Take charge of your health

Choose Aetna, choose affordable coverage

The information you need to choose quality and affordable health benefits and insurance coverage
First things first. Is my doctor covered?

We believe a healthier experience begins with what matters most to you. And we have helpful tools like our online provider directory to help you find your doctor or hospital.

Just visit http://www.aetnaindividualdocfind.com to find the doctors and hospitals you trust most.
Aetna individual health insurance plans are underwritten by Aetna Life Insurance Company and/or by Aetna Health Inc. (Aetna).
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.
Thank you for your interest in Aetna individual health plans

We know how important it is for you to make the right choice. Take a look at the information in this packet. It contains important tips and tools that will help you along the way. If you have questions or want to talk, just call us.

Call 1-800-MY-HEALTH (1-800-694-3258, TTY: 711).

We’re here to help
Focusing on what matters most

We know there are few things more important than making the best choice for your health coverage. That’s why every benefits and insurance plan we provide begins with what matters most:

<table>
<thead>
<tr>
<th>Your doctors</th>
<th>For 2016 benefits, the open enrollment period is November 1, 2015 through January 31, 2016. If you miss this window, you must wait until the next open enrollment period, unless you qualify for a special enrollment period. If you have a qualifying life event after the open enrollment period has ended, you may be eligible for a special enrollment period. Some examples of qualifying life events are getting married or having a baby. See a full list of qualifying events at <a href="http://www.healthcare.gov">http://www.healthcare.gov</a>.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your prescriptions</td>
<td>All of our plans include prescription drug coverage and medical care.</td>
</tr>
<tr>
<td>A plan that works for you</td>
<td>Good news. You can choose a plan that meets your needs and offers you more control over how you manage your health. Whether you want to do that by phone, online, in print or in person – the choice is yours.</td>
</tr>
<tr>
<td>Your confidence</td>
<td>We’ve been in business for more than 160 years. We strive to direct our business – and our industry – toward more simple and honest services.</td>
</tr>
</tbody>
</table>
What does that mean?

Here are a few definitions of terms you’ll see throughout this brochure.

**Benefit**  
A covered service, medical supply or drug that health insurance helps pay for. Some examples are doctor visits, tests and X-rays.

**Coinsurance**  
The amount you pay after you meet your yearly deductible.

**Copayment (copay)**  
A set cost you pay when you receive a covered service. Most plans have copays for doctor visits. You pay your copay to the physician or other health care provider. Copays may differ by type of service.

**Deductible**  
A set amount that you must pay for your covered services before the health plan starts to pay.

**Exclusions and limitations**  
Specific conditions or circumstances that aren’t covered under a plan.

**Health insurance exchange**  
The health insurance exchange (or marketplace) is a new way to shop for health insurance. Online stores help you find, compare and choose a health insurance plan that fits your needs.

**Out-of-pocket maximum**  
The limit on the amount an individual has to pay for health care services that his/her benefits plan covers.

**Premium**  
The amount a health insurer charges for a health insurance policy. It’s a set amount that you pay each month. If you have a health plan through your employer, you and your employer may share this cost. If you buy a health plan yourself, you pay the full amount.

**Provider network**  
A group of health care providers that works with us to offer services to our members at a discounted price. In-network benefits apply when you receive care from physicians or facilities that are part of our network.
Top reasons to choose Aetna

**Quality coverage, competitive costs**
We offer health benefits and health insurance plans with valuable features. They include an excellent combination of quality coverage and competitively priced premiums. Most plans also include:

- The freedom to see doctors whenever you need to – without referrals*
- Coverage for preventive care, prescription drugs, doctor visits, hospitalization and immunizations
- No copayments for preventive care when you visit a network provider
- No claim forms to fill out when you use a network provider

**Walk-in clinics**
These health care clinics are located in retail stores, supermarkets and pharmacies. They treat minor illnesses. They also provide preventive health care services. Walk-in clinics (or convenient care clinics) are often open nights, weekends and holidays when you can’t see your regular doctor.

**E-visits**
These are electronic visits between you and your health care providers. You can send a medical concern to them, and they can securely give you medical advice and/or care. They can also prescribe medication/therapy online.

**Family coverage**
Apply for coverage for yourself, for you and your spouse, or for your whole family.

**Tax breaks with health savings accounts (HSAs)**
It’s easy—you set up a personal account that lets you pay for qualified medical expenses. Then, you or an eligible family member makes contributions. That money earns interest. All contributions and withdrawals for qualifying expenses are tax free, so you pay less.

Once you enroll in a qualifying high-deductible health plan, we’ll send you a letter outlining how to enroll in an HSA. Once you’re enrolled in an HSA, we’ll send you a welcome letter. Review the material so we can help you start using your HSA.

**Embedded deductible**
An embedded deductible means one person on a plan with two or more members can meet the individual deductible and start receiving covered benefits.

**Example:**
Let’s say you have a plan with four family members, John, Jane, Billy and Katie. Each family member has a $500 individual deductible OR $1,000 for the family. John meets his $500 individual deductible; therefore, he can start receiving covered plan benefits. The remaining three family members can contribute any portion to satisfy the $1,000 family deductible. Jane can contribute $125, Billy $275 and Katie can contribute the final $100. Or Jane can contribute the entire $500. Then the family deductible is met.

Note: This is an example for illustrative purposes only. The amounts above don’t reflect an actual plan deductible.

*Referrals are required for HMO plans and all plans in New Jersey.
We’re here to help

Many people have never had to shop for health insurance. An employer often provides it. But if you have to buy health insurance on your own, it’s important to understand the process.

### Online
Go online for easy ways to find the plan that’s best for you. Then, follow the step-by-step guide to enroll in the plan you choose.


For off exchange plans: [http://www.aetnaindividual.com](http://www.aetnaindividual.com)

### By mail (applies only if you are applying for off exchange plans)
Complete and return the enclosed enrollment form.

### By phone
Call us toll-free at 1-800-MY-HEALTH (1-800-694-3258, TTY: 711).

We can also help you complete the application.

### Broker
You have an ally in the process. Get personalized help from your broker, who can answer your questions, help you choose the plan that’s right for you and guide you through the enrollment process.
What happens next?

After you enroll, you can use this checklist to keep track of your new plan.

<table>
<thead>
<tr>
<th>Material name</th>
<th>Description</th>
<th>Delivery</th>
<th>When to expect</th>
</tr>
</thead>
<tbody>
<tr>
<td>“What comes next” letter</td>
<td>This will let you know how to pay your first monthly premium to activate your coverage.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(you’ll receive this only if you’re applying for on exchange plans)</td>
<td></td>
<td>7 – 10 days</td>
</tr>
<tr>
<td>Welcome letter</td>
<td>The welcome letter lets you know when to expect your member ID card and plan documents. It’ll also tell you how to sign up for your Aetna NavigatorSM secure member website.</td>
<td></td>
<td>7 – 10 days</td>
</tr>
<tr>
<td>Quick start guide</td>
<td>This will remind you to register for your Aetna Navigator secure member website. You can also download our mobile app and find out how to talk with a registered nurse. The guide also includes your member ID card and a copy of our privacy notice.</td>
<td></td>
<td>7 – 10 days</td>
</tr>
<tr>
<td>Summary of Benefits and Coverage (SBC)</td>
<td>An easy-to-read summary of the benefits for the plan you selected.</td>
<td></td>
<td>7 days</td>
</tr>
<tr>
<td>Plan documents</td>
<td>You’ll get a postcard that directs you to your Aetna Navigator secure member website. There you can find plan documents like your certificate of coverage. Think of these documents as your owner’s manual. They’ll tell you about how to use your plan, what’s covered and who to call if you have questions.</td>
<td></td>
<td>30 days</td>
</tr>
</tbody>
</table>
Health care reform — What you need to know

Since President Obama signed the Affordable Care Act (ACA), we regularly update the Aetna individual health insurance plans to include required changes.

Be assured – your Aetna individual health plan meets the federal health care reform legislation requirements.

Quick facts about health care reform

- Most people must have insurance or risk paying a fine. In 2016, the fine is 2.5 percent of your income or $695 per person, whichever amount is higher.
- You can get preventive care (including immunizations) without cost share. This includes enhanced coverage of women’s preventive health benefits.
- Coverage includes Essential Health Benefits.
- You can see if you qualify for a lower cost or tax credit through the exchanges. They help cover monthly payments.
- There are no annual or lifetime limits on Essential Health Benefits.
- There are no pre-existing condition exclusions.
- There are public exchanges or “online marketplaces” where you can compare/buy plans.
- Five factors can affect marketplace plan prices: location, age, family size, tobacco use, and plan category. Health status and gender don’t affect pricing.
- Young adults up to age 26 can stay on their parents’ plan.

Learn more about health care reform

Better health, better care, better cost

Accountable care plans are a new way of looking at health care. They’re also known as Aetna Whole HealthSM plans in some areas. These plans strive to better coordinate your care, improve your health and save you money. That’s because they’re special networks of primary care doctors, specialists and hospitals focused on you. So as a member, you’ll have access to a health care team from this special network. You’ll pick a primary care doctor. Your doctor will lead your health care team. They’ll work with you to:

• Help keep you healthy or improve your health, not just treat you when you’re sick or injured
• Better coordinate your care and keep tabs on your prescriptions, lab results, health history and more
• Build personalized care plans to treat you
• Encourage you to play an active and informed role in your health and health care decisions

How accountable care works

Like most plans, we pay accountable care doctors and hospitals on a fee-for-service basis. But we also pay these doctors for the quality of their care. This means we reward them for meeting certain goals. For example, they can earn more if they perform more cancer, diabetes or cholesterol screenings. Or if they reduce avoidable emergency room visits or repetitive tests. On the other hand, they may need to pay back some of their fees if they miss their goals. All of that helps create value, savings and better health outcomes for you.

We may also share your health information with accountable care providers. This can help them better coordinate your care. That extra data gives them a 360-degree view of your medical record and unique needs. And it could also help cut down on duplicate tests and other things that can increase your costs.
Resources at your fingertips
To be an active and informed member of your care team, you need to be in the know. And we can help get you there. Better manage your plan, your health and your budget. Start at http://www.myaelawholehealth.com to learn about your plan. From here you can register for your secure member site, where you can:

• Search for doctors, hospitals, pharmacies and more in your area
• Check your personal health record and see reminders for important preventive screenings
• Download the iTriage® app to set and track your health goals, make appointments and more
• Shop for the best deals on tests and procedures with Member Payment Estimator
• Review your claims and pay your bills

Tip: You’ll save money and get the most coordinated care when you stay in network and use accountable care doctors and hospitals.

Tip: If your health or life is in serious danger, go to the nearest hospital or call 911. But if you need care after hours and your health or life isn’t in immediate danger, consider going to an urgent care clinic in our network. They often have extended and weekend hours. They may even be open on holidays. That’s more convenient and costs less than a trip to the emergency room.

Tip: Visit http://www.myaelawholehealth.com to see what it’s like to be an accountable care plan member. There you’ll find a new member guide and video created just for you.

We’re here to help
To learn more, look for “accountable care” in the bronze, silver and gold plan options pages in this brochure. Or call us at 1-800-MY-HEALTH (1-800-694-3258, TTY: 711). You can also visit us online at http://www.aetnaindividual.com.
Save money — 
use Aetna’s provider network

Maybe you’ve read that one of the best ways to save on health care costs is to “stay in network.” But you’re not sure what that means.

You’re not alone. Many people find the term confusing. We’re here to help you understand what in network means for you.

How our network helps you save

A network is a group of health care providers. It includes doctors, specialists, dentists, hospitals and other facilities. These health care providers have a contract with us. As part of the contract, they provide services to our members at a lower rate.

This contract rate is usually much lower than what the doctor would charge if you weren’t an Aetna member. And the network doctor agrees to accept the contract rate as payment. You pay your coinsurance or copay, along with your deductible.

So what does this all mean? It means you have access to the care you need at a lower price. And the difference in cost can be huge — for the same type of service or procedure.

How much you can save

You can see detailed examples of how much you might save — on the same service — just by staying in network.

Find doctors and hospitals in the network

It’s easy to look up in network doctors and hospitals using our DocFind® directory. It’s a good idea to check every time you make an appointment.

Visit http://www.aetnaindividualdocfind.com. Then select “your primary state of residency.” Or, call 1-800-MY-HEALTH (1-800-694-3258, TTY: 711) and ask for provider information.

Example 1

You’ve been getting care for an ongoing condition from a specialist who isn’t in the Aetna network. You’re thinking about switching to a specialist in the Aetna network. This example illustrates what you may save if you switch.

<table>
<thead>
<tr>
<th>Office visit</th>
<th>In network</th>
<th>Out of network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor bill</td>
<td>$150</td>
<td>$150</td>
</tr>
<tr>
<td>Amount Aetna uses to calculate payment</td>
<td>Aetna’s rate* in network</td>
<td>$90*</td>
</tr>
<tr>
<td>Recognized amount** out of network</td>
<td>$90**</td>
<td></td>
</tr>
<tr>
<td>What we’ll pay</td>
<td>Amount of Aetna’s negotiated rate/recognized amount</td>
<td>$90</td>
</tr>
<tr>
<td>Percent your plan pays</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Amount of Aetna’s negotiated rate/recognized amount covered under plan</td>
<td>$72*</td>
<td>$54**</td>
</tr>
<tr>
<td>What you owe</td>
<td>Your coinsurance responsibility</td>
<td>$18</td>
</tr>
<tr>
<td>Amount that can be balance billed to you</td>
<td>$0</td>
<td>$60</td>
</tr>
<tr>
<td><strong>Your total responsibility</strong></td>
<td><strong>$18</strong>*</td>
<td><strong>$96</strong>*</td>
</tr>
</tbody>
</table>

View more examples on the following page.
Example 2
You need outpatient surgery for a simple procedure and are deciding if you’ll have it done by a physician in the Aetna network. This example gives you an idea of how much you might owe depending on your choice.

<table>
<thead>
<tr>
<th>Surgery type</th>
<th>Amount billed</th>
<th>In network</th>
<th>Out of network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery bill**</td>
<td>$2,000</td>
<td>$2,000</td>
<td></td>
</tr>
<tr>
<td>Amount Aetna uses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>to calculate payment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aetna’s rate* in network</td>
<td>$600*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recognized amount** out of network</td>
<td>$600**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What we’ll pay</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aetna’s negotiated rate/recognized amount</td>
<td>$600</td>
<td>$600</td>
<td></td>
</tr>
<tr>
<td>Percent your plan pays</td>
<td>80%</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>Amount of Aetna’s negotiated rate/recognized amount covered under plan</td>
<td>$480*</td>
<td>$360**</td>
<td></td>
</tr>
<tr>
<td>What you owe</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your coinsurance responsibility</td>
<td>$120</td>
<td>$240</td>
<td></td>
</tr>
<tr>
<td>Amount that can be balance billed to you</td>
<td>$0</td>
<td>$1,400</td>
<td></td>
</tr>
<tr>
<td>Your total responsibility</td>
<td>$120***</td>
<td>$1,640***</td>
<td></td>
</tr>
</tbody>
</table>

Example 3
You need to go to the hospital, but it’s not an emergency. It turns out that you have to stay in the hospital for five days. This example gives you an idea of how much you might owe to the hospital depending on whether it’s in the Aetna network.

<table>
<thead>
<tr>
<th>Hospital stay</th>
<th>Amount billed</th>
<th>In network</th>
<th>Out of network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital bill</td>
<td></td>
<td>$25,000</td>
<td>$25,000</td>
</tr>
<tr>
<td>Amount Aetna uses</td>
<td></td>
<td>$8,750*</td>
<td>$8,750*</td>
</tr>
<tr>
<td>to calculate payment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aetna’s rate* in network</td>
<td></td>
<td>$8,750*</td>
<td>$8,750*</td>
</tr>
<tr>
<td>Recognized amount** out of network</td>
<td>$8,750**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>What we’ll pay</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aetna’s negotiated rate/recognized amount</td>
<td>$8,750</td>
<td>$8,750</td>
<td></td>
</tr>
<tr>
<td>Percent your plan pays</td>
<td>80%</td>
<td>60%</td>
<td></td>
</tr>
<tr>
<td>Amount of Aetna’s negotiated rate/recognized amount covered under plan</td>
<td>$7,000*</td>
<td>$5,250**</td>
<td></td>
</tr>
<tr>
<td>What you owe</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your coinsurance responsibility</td>
<td>$1,750</td>
<td>$3,500</td>
<td></td>
</tr>
<tr>
<td>Amount that can be balance billed to you</td>
<td>$0</td>
<td>$16,250</td>
<td></td>
</tr>
<tr>
<td>Your total responsibility</td>
<td>$1,750***</td>
<td>$19,750***</td>
<td></td>
</tr>
</tbody>
</table>

*Doctors, hospitals and other health care providers in the Aetna network accept our payment rate and agree that you owe only your copay, coinsurance and deductible.
**When you go out of network, the plan determines a recognized amount. You may be responsible for the difference between the billed amount and the recognized amount. See your plan documents for details. Your plan may instead call the recognized amount the recognized charge.
***Most plans cap out-of-pocket costs for covered services. The deductible and coinsurance you owe count toward that cap. But when you go outside the network, the difference between the health care provider’s bill and the recognized amount does not count toward that cap.
††You also may be responsible for a portion of fees charged by the facility in which the surgery takes place. The figures in the example do not include those facility fees.

These examples are for illustrative purposes only.
Costs for out-of-network doctors and hospitals

People pay more of their health care costs these days. It’s no wonder there’s a lot of interest in keeping these costs down.

A smart way to do this is to avoid using doctors and hospitals that are “out of network.” We don’t have a contract for reduced rates with an out-of-network doctor or hospital. So you could end up with higher costs and more work.

Why out-of-network costs more

There are a few reasons you probably will pay more out of pocket:

- Your Aetna health benefits or insurance plan may pay part of the doctor’s bill. But it pays less of the bill than if you get care from a network doctor.
- Some plans may not pay any benefits if you go out of network. Some plans cover out of network only in an emergency.

Cost sharing is more

With most plans, your coinsurance is higher for out-of-network care. Coinsurance is the part of the covered service you pay for. (For example, the plan pays 80 percent of the covered amount, and you pay 20 percent coinsurance.)

Out-of-network rates are higher

- An out-of-network doctor sets the rate to charge you. It’s usually higher than the amount your Aetna plan “recognizes” or “allows.”
- An out-of-network doctor can bill you for anything over the amount that we recognize or allow. This is called “balance billing.” A network doctor agrees not to do that.
- We don’t base our payments on what the out-of-network doctor bills you. We don’t know in advance what the doctor will charge.
Deductibles are separate, higher
What you pay when you’re balance billed doesn’t count towards your deductible. It’s also not part of any cap your plan has on how much you have to pay for services.
Plus, many plans have a separate deductible for out-of-network services. They’re usually higher than your in-network deductible, which you may not even have. You must meet the out-of-network deductible before we pay out-of-network benefits.

You’ll have more work, too
Plus, when you visit an out-of-network doctor, you may have to get precertification, or preapproval of some health care services. This means more time and more paperwork for you.

We cover emergency care
You’re covered for emergency care. You have this coverage while you’re traveling or at home. This includes students who are away at school. You can find detailed information in the disclosure section of this packet.

Know your costs before you go
Before you decide where to receive care, look up your estimated costs. It’s easy with our cost-of-care tools. Once you’re a member, log in to your Aetna Navigator® secure member website to use these tools.
Your plan options

Plans are grouped in three types: Bronze, Silver and Gold. The plan type lets you know how much you pay for premiums and out-of-pocket costs. Generally, the more you pay for your premium, the less you pay for your doctor visits and other care.

<table>
<thead>
<tr>
<th>Plan type</th>
<th>Monthly premium</th>
<th>Costs you pay out of pocket</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bronze</td>
<td>$</td>
<td>$$$</td>
</tr>
<tr>
<td>Silver</td>
<td>$$</td>
<td>$</td>
</tr>
<tr>
<td>Gold</td>
<td>$$$</td>
<td>$</td>
</tr>
</tbody>
</table>

Note: Not all plan types are available in every state. Check the plans on the following pages for what’s available in your state. If you are under 30 years old or have a very low income, you might be able to buy what’s called a “catastrophic plan.” These are not available in all states.
Aetna Health Plan options in Texas
These plans include pediatric dental (PD).

<table>
<thead>
<tr>
<th>Member benefits</th>
<th>TX Aetna Bronze</th>
<th>TX Aetna Bronze</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$15 Copay PD</td>
<td>HSA Eligible PD</td>
</tr>
<tr>
<td>(applies to out-of-pocket maximum)</td>
<td>$6,850/$13,700</td>
<td>$6,450/$12,900</td>
</tr>
<tr>
<td>Member coinsurance</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>maximum you will pay for all covered services (age and frequency visit limits apply)</td>
<td>$6,850/$13,700</td>
<td>$6,450/$12,900</td>
</tr>
<tr>
<td>Primary care visit</td>
<td>$15 copay; ded waived</td>
<td>Covered in full after ded</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>Covered in full after ded</td>
<td>Covered in full after ded</td>
</tr>
<tr>
<td>Hospital stay</td>
<td>Covered in full after ded</td>
<td>Covered in full after ded</td>
</tr>
<tr>
<td>Outpatient surgery (ambulatory surgical center/hospital)</td>
<td>Covered in full after ded</td>
<td>Covered in full after ded</td>
</tr>
<tr>
<td>Emergency room</td>
<td>Covered in full after ded</td>
<td>Covered in full after ded</td>
</tr>
<tr>
<td>Urgent care</td>
<td>$100 copay; ded waived</td>
<td>Covered in full after ded</td>
</tr>
<tr>
<td>Preventive care/screening/immunization</td>
<td>Covered in full; ded waived</td>
<td>Covered in full; ded waived</td>
</tr>
<tr>
<td>Annual routine gyn exam (annual pap/mammogram)</td>
<td>Covered in full; ded waived</td>
<td>Covered in full; ded waived</td>
</tr>
<tr>
<td>Diagnostic lab</td>
<td>Covered in full after ded</td>
<td>Covered in full after ded</td>
</tr>
<tr>
<td>Diagnostic X-ray</td>
<td>Covered in full after ded</td>
<td>Covered in full after ded</td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>Covered in full after ded</td>
<td>Covered in full after ded</td>
</tr>
<tr>
<td>Vision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pediatric eye exam (1 visit per year)</td>
<td>Covered in full; ded waived</td>
<td>Covered in full; ded waived</td>
</tr>
<tr>
<td>Pediatric glasses/contacts (coverage is limited to 1 set of frames and 1 set of contact lenses or eyeglass lenses per calendar year)</td>
<td>Covered in full; ded waived</td>
<td>Covered in full; ded waived</td>
</tr>
<tr>
<td>Pediatric dental</td>
<td>Covered in full; ded waived</td>
<td>Covered in full after ded</td>
</tr>
<tr>
<td>Dental checkup/preventive dental care (2 visits per year)</td>
<td>Covered in full; ded waived</td>
<td>Covered in full after ded</td>
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<tr>
<td>Basic dental care</td>
<td>Covered in full after ded</td>
<td>Covered in full after ded</td>
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<tr>
<td>Major dental care</td>
<td>Covered in full after ded</td>
<td>Covered in full after ded</td>
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<tr>
<td>Orthodontia (medically necessary only)</td>
<td>Covered in full after ded</td>
<td>Covered in full after ded</td>
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<tr>
<td>Pharmacy</td>
<td>Integrated with medical ded</td>
<td>Integrated with medical ded</td>
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<tr>
<td>Preferred generic drugs</td>
<td>Generic: Covered in full after ded</td>
<td>Generic: Covered in full after ded</td>
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<tr>
<td>Preferred brand drugs</td>
<td>Covered in full after ded</td>
<td>Covered in full after ded</td>
</tr>
<tr>
<td>Nonpreferred drugs</td>
<td>Generic &amp; Brand: Covered in full after ded</td>
<td>Generic &amp; Brand: Covered in full after ded</td>
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<tr>
<td>Specialty drugs*</td>
<td>P: Covered in full after ded</td>
<td>P: Covered in full after ded</td>
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</table>

*The family deductible and/or out-of-pocket limit can be met by a combination of family members. Each covered family member only needs to satisfy his or her individual deductible and/or out-of-pocket limit.

*Aetna individual health insurance plans are underwritten by Aetna Life Insurance Company and/or by Aetna Health Inc. (Aetna).
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<thead>
<tr>
<th>TX Aetna Silver $10 Copay PD</th>
<th>TX Aetna Gold $10 Copay PD</th>
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<tr>
<td>TX Aetna Silver $10 Copay Memorial Hermann PD</td>
<td>TX Aetna Gold $10 Copay Memorial Hermann PD</td>
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<td>TX Aetna Silver $10 Copay San Antonio Community Plan PD</td>
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<tr>
<th>In network you pay</th>
<th>In network you pay</th>
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<tr>
<td>$3,500/$7,000</td>
<td>$1,400/$2,800</td>
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<tr>
<td>30%</td>
<td>20%</td>
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<tr>
<td>$6,250/$12,500</td>
<td>$5,000/$10,000</td>
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<tr>
<td>$10 copay; ded waived</td>
<td>$10 copay; ded waived</td>
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<tr>
<td>$75 copay; ded waived</td>
<td>$40 copay; ded waived</td>
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<tr>
<td>$500 copay per admission after ded; then 30%</td>
<td>20% after ded</td>
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<tr>
<td>$250 copay after ded; then 30%</td>
<td>20% after ded</td>
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<tr>
<td>$500 copay after ded</td>
<td>$250 copay after ded</td>
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<tr>
<td>$75 copay; ded waived</td>
<td>$75 copay; ded waived</td>
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<td>Covered in full; ded waived</td>
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<td>30% after ded</td>
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<tr>
<td>$250 copay after ded; then 30%</td>
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<td>Covered in full; ded waived</td>
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<td>$500 per member</td>
<td>$250 per member</td>
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<tr>
<td>Low Cost Generic: $5 copay; ded waived</td>
<td>Low Cost Generic: $3 copay; ded waived</td>
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<tr>
<td>Generic: $15 copay; ded waived</td>
<td>Generic: $10 copay; ded waived</td>
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<tr>
<td>$40 copay after ded</td>
<td>$40 copay after ded</td>
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<tr>
<td>Generic &amp; Brand: $75 copay after ded</td>
<td>Generic &amp; Brand: $70 copay after ded</td>
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<td>P: 40% after ded</td>
<td>P: 40% after ded</td>
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<td>NP: 50% after ded</td>
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This plan comparison guide shows in-network benefits only.

Out-of-network benefits are not available for HMO plans, except in an emergency.

Out-of-network benefits are available for Point of Service (POS) and Preferred Provider Organization (PPO) plans.

To learn more details about specific plans, including whether a plan includes out of network benefits, see the Summary of Benefits and Coverage at [https://www.aetna.com/sbcsearch/home](https://www.aetna.com/sbcsearch/home).

- Choose Aetna under “Select a Carrier”
- Click the “General Search” tab
- Fill out the required fields (choose “Individual and Family” Group Size)
- Click “Submit”
- Select a plan (or plans) and click “Download”
- Open the SBC you selected.

This information is a partial description of the benefits and in no way details all of the benefits, limitations, or exclusions of the plan. Please refer to the individual policy, schedule of benefits, and applicable riders to determine exact terms, conditions and scope of coverage, including all exclusions and limitations and defined terms.

This material is for information only. A summary of exclusions is listed in the Aetna Health Plan brochure. For a full list of benefits coverage and exclusions refer to the plan documents. Rates and benefits vary by location. Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna’s Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Health insurance plans contain exclusions and limitations. Investment services are independently offered by the HSA Administrator. Information is believed to be accurate as of the production date; however, it is subject to change.
Things to think about when choosing your 2016 health insurance plan:

**How your health care needs may be changing.** Maybe you’re planning to add to your family. Or maybe you had major surgery this year and expect next year to be less eventful. Planning ahead can help you find the right balance between your monthly payment and what you’ll pay out of pocket.

**The total cost for your plan.** When comparing your plan options, make sure you’re looking at more than just the monthly payment (also called premium). Take a close look at the plan benefits too. Look for terms like “copay” and “deductible.” These will tell you what you could pay for your care when you go to the doctor, pick up a prescription, or have a hospital stay.

**Who is in your plan’s network.** Networks can be different depending on the plan you pick. Even plans offered by the same insurance company could have different networks with different hospitals and doctors. Check that all your doctors are in your plan’s network before choosing a plan.

*For 2016, your insurance company may automatically enroll you in the same or a similar plan. You can change your plan during Open Enrollment.*
Due to changes related to health care reform, the federal government redefined rating areas. This list of rating areas shows where Aetna Health Plans are available in your state. Just look for your county in one of the area listings below.

Your rates will depend on the area in which your county is located. For more information or a quote on what your rate would be, call your broker or 1-800-MY-HEALTH (1-800-694-3258).

<table>
<thead>
<tr>
<th>Rating areas*</th>
<th>Area 3</th>
<th>Area 4</th>
<th>Area 8</th>
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<tr>
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<td>Rockwall</td>
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<tr>
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<th>Area 11</th>
<th>Area 19</th>
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<td>Bell</td>
<td>Atascosa</td>
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<tr>
<td>Brazoria</td>
<td>Liberty</td>
<td>Coryell</td>
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<td>Montgomery</td>
<td>Lampasas</td>
<td>Bexar</td>
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<td>San Jacinto</td>
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<td>Waller</td>
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<td>Guadalupe</td>
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<td>Kendall</td>
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<td>Medina</td>
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<th>Aetna Memorial Hermann plans</th>
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<tbody>
<tr>
<td>Area 10</td>
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<tr>
<td>Fort Bend</td>
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<td>Harris</td>
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<td>Montgomery</td>
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<tr>
<th>Aetna San Antonio Community plans</th>
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<tr>
<td>Area 19</td>
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<tr>
<td>Atascosa</td>
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<tr>
<td>Bandera</td>
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<tr>
<td>Bexar</td>
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<tr>
<td>Comal</td>
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</tbody>
</table>

*Networks may not be available in all zip codes and are subject to change.
Language access services:

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-MY-HEALTH (1-800-694-3258).

Dinek’ehgo shika at’ohwol ninisingo, kwijjigo holne’ 1-800-MY-HEALTH (1-800-694-3258).

如果需要中文的帮助，请拨打这个号码 1-800-MY-HEALTH (1-800-694-3258).

Para obtener asistencia en Español, llame al 1-800-MY-HEALTH (1-800-694-3258).
Eligibility and requirements

What you need to know

To qualify for an Aetna individual health plan, you must:
• Be a resident of the state in which you’re applying and a state in which we offer coverage
• Not be entitled to or enrolled in Medicare

We offer dependent coverage up to age 26, with some state exceptions. In Ohio, we offer dependent coverage up to age 28; in Florida, up to age 30.

10-day right to review*

Don’t cancel your current insurance until we let you know we accepted you for coverage. We’ll review your enrollment form or application to determine if you meet eligibility requirements. You’ll get a letter if we close your application or enrollment form. You’ll get an Aetna individual health plan contract and ID card by mail if we approve your application or enrollment form.

If you’re not satisfied after reviewing your contract, simply return it to us within 10 days. We’ll refund any monthly payment you paid (including any contract fees or other charges), less the cost of any medical or dental services paid on behalf of you or any covered dependent.

Convenient monthly payments

Easy Pay** from Aetna is a fast, easy way to pay your monthly payment. Each month on the due date, funds are automatically withdrawn from your checking account.

Easy Pay saves you money by eliminating the cost of checks, envelopes and postage. Plus, you don’t have to worry about your monthly payment being late or getting lost in the mail. It’s available to anyone currently enrolled or has been accepted into an Aetna individual health insurance plan. As long as you have a checking account and are a customer in good standing, you can participate in this billing plan.

You can also pay your monthly payment with most major credit cards. To learn more, visit http://www.aetna.com and select “Individuals & Families.”

Your coverage

Your coverage stays in effect as long as you pay the required monthly payment on time, and as long as you are eligible in the plan. Your coverage ends if you:
• Don’t pay your monthly bill
• Move to another state
• Get duplicate coverage

Levels of coverage and enrollment

These plans are subject to the final rating factors applicable in your state. Once we confirm your eligibility, you may be enrolled in your selected plan at:
• The lowest rate available (known as the standard premium charge)
• A higher monthly payment due to age, where you live and if you use tobacco, if applicable in your state

*For New Jersey it’s a 30-day right to review.
**The Easy Pay program is administered by MFS Funding Services, Inc. MFS is not affiliated with Aetna and Aetna is not responsible for the actions of MFS.
Limitations and exclusions

Medical

These medical plans don’t cover all health care expenses and include limitations and exclusions. Please refer to your plan documents to determine which health care services are covered and to what extent. The following is a partial list of services and supplies that are generally not covered. **However, your plan documents may contain exceptions to this list based on state mandates, essential health benefits or the plan design.**

- All medical and hospital services not specifically covered in, or that are limited or excluded by your plan documents, including costs of services before coverage begins and after coverage ends
- Cosmetic surgery
- Custodial care
- Dental care and dental X-rays for individuals age 19 and older
- Donor egg retrieval
- Experimental and investigational procedures (except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial)
- Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for individuals age 19 and older or cosmetic purposes
- Hearing aids
- Home births
- Immunizations for travel or work
- Implantable drugs and certain injectable drugs, including injectable infertility drugs
- Infertility services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents
- Non-emergency care when traveling outside the U.S.
- Non-medically necessary services or supplies
- Office visits to an ophthalmologist, optometrist or optician related to the fitting of prescription contact lenses
- Orthotics
- Over-the-counter medications and supplies
- Radial keratotomy or related procedures
- Reversal of sterilization
- Services for the treatment of sexual dysfunction or inadequacies including therapy, supplies or counseling
- Special or private duty nursing
- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens, and supplements, appetite suppressants and other medications; food or food supplements, exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including morbid obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions

Pediatric dental*

These medical plans don’t cover all pediatric dental care expenses and include limitations and exclusions. Please refer to your plan documents to see which services we cover. The following is a partial list of services and supplies that we generally don’t cover. **However, your plan documents may have exceptions to this list.**

We base these documents on state laws, essential health benefits or the plan design.

- All pediatric dental services not specifically covered in, or that your plan documents limit or exclude, including costs of services before coverage begins and after coverage ends
- Instructions for diet, plaque control and oral hygiene
- Dental services or supplies that you may primarily use to change, improve or enhance appearance
- Dental implants
- Experimental or investigational drugs, devices, treatments or procedures
- Services not necessary for the diagnosis, care or treatment of a condition
- Orthodontic treatment that isn’t medically necessary for a severe or handicapping condition
- Replacement of lost or stolen appliances
- Services and supplies provided where there is no evidence of pathology, dysfunction or disease

*Not all plans sold on exchanges include coverage for pediatric dental care. Please refer to your plan documents to confirm coverage.
Aetna Open Access® Elect Choice® health insurance plans are underwritten by Aetna Life Insurance Company – a licensed insurer in 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 Open Access Elect Choice® EPO health insurance plans that use these networks:
• QHP OA EPO – Austin
• QHP OA EPO – Dallas
• QHP OA EPO – Houston
• QHP OA EPO – San Antonio
• Memorial Hermann ACO EPO
• San Antonio Community Plan
• Savings Plus EPO Longview
• Savings Plus EPO Amarillo

Get plan information online and by phone

If you’re already enrolled in an Aetna health plan
You have three convenient ways to get plan information anytime, day or night:

1. Log in to your secure Aetna Navigator® member website
   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.
   Have your Aetna ID card handy to register. Then visit http://www.aetna.com and click “Log In/Register.” Follow the prompts to complete the one-time registration.
   Then you can log in any time to:
   • 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 DocFind® search tool to find in-network care
   • Use our Cost of Care tools so you can know before you go
   • Learn more about and access any wellness programs that come with your plan

2. Use your mobile device to access a streamlined version of Aetna Navigator
   Go to your Play Store (Android) or App Store (iPhone) and search for Aetna Mobile. You can also text APPS to 23862 to download.
   Here’s just some of what you can do from Aetna Mobile:
   • Find a doctor or facility
   • View alerts and messages
   • View your claims, coverage and benefits
   • View your ID card information
   • Use the Member Payment Estimator
   • Contact Us by phone or e-mail

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

3. **Call Member Services at the toll-free number on your Aetna ID card**

As an Aetna member you can use the Aetna Voice Advantage self-service options:

- Verify who’s covered under your plan
- Find out what’s covered under your plan
- Get an address to mail your claim and check a claim status
- Find out other ways to contact Aetna
- Order a replacement Aetna ID card
- Be transferred to Behavioral Health services (if included in your plan)

You can also speak with a representative to:

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

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

If you require language assistance, please call the Member Services number on your Aetna 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 de Servicios al Miembro que figura en su tarjeta de identificación de Aetna, 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.

**Medically necessary covered benefits**

As an Open Access Elect Choice member, you will be entitled to the medically necessary covered benefits as listed in your Policy under “What the Medical Benefit Covers.” Your plan provides medically necessary covered benefits when provided by providers who have a contract with Aetna. The plan does not cover services from providers who do not have a contract with Aetna except in certain situations described in this handbook and your policy.

This plan does not cover all health care expenses. You should read your Policy carefully to determine which health care services are covered benefits and to what extent.

See also the Exclusions and Limitations section for information about what’s not covered. To find out before you enroll whether your Policy contains exclusions and limitations different from those listed in this handbook, or to request a sample copy of the Policy, call us toll-free at 1-866-565-1236. (If you purchased your plan at [http://www.healthcare.gov](http://www.healthcare.gov), call us at 1-855-586-6960 instead.)
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. You are also responsible for cost sharing as outlined in your Policy and Schedule of Benefits. See the "What you pay" section for more.

Medically necessary covered services include:

- Primary care physician and specialist physician outpatient and inpatient visits
- Evidence-based items or services that have a rating of “A” or “B” in effect in the current recommendations of the United States Preventive Services Task Force (USPSTF)
- Routine adult physical examinations (including immunizations, routine vision and hearing screenings)
- Routine well-child care (including immunizations)
- 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 gynecological exams, including routine Pap smears, the CA 125 blood test, or liquid-based cytology methods for detection of human papillomavirus and cervical or ovarian cancer
- Routine vision, speech and hearing screenings (including newborns)
- Injections, including allergy desensitization injections
- Diagnostic, laboratory, X-ray services
- Cancer chemotherapy and cancer hormone treatments and services that have been approved by the United States Food and Drug Administration for general use in treatment of cancer
- Diagnosis and treatment of gynecological or infertility problems by participating gynecologists or participating infertility specialists. Benefits for infertility treatment are limited, and you should call 1-800-575-5999 for more information about coverage under your specific health plan.
- Outpatient and inpatient prenatal and postpartum care and obstetrical services
- 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 by 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.
- 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 and home health mental health services.
- Serious mental illness: diagnosis and medical treatment of a serious mental illness. Serious mental illness means the following psychiatric illnesses (as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM)III-R): schizophrenia; paranoid and other psychotic disorders; bipolar disorders (hypomanic; mixed, manic and depressive); major depressive disorders (single episode or recurrent); schizoaffective disorders (bipolar or depressive); pervasive developmental disorders; obsessive-compulsive disorders and depression in childhood and adolescence. Emergency medical services, including screening/evaluation to determine whether an emergency medical condition exists, and for emergency medical transportation. See the “Emergency and urgent care and care after office hours” section for more information. As a reminder, a referral from your PCP is not required for this service.
- Urgent, non-emergent 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. As a reminder, a referral from your PCP is not required for this service.
Inpatient and outpatient physical, occupational and speech rehabilitation services when they are medically necessary and meet or exceed the treatment goals established for the patient.

We will not exclude coverage for cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing or treatment, neurofeedback therapy, remediation, postacute transition services, or community reintegration services necessary as a result of and related to an acquired brain injury.

Cardiac rehabilitation benefits following an inpatient hospital stay. A limited course of outpatient cardiac rehabilitation is covered following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction.

Home health benefits rendered by a participating home health care agency. Preauthorization must be obtained from the member’s attending participating physician. Home health benefits are not covered if Aetna determines the treatment setting is not appropriate or if there is a more cost-effective setting in which to provide appropriate care.

Hospice care medical benefits when preauthorized.

Initial provision of prosthetic appliances. Covered prosthetic appliances generally include those items covered by Medicare unless otherwise excluded under your specific health plan.

Certain injectable medications when an oral alternative drug is not available and when preauthorized, unless excluded under your specific health plan.

Mastectomy-related services including reconstructive breast surgery, prostheses and 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.

Routine sterilizations.

Administration, processing of blood, processing fees, and fees related to autologous blood donations only.

Diagnostic and surgical treatment of the temporomandibular joint that is medically necessary as a result of an accident, a trauma, a congenital defect, a developmental defect or a pathology.

Diabetic outpatient self-management training and education (including medical nutrition therapy for the treatment of diabetes), equipment and supplies (including blood glucose monitors and monitor-related supplies including test strips and lancets; injection aids; syringes and needles; insulin infusion devices; and insulin and other pharmacological agents for controlling blood sugar).

Certain infertility services. Refer to the “What the Medical Benefit Covers” section of the Policy for detailed information. Benefits for infertility treatment are limited. Call 1-800-575-5999 for more information about coverage under your specific health plan.

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

Orthotic and prosthetic devices.

Routine patient care costs associated with approved clinical trials.

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

Check your plan documents to see if your plan includes prescription drug benefits. 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 Aetna 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 on 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 on 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.

**Mail-order and specialty-drug services from Aetna owned pharmacies**

Mail-order and specialty drug services are from pharmacies that Aetna owns. These pharmacies are called Aetna Rx Home Delivery and Aetna Specialty Pharmacy, which are for-profit pharmacies.

**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.

**Some drugs are not covered at all**

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

**New drugs may not be covered**

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

**Get a copy of the preferred drug guide**

You can find the Aetna Preferred Drug Guide on our website at [http://www.aetna.com/formulary](http://www.aetna.com/formulary). You can call the toll-free number on your Aetna ID card to ask for a printed copy. We frequently add new drugs to the guide. Look online or call Member Services for the latest updates.

**Have questions? Get answers.**

Ask your doctor about specific medications. Call the number on your Aetna 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. If you have time, call your doctor or PCP.
• Tell your doctor or PCP as soon as possible afterward. A friend or family member may call on your behalf.
• 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 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 to http://www.aetna.com and search our list of doctors and other health care providers. Check your plan documents to see how much you must pay for urgent care services.

Out-of-area services and benefits

If you are away from home, your plan pays for emergency care and urgent care.

What you pay

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.

Coinsurance – Your share of the costs for a covered service. This is usually a percent (for example, 20%) of the allowed amount for the service. For example, if the health plan’s allowed amount for an office visit is $100 and you’ve met your deductible, your coinsurance payment of 20% would be $20. The health plan pays the rest of the allowed amount.

Deductible – 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 for out-of-network care

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.
Exclusions and limitations

The following is a summary of services that are not covered. You are responsible for all costs. Other exclusions and limitations may apply to your specific plan so be sure to consult your Policy for details.

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

- Acupuncture and acupuncture therapy, except when performed by a participating physician as a form of anesthesia in connection with covered surgery
- Air or Water Ambulance (except as provided in the “What the Medical Benefit Covers” section of the Policy):
  - If an ambulance service is not required by your physical condition; or
  - If the type of ambulance service provided is not required for your physical condition; or
  - By any form of transportation other than a professional ambulance service; or
  - Fixed wing air ambulance from an out-of-network provider.
- Any charges in excess of the benefit, dollar, day, visit, or supply limits stated in this Policy.
- Any charge incurred by an out-of-network provider except in an emergency or urgent care situation.
- Artificial organs: Any device intended to perform the function of a body organ.
- Behavioral health services that are not primarily aimed at treatment of illness, injury, restoration of physiological functions or that do not have a physiological or organic basis including treatment in wilderness programs or other similar programs.
- Bereavement counseling, funeral arrangements, pastoral counseling, financial or legal counseling, homemaker or caretaker services, respite care, and any service not solely related to the care of the member, including but not limited to, sitter or companion services for the member or other members of the family, transportation, house cleaning and maintenance of the house
- Biofeedback
- Blood and blood plasma, including provision of blood, blood plasma, blood derivatives, synthetic blood or blood products other than blood-derived clotting factors, the collection or storage of blood plasma, the cost of receiving the services of professional blood donors, apheresis (removal of the plasma) or plasmapheresis (cleaning and filtering of the plasma). Only administration, processing of blood and blood plasma, processing fees, and fees related to autologous blood donations are covered.
- Care for conditions that state or local law requires to be treated in a public facility, including but not limited to mental illness commitments
- Care Furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury. Examples include asbestos removal, air filtration, and special ramps or doorways.
- Cosmetic surgery, or treatment relating to the consequences of, or as a result of, cosmetic surgery, including but not limited to surgery to correct gynecomastia, breast augmentation, and otoplasties. This exclusion does not apply to (i) surgery to restore normal bodily functions, including but not limited to, cleft lip and cleft palate or as a continuation of a staged reconstruction procedure, or congenital defects; (ii) breast reconstruction following a mastectomy, including the breast on which mastectomy surgery has been performed and the breast on which mastectomy surgery has not been performed; and (iii) reconstructive surgery performed on a member who is less than 18 years of age to improve the function of or to attempt to create a normal appearance of a craniofacial abnormality.
- Costs for court-ordered services, or those required by court order as a condition of parole or probation
- Custodial care
- Dental services except for what is specifically covered under the “What the Medical Plan Covers” section of the Policy.
- Durable medical equipment and household equipment, including but not limited to crutches, braces, the purchase or rental of exercise cycles, water purifiers, hypo-allergenic pillows, mattresses or waterbeds, whirlpool or swimming pools, exercise and massage equipment, central or unit air conditioners, air purifiers, humidifiers, dehumidifiers, escalators, elevators, ramps, stair glides, emergency alert equipment, handrails, heat appliances, improvements made to a member’s house or place of business and adjustments made to vehicles
- Educational services and treatment of behavioral disorders and services for remedial education including evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, behavioral training, and cognitive rehabilitation. This includes services, treatment or educational testing and training related to behavioral (conduct) problems, learning disabilities, or developmental delays unless specifically listed in the Policy. Special education, including lessons in sign language to instruct a member, whose ability to speak has been lost or impaired, to function without that ability, are not covered.
- Experimental or investigational drugs, devices, treatments or procedures, except as described in the “What the Medical Benefit Covers” section of the Policy.
• Facility charges for care services or supplies provided in:
  - Rest homes;
  - Assisted living facilities;
  - Similar institutions serving as an individual’s primary
    residence or providing primarily custodial or rest care;
  - Health resorts;
  - Spas, sanitariums; or
  - Infirmaries at schools, colleges or camps.

The exclusion listed above for care provided in an assisted
living facility will not apply for care relating to the treatment
of Acquired Brain Injury, when such care is provided:
- For eligible charges related to Acquired Brain Injury
treatment as outlined in the “What the Medical Benefits
Covers” section of the Policy;
- within the scope of the license of the assisted living
facility; and
- within the scope of the services provided under a
CARF-accredited rehabilitation program for brain injury or
another nationally recognized accredited rehabilitation
program for brain injury.

When care relating to treatment of Acquired Brain Injury
is provided as noted above, it will not be considered
custodial care.

• Food and nutritional items: Any food item, including infant
  formulas, nutritional supplements, vitamins, including
  prescription vitamins, medical foods and other nutritional
  items, even if it is the sole source of nutrition. This limitation
  will not apply to formulas and special modified food
products as specifically stated in this Policy.

• Foot care: Except as specifically covered for medical
  necessity due to illness or diabetic care, any services,
  supplies, or devices to improve comfort or appearance of
toes, feet or ankles, including:
  - Treatment of calluses, bunions, toenails, hammer-toes,
subluxations, fallen arches, weak feet, chronic foot pain or
  conditions caused by routine activities such as walking,
running, working or wearing shoes; and
  - Shoes (including orthopedic shoes), foot orthotics, arch
supports, shoe inserts, ankle braces, guards, protectors,
creams, ointments and other equipment, devices and
  supplies, even if required following a covered treatment of
an illness or injury.

• Genetics: except as described in the “What the Medical
Benefit Covers” section of the Policy, the plan does not
cover 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.

• Growth/Height: Any treatment, device, drug, service or
  supply to increase or decrease height or alter the rate of
growth, including surgical procedures, devices to stimulate
growth, and growth hormones.

• Hair analysis

• Health services, including those related to pregnancy,
  rendered before the effective date or after the termination
  of the member’s coverage

• Hearing: Related services and supplies, except as described
  in the “What the Medical Benefit Covers” section.

• Home and mobility: Any addition or alteration to a home,
  workplace or other environment, or vehicle and any related
  equipment or device, including:
  - Bathroom equipment such as bathtub seats, benches,
rails, and lifts;
  - Purchase or rental of exercise equipment, air purifiers,
central or unit air conditioners, water purifiers, waterbeds
  and swimming pools;
  - Exercise and training devices, whirlpools, portable
whirlpool pumps, sauna baths, massage devices or
  over-bed tables;
  - Equipment or supplies to aid sleeping or sitting, including
electric beds, water beds, air beds, pillows, sheets,
blankets, warming or cooling devices, elevator chairs, bed
  tables, and reclining chairs;
  - Equipment installed in your home, workplace or other
environment, including stair-glides, elevators, wheelchair
ramps, or equipment to alter air quality, humidity
  or temperature;
  - Other additions or alterations to your home, workplace
  or other environment, including room additions, changes
in cabinets, countertops, doorways, lighting, wiring,
furniture, communication aids, wireless alert systems, or
home monitoring;
  - Services and supplies furnished mainly to provide a
surrounding free from exposure that can worsen your
illness or injury;
  - Removal from your home, worksite or other environment
  of carpeting, hypo-allergenic pillows, mattresses, paint,
mold, asbestos, fiberglass, dust, pet dander, pests or other
potential sources of allergies or illness; and
  - Transportation devices, including stair-climbing
wheelchairs, personal transporters, bicycles, automobiles,
vans or trucks, or alterations to any vehicle or
transportation device.

• Home births
Home Health Care. Unless specified in “What the Medical Benefit Covers” section of the Policy, charges for the following are not covered:
- Services or supplies that are not a part of the home health care plan;
- Services of a person who usually lives with you, or who is a member of your, or your spouse’s or your domestic partner’s family;
- Services for infusion therapy;
- Transportation;
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present;
- Services that are custodial care; and

Home urterine activity monitor

Hospice. Unless specified in “What the Medical Benefit Covers” of the Policy, charges for the following are not covered under this benefit:
- Daily room and board charges over the semi-private room rate;
- Bereavement counseling;
- Funeral arrangements;
- Pastoral counseling;
- Financial or legal counseling. This includes estate planning and the drafting of a will;
- Homemaker or caretaker services. These are services which are not solely related to your care. These include, but are not limited to: sitter or companion services for either you or other family members; transportation; maintenance of the house.

Hypnotherapy

Infertility: except as specifically described in the “What the Medical Benefit Covers” section of the Policy, any services, treatments, procedures or supplies that are designed to enhance fertility or the likelihood of conception, including but not limited to:
- Drugs related to the treatment of non-covered expenses;
- Injectable infertility medications, including but not limited to menotropins, hCG, GnRH agonists, and IVIG;
- Artificial insemination;
- Any advanced reproductive technology (“ART”) procedures or services related to such procedures, including but not limited to in vitro fertilization (“IVF”), gamete intra-fallopian transfer (“GIFT”), zygote intra-fallopian transfer (“ZIFT”), and intra-cytoplasmic sperm injection (“ICSI”); artificial insemination for covered females attempting to become pregnant who are not infertile as defined by the plan;
- Infertility services for couples in which one of the partners has had a previous sterilization procedure, with or without surgical reversal;
- Procedures, services and supplies to reverse voluntary sterilization;
- Infertility services for females with FSH levels 19 or greater mIU/ml on day three of the menstrual cycle;
- The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers or surrogacy; donor egg retrieval or fees associated with donor egg programs, including but not limited to fees for laboratory tests;
- Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, hospital, ultrasounds, laboratory tests); any charges associated with a frozen embryo or egg transfer, including but not limited to thawing charges;
- Home ovulation prediction kits or home pregnancy tests; and
- Any charges associated with care required to obtain ART Services (e.g., office, hospital, ultrasounds, laboratory tests); and any charges associated with obtaining sperm for any ART procedures; and
- Ovulation induction and intrauterine insemination services if you are not fertile. Call 1-800-575-5999 for more information about these exclusions.

Injectable drugs as follows: experimental drugs or medications, or drugs or medications that have not been proven safe and effective for a specific disease or approved for a mode of treatment by the U.S. Food and Drug Administration (FDA) and the National Institutes of Health (NIH); needles, syringes and other injectable aids (except for diabetic supplies.); drugs related to the treatment of non-covered services; and drugs related to contraception, the treatment of infertility and performance enhancing steroids.

Maintenance care: Care made up of services and supplies that are furnished mainly to maintain, rather than to improve, a level of physical or mental function; and provide a surrounding free from exposures that can worsen the person’s physical or mental condition.
• 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 dissocial personality disorder
    - Pathological gambling, kleptomania, pyromania
    - Specific delays in development (learning disorders,
      academic underachievement)
    - Intellectual disability
    - Wilderness treatment programs or any such related or
      similar programs, school and/or education services.
• Military service-related diseases, disabilities or injuries for
  which the member is legally entitled to receive treatment at
  government facilities and which facilities are reasonably
  available to the member
• Missed appointment charges
• Non-diagnostic and non-medical/surgical treatment of
  temporomandibular joint disorder (TMJ)
• Oral or topical drugs used for sexual dysfunction
  or performance
• Orthoptic therapy (vision exercises)
• Outpatient medical consumable or disposable supplies
  such as syringes, incontinence pads, elastic stockings
  and reagent strips. This exclusion does not apply to
  diabetic supplies.
• Performance, athletic performance or lifestyle
  enhancement drugs and supplies
• Personal comfort or convenience items
• Prescription or nonprescription drugs and medicines, except
  as provided on an inpatient basis (unless covered by a
  prescription drug rider). This exclusion does not apply to
  diabetes supplies, including but not limited to insulin.
• Private-duty or special-nursing care (unless medically
  necessary and preauthorized by Aetna)
• Recreational, educational and sleep therapy, including any
  related diagnostic testing
• Religious, marital and sex counseling, including services and
  treatment related to religious counseling, marital/
  relationship counseling and sex therapy
• Reversal of voluntary sterilizations
• Routine foot/hand care
• Services for which a member is not legally obligated to pay
  in the absence of this coverage
• Services for the treatment of sexual dysfunctions or
  inadequacies, including therapy, supplies, or counseling for
  sexual dysfunctions or inadequacies that do not have a
  physiological or organic basis
• The following services or supplies:
  - Those that do not require the technical skills of a medical,
    mental health or a dental professional
  - Those furnished mainly for the personal comfort or
    convenience of the member, or any person who cares for
    the member, or any person who is part of the member’s
    family, or any provider
  - Those furnished solely because the member is an inpatient
    on any day in which the member’s disease or injury could
    safely and effectively be diagnosed or treated while the
    member is not an inpatient
  - Those furnished in a particular setting that could safely
    and effectively be furnished in a physician’s or a dentist’s
    office or other less costly setting consistent with the
    applicable standard of care
• Services performed by a relative of a member for which, in
  the absence of any health benefits coverage, no charge
  would be made
• Services rendered for the treatment of delays in speech
  development, unless resulting from disease, injury, or
  congenital defects
• Services required by third parties, including but not limited
  to, physical examinations, diagnostic services and
  immunizations in connection with obtaining or continuing
  employment, insurance, travel, school admissions or
  attendance, including examinations required to participate
  in athletics, except when such examinations are considered
  to be part of an appropriate schedule of wellness services
• Specific non-standard allergy services and supplies,
  including but not limited to, physical examinations, diagnostic services and
  immunizations in connection with obtaining or continuing
  employment, insurance, travel, school admissions or
  attendance, including examinations required to participate
  in athletics, except when such examinations are considered
  to be part of an appropriate schedule of wellness services
• Special medical reports, including those not directly related
  to treatment of the member (i.e., reports prepared in
  connection with litigation)
• Surgical operations, procedures or treatment of obesity
• Therapy or rehabilitation as follows: primal therapy (intense
  non-verbal expression of emotion expected to result in
  improvement or cure of psychological symptoms), chelation
  therapy (removal of excessive heavy metal ions from the
  body), rolfing, psychodrama, megavitamin therapy, purging,
  bio-energetic therapy, vision perception training, carbon
  dioxide and other therapy or rehabilitation not supported by
  medical and scientific evidence. This exclusion does not
  apply to rehabilitative services such as physical, speech and
  occupational therapy.
• Treatment in a federal, state, or governmental entity,
  including care and treatment provided in a nonparticipating
  hospital owned or operated by any federal, state or other
  governmental entity, except to the extent required by
  applicable laws
• Treatment of intellectual disability, defects, and deficiencies
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 case 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.
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</td>
</tr>
<tr>
<td>A terminal illness</td>
<td>9 months</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>
</tr>
</tbody>
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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

What to do if you disagree with us

Complaints, appeals and external review

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

Call Member Services to file a verbal complaint or to ask for the address to mail a written complaint.

The phone number is on your Aetna ID card. You can also e-mail Member Services through the secure member website 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 [http://www.tdi.texas.gov](http://www.tdi.texas.gov). Their toll-free telephone number is 1-800-578-4677.

A “rush” review may be possible

If your doctor thinks you cannot wait 30 days, ask for an “expedited review.” Examples include denials for emergency care, continued hospital stays and care after your condition has stabilized (post-stabilization). 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

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

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. In life-threatening situations, you are entitled to an immediate appeal to an IRO.

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

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

Use our DocFind 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: Visit http://www.aetna.com and log in. From your secure member website home page, select Find a Doctor from the top menu bar and start your search.

Considering enrollment: Visit http://www.aetna.com and scroll down to “Find a doctor, dentist, facility or vision provider” from the home page. 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 Aetna ID card. If you’re not yet a member, call 1-866-565-1236. (If you purchased your plan at http://www.healthcare.gov, call us at 1-855-586-6960 instead.) You may also write to: Aetna, PO Box 569441, Dallas, TX, 75356-9441.

Our provider directory will identify hospitals that have contractually agreed to facilitate the use of preferred doctors. 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 prior to the services being rendered, the hospital will provide you with information at least 24 hours prior to services being rendered enough information for you to determine if the assigned facility based physician or physician group is a preferred/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 ID card.

We must pay for out-of-network services at in-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 preferred provider as specified in:

• Our provider listing; 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:

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

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 DocFind 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.

*The specific goals will vary from network to network.
Aetna service areas

This plan generally covers benefits provided through the networks shown below. See “Emergency and urgent care and care after office hours” and “Your costs when you go outside the network” for more information.

**Austin**

**Network name:** Aetna Whole Health – Seton Health Alliance  
**Counties:** Hays, Travis, Williamson

**Dallas**

**Network name:** Aetna Whole Health – Baylor Scott & White Quality Alliance  
**Counties:** Collin, Dallas, Denton, Ellis, Rockwell, Tarrant, Parker

**Houston**

**Network name:** Aetna Whole Health – Memorial Hermann Accountable Care Network  
**Counties:** Fort Bend, Harris, Montgomery

**San Antonio**

**Network name:** Aetna Whole Health – Baptist Health System & HealthTexas Medical Group  
**Counties:** Bexar, Comal, Guadalupe, Kendall

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 [http://www.aetna.com/docfind/cms/assets/pdf/TX_NonContracted_Privdr_Rprt.pdf](http://www.aetna.com/docfind/cms/assets/pdf/TX_NonContracted_Privdr_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 referral for out-of-network services because no preferred provider is available, or if you have received out-of-network emergency care, your insurer must, in most cases, resolve the nonpreferred provider’s bill so that you only have to pay any applicable coinsurance, copay and deductible amounts.

You may obtain a current directory of preferred providers at the following website: [http://www.aetna.com/docfind](http://www.aetna.com/docfind) or by calling 1-866-565-1236 (if you purchased your plan at [http://www.healthcare.gov](http://www.healthcare.gov), call us at 1-855-586-6960 instead) for assistance in finding available preferred providers.

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

Other covered benefits

Mental health and addiction benefits

Here’s how to get inpatient and outpatient services, partial hospitalization and other mental health services:

• Call 911 if it’s an emergency.
• Call the toll-free Behavioral Health number on your Aetna ID card.
• Call Member Services if no other number is listed.
• Employee Assistance Program (EAP) professionals can also help you find a mental health specialist.

Get information about using network therapists

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

Aetna Behavioral Health offers two screening and prevention programs for our members

• Beginning Right® Depression Program: Perinatal and Postpartum Depression Education, Screening and Treatment Referral and
• SASADA Program: Substance Abuse Screening for Adolescents with Depression and/or Anxiety Call Member Services for more information on either of these programs.

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, coinsurance and referral requirements, if any, as outlined in your plan documents.

Transplants and other complex conditions

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

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

We study the latest medical technology

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 http://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 http://www.aetna.com. You can find them under “Individuals & Families.” No Internet? Call Member Services at the toll-free number on your ID card. Ask for a copy of a CPB for any product or service.
**Member rights & responsibilities**

**Know your rights as a member**

You have many legal rights as a member of a health plan. You also have many responsibilities. You have the right to suggest changes in our policies and procedures. 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 [http://www.aetna.com/individuals-families/member-rights-resources.html](http://www.aetna.com/individuals-families/member-rights-resources.html) to view the list. You can also call Member Services at the number on your ID card to ask for a printed copy.

**Making medical decisions before your procedure**

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

There are three types of advance directives:

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

You can create an advance directive in several ways:

- Ask your doctor for an advance directive form.
- 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 about our quality management programs**

We make sure your doctor provides quality care for you and your family. To learn more about these programs, go to our website at [http://www.aetna.com](http://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 Aetna 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 ID card or visit us at [http://www.aetna.com](http://www.aetna.com).

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Anyone can get health care
We do not consider your race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age or national origin when giving you access to care. Network providers are legally required to do 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 31 days after your coverage ends.

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 31 days after a life event if you chose not to enroll during the normal open enrollment period. Life events include:
• Marriage
• Birth
• Adoption
• Placement for adoption

Call Member Services for more information or to request special enrollment.
We are committed to Accreditation by the National Committee for Quality Assurance (NCQA) as a means of demonstrating a commitment to continuous quality improvement and meeting customer expectations. You can find a complete list of health plans and their NCQA status on the NCQA website located at [http://reportcard.ncqa.org](http://reportcard.ncqa.org).

To refine your search, we suggest you search these areas: **Health Insurance Plans** – for HMO and PPO health plans and **Physicians and Physician Practices** – for physicians recognized by NCQA in the areas of Physician Practice Connections, Physician Practice Connections-Patient Centered Medical Home, Patient Centered Medical Home, Heart/Stroke, Diabetes, and Patient Center Specialty Practice. Providers, in all settings, achieve recognition by submitting data that demonstrate they provide quality care. The program constantly assesses key measures that were carefully defined and tested for their relationship to improved care; therefore, NCQA provider recognition is subject to change.

See “Other Reports on Health Care Quality” in the dropdown menu for **Managed Behavioral Healthcare Organizations** – for mental health accreditation and **Credentials Verifications Organizations** – for credentialing certification.

**If you need this material translated into another language, please call Member Services at 1-855-586-6960.**

**Si usted necesita este material en otro lenguaje, por favor llame a Servicios al Miembro al 1-855-586-6960.**
Better manage your health and health care

Your secure member website

Your Aetna Navigator® website puts all of your plan information and cost-saving tools in one place. It’s where you go to:

- **Find the right doctor** — and save money. Locate in-network doctors who accept your plan.
- **See what you owe.** Look up claims to see how much the plan paid and what you may have to pay.
- **Know your plan.** Check who is covered by your plan and what it covers.
- **Get valuable information.** See which doctors and hospitals have met extra standards for quality and efficiency.
- **Know costs before you go.** See cost estimates before you make an appointment for an office visit, test or procedure.
- **Get healthier.** Take a health assessment to learn about your health and how to lower your risks.
- **Check your health accounts.** Easily look up your health savings account or health fund balances.
This material is for information only. Plan features and availability may vary by location. Rates and benefits may vary by location. Health benefits and insurance plans and dental insurance plans contain exclusions and limitations. Investment services are independently offered by the HSA administrator. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services. If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists or hospitals that are affiliated with the physician group or delivery system. Not all health/dental services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features are subject to change. Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna’s Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a subsidiary of Aetna Inc., which is a licensed pharmacy providing prescription services by mail. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional. Information is believed to be accurate as of production date; however, it is subject to change.

For more information about Aetna plans, refer to http://www.aetna.com
You can always visit us online for more information: http://www.aetnaindividual.com