check your plan documents to see what’s covered before you get health care. Can’t find your plan documents? Call Member Services to ask a specific question or have a copy mailed to you.

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
• Must 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 decide if a treatment or service is not medically necessary. We do not reward Aetna employees for denying coverage. Sometimes a physician’s group will determine medical necessity. 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. You can call Member Services to ask for a free copy of the materials we use to make coverage decisions.

Or visit www.aetna.com/about/cov_det_policies.html to read our Clinical Policy Bulletins. Doctors can write or call our Patient Management department with questions. Contact Member Services either online or at the phone number on your digital member ID card for the appropriate address and phone number.

We study the latest medical technology

We look at scientific evidence published in medical journals to help us decide what is medically necessary. 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 MCG (formerly Milliman Care Guidelines).

We also review the latest medical technology, including drugs, equipment and 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

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

CPBs help us decide whether to approve a coverage request. Your plan may not cover everything 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. You can find them under “Individuals & Families.” No Internet? Call Member Services at the toll-free number on your digital member ID card. You can ask for a copy of any CPB named in a denial letter.

Renewability and premium information

**Guaranteed renewable**
You can renew this policy each year (“guaranteed renewable”). We decide the premium rates. We may make changes to the benefits and/or premium rates during the term of this policy:
- As allowed by law and under the terms of this policy
- Upon renewal.

**When will your coverage end?**
Your coverage under this policy will end if:
- This policy is discontinued
- You voluntarily stop your coverage by notifying us in writing 31 days before the date you want your coverage to end
- You are no longer eligible for coverage including moving out of the service area
- You do not pay the required premium payment by the end of the grace period
- This product is discontinued in the state, if approved by the insurance department of the state where this policy was issued
- We withdraw from the individual market in the state, if approved by the insurance department of the state where this policy was issued
- We rescind your coverage, as permitted under this policy
- You commit fraud

**Premium agreement**
Your premium rate will not change for the initial month of this policy as long as there are no changes to this policy. This is called a guaranteed period. A “change to the policy” means:
- A change in the area in which you live
- A change in the benefit plan
- The addition of dependents to the policy.

Premium rates are expected to change over time as the cost of health care services change. Each premium will be based on the rates that apply on that premium due date. We will let you know in writing at least 60 days before the premium rate changes. In the event of any changes in premium rates, payment of the premium by you means that you accept the premium changes.

**Grace period**
You have a grace period of ten days after the due date for the payment of each premium due after the first premium payment. If premiums are not paid by the end of the grace period, your coverage will automatically terminate at the end of the grace period.

We have the right to require the return of any payments for claims paid during the grace period for which premium was not received.

Member rights and 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. This includes our Member Rights and Responsibilities.

Some of your rights are below. We also publish a list of rights and responsibilities on our website. Visit www.aetna.com and enter “rights and resources” into the search bar to view the list. You can also call the number on your digital member ID card to request a printed copy or for more information.

**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.
- Write your wishes down by yourself.
- Pick up a form at state or local offices on aging, 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.

Learn more about care management and quality management programs

We make sure your doctor provides quality care for you and your family. To learn more about these programs, log in to your secure member website at www.aetna.com. Enter “commitment to quality” in the search bar. You can also call Member Services to ask for a printed copy. The toll-free number is on your digital member ID card.

We protect your privacy

We consider personal information to be private. Our policies protect your personal information from unlawful use. By “personal information,” we mean information that can identify you as a person, as well as your financial and health information.

Personal information does not include what is available to the public. For example, anyone can access information about what the plan covers. It also does not include reports that do not identify you.

Summary of the Aetna privacy policy

When necessary for your care or treatment, the operation of our health plans or other related activities, we use personal information within our company, share it with our affiliates and may disclose it to:

• Your doctors, dentists, pharmacies, hospitals and other caregivers
• Other insurers
• Vendors
• Government departments
• Third-party administrators (TPAs)

These parties are required to keep your information private as required by law.

Some of the ways in which we may use your information include:

• Paying claims
• Making decisions about what the plan covers
• Coordination of payments with other insurers
• Quality assessment
• Activities to improve our plans
• Audits

We consider these activities key for the operation of our plans. When allowed by law, we use and disclose your personal information in the ways explained above without your permission. Our privacy notice includes a complete explanation of the ways we use and disclose your information. It also explains when we need your permission to use or disclose your information.

We are required to give you access to your information. If you think there is something wrong or missing in your personal information, you can ask that it be changed. We must complete your request within a reasonable amount of time. If we don’t agree with the change, you can file an appeal.

For more information about our privacy notice or if you’d like a copy, call the toll-free number on your digital member ID card or visit us at https://myaetna.com.

Anyone can get health care

We do not consider your race, disability, religion, sex, gender identity, sexual orientation, health, ethnicity, creed, age or national origin when giving you access to care. Network providers are legally required 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. This includes enrolling your spouse or children and other dependents. If that happens, you must apply within 60 days before you expect to lose coverage and 60 days after your coverage has ended.

When you have a new dependent

Getting married? Having a baby? A new dependent changes everything. And you can change your mind. You can enroll within 60 days after certain life events if you chose not to enroll during the normal open enrollment period. These life events include:

• Marriage
• Birth
• Adoption
• Placement for adoption

Call Member Services for more information or to request special enrollment.
No coverage based on U.S. sanctions

If U.S. trade sanctions consider you a blocked person, the plan cannot provide benefits or coverage to you. If you travel to a country sanctioned by the United States, the plan in most cases cannot provide benefits or coverage to you. Also, if your health care provider is a blocked person or is in a sanctioned country, we cannot pay for services from that provider. For example, if you receive care while traveling in another country and the health care provider is a blocked person or is in a sanctioned country, the plan cannot pay for those services. For more information on U.S. trade sanctions, visit www.treasury.gov/resource-center/sanctions/Pages/default.aspx.
Aetna does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in the administration of the plan, including enrollment and benefit determinations.

We are committed to Health Plan Accreditation by the National Committee for Quality Assurance (NCQA) as a means of demonstrating a commitment to continuous quality improvement and meeting customer expectations. You can find a complete list of health plans and their NCQA status on the NCQA website located at [www.ncqa.org](http://www.ncqa.org). Click on the “Report Cards” tab to search on “Health Plans.”

To refine your search for other health care providers, click on “Clinicians” or “Other Healthcare Organizations.” The link for “Clinicians” includes doctors recognized by NCQA in the areas of heart/stroke care, diabetes care, patient centered medical home and patient centered specialty practice. The recognition programs are built on evidence-based, nationally recognized clinical standards of care; therefore, NCQA provider recognition is subject to change. You can access the official NCQA directory of recognized clinicians at [http://recognition.ncqa.org](http://recognition.ncqa.org). The link for “Other Healthcare Organizations” includes “Managed Behavioral Healthcare Organizations” for behavioral health accreditation and “Credentials Verifications Organizations” for credentialing certification.

[https://myaetna.com](https://myaetna.com)

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Nondiscrimination Notice

Aetna complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Aetna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Aetna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact our Civil Rights Coordinator.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with our Civil Rights Coordinator at:

Address: P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779)
Telephone: 1-800-648-7817 (TTY: 711), Fax: 1-859-425-3379 (CA HMO customers: 860-262-7705)
Email: CRCoordinator@aetna.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD).


Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, and its affiliates.
For language assistance in English call 855.425.8706 at no cost. (English)

Para obtener asistencia lingüística en español, llame sin cargo al 855.425.8706. (Spanish)

欲取得繁體中文語言協助，請撥打 855.425.8706，無需付費。 (Chinese)

Pour une assistance linguistique en français appeler le 855.425.8706 sans frais. (French)

Para sa tulong sa wika na Tagalog, tawagan ang 855.425.8706 nang walang bayad. (Tagalog)

T’aiá shi shizaad k’ehji bee shiká a’doowol nínizíng Diné k’ehji kojjí t’aiá jiik’e hólne’ 855.425.8706 (Navajo)

Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 855.425.8706 an. (German)

تب♡ leggings ♠יよコ♠ら♀℃나。مرأة فرنسية (Amharic)

Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 855.425.8706. (Dutch)

Pour une assistance linguistique en français appeler le 855.425.8706 sans frais. (French Creole)

Για γιασιση γονεια ςτα Ελληνικα καλέστε το 855.425.8706 χωρίς χρέωση. (Greek)

(Gujarati) સુધી તમને માનસમાં સહાય માટે કોઈ પણ પણ યોગ્ય પણ 855.425.8706 પર કોપક કરો. (Hindi)

(Indonesia) मैं आपके लिए सहायता के लिए, 855.425.8706 पर मुफ्त फोन करें। (Hmong)

Maka enyemaka asuṣi na Igbo kpọg ọgọ 855.425.8706 na akwughị ọgwọ ọ buła (Ibo)

Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 855.425.8706. (Italian)

日本語で援助をご希望の方は、855.425.8706まで無料でお電話ください。 (Japanese)

Karen (Karen)
한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 855.425.8706번으로 전화해 주십시오.

(Korean)

'Bę m kê gbo-kpá-kpá dyé pído dję Bäsö-wuqùün wée, dja 855.425.8706 (Kru-Bassa)

(Kurdish)

بو وركرتنى زينوينى پيووندىار به زمان به زمانى 855.425.8706 به خوارىي پيووندى بکمن. (Kurdish)

(Kinyarwanda)

N'ima by'umwe iziberehe mu muriye iyi mu kuganga mu kuganga, kana mu mu runye mu 855.425.8706 giyo umwe ry'ихия. (Kinyarwanda)

(Mon-Khmer, Cambodian)

(नेपाली) मा निषेधक भाषा सहायता पाउनका लागि 855.425.8706 मा फोन गर्नुहोस्। (Nepali)

Fer Helfe in Deitsch, ruf: 855.425.8706 aa. Es Aaruf koschtet nix. (Pennsylvania Dutch)

(Persian)

برای راهنمایی به زبان فارسی با شماره 855.425.8706 پهون نه. 855.425.8706 بدون هیچ هزینه ای ترجمه نگری. انگلیسی (Persian)

Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 855.425.8706. (Polish)

Para obter assistência linguística em português ligue para o 855.425.8706 gratuitamente. (Portuguese)

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 855.425.8706. (Russian)

Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 855.425.8706. (Serbo-Croatian)

(Šyriac-Assyrian)

(Šyriac-Assyrian)

(උංග්‍ර‍ී) (Telugu)

สำหรับความช่วยเหลือทางภาษาอันภาษาไทย ใน 855.425.8706 ค่อยๆแจ้งไปชัดเจน (Thai)

Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 855.425.8706. (Ukrainian)

(Urdu)

(Urdu)

Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 855.425.8706. (Vietnamese)

Fún iránlowo nípa èdè (Yorùbá) pe 855.425.8706 lái san owó kankan rárá. (Yoruba)