

Quality health plans & benefits
Healthier living
Financial well-being
Intelligent solutions

aetna®

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 **www.aetnaindividualdocfind.com**
to find the doctors and hospitals you trust most.

Aetna individual health benefits and health insurance plans are offered and/or underwritten by Aetna Health Inc. and/or Aetna Life Insurance Company (Aetna). Each insurer has sole financial responsibility for its own products.

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 plan brochure. It contains important tips and tools that will help you along the way. If you have questions or want to talk, just call us.

We're here to help

Call **1-844-829-8875**.

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Nondiscrimination Notice

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

Aetna:

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

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

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

Address: P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779)

Telephone: **1-800-648-7817 (TTY: 711)**, Fax: **1-859-425-3379** (CA HMO customers: 860-262-7705)

Email: CRCoordinator@aetna.com

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

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

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

TTY: 711

For language assistance in English call 855.208.4606 at no cost. (English)

Para obtener asistencia lingüística en español, llame sin cargo al 855.208.4606. (Spanish)

欲取得繁體中文語言協助，請撥打 855.208.4606，無需付費。(Chinese)

Pour une assistance linguistique en français appeler le 855.208.4606 sans frais. (French)

Para sa tulong sa wika na nasa Tagalog, tawagan ang 855.208.4606 nang walang bayad. (Tagalog)

T'áá shí shizaad k'ehjí bee shíká a'doowoł nínízingo Diné k'ehjí kojił' t'áá jíík'e hólne' 855.208.4606
(Navajo)

Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 855.208.4606 an. (German)

Për asistencë në gjuhën shqipe telefononi falas në 855.208.4606. (Albanian)

በ አሚኛ የቋንቋ እገዛ ለማግኘት በ 855.208.4606 በካ ጸ ይደውሉ (Amharic)

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 855.208.4606 (Arabic)

Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 855.208.4606 ku busa. (Bantu-Kirundi)

বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে ৮৫৫.২০৮.৪৬০৬-তে কল করুন। (Bengali-Bangala)

ငွေကျပ်ခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 855.208.4606 ကို ခေါ်ဆိုပါ။ (Burmese)

[illegible]

Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsaa bilbilaa 855.208.4606 irratti bilisaan bilbilaa.
(Cushite)

Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 855.208.4606. (Dutch)

Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 855.208.4606 gratis. (French Creole)

Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 855.208.4606 χωρίς χρέωση. (Greek)

(Gujarati) ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 855.208.4606 પર કોલ કરો.

(Hindi) हिन्दी में भाषा सहायता के लिए, 855.208.4606 पर मुफ्त कॉल करें।

Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 855.208.4606. (Hmong)

Maka enyemaka asụsụ na Igbo kpọọ 855.208.4606 na akwughị ụgwọ ọ bụla (Ibo)

Para iti tulong ti pagsasao iti pagsasao tawagan ti 855.208.4606 nga awan ti bayadanyo. (Ilocano)

Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 855.208.4606. (Italian)

日本語で援助をご希望の方は、855.208.4606まで無料でお電話ください。 (Japanese)

လၢတၢ်မၤစၢၤတၢ်ကတိၤကျိၣ်အိၣ် ကျိၣ် ကိး 855.208.4606 လၢတၢ်အိၣ်ဒီးတၢ်လၢၣ်ဘျၣ်လၢၣ်စ့ၤဘျၣ် (Karen)

한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 855.208.4606번으로 전화해 주십시오. (Korean)

Bé m ké gbo-kpá-kpá dyé pídyi dé Bǎsɔ̀̀-wùdùùn wěɛ, dǎ 855.208.4606 (Kru-Bassa)

بو و مرگرتنی رینوینی پیومنیدار به زمان به زمان به ژماره ی 855.208.4606 به خۆرای پیومنندی بکەن. (Kurdish)

ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 855.208.4606 ໂດຍບໍ່ເສຍຄ່າໂທ. (Laotian)

Ñan bōk jipañ ilo Kajin Majol, kallok 855.208.4606 ilo ejjelok wōnān. (Marshallese)

សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 855.208.4606 ដោយឥតគិតថ្លៃ។ (Mon-Khmer, Cambodian)

(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 855.208.4606 मा फोन गर्नुहोस् । (Nepali)

Tën kuwoɲy ë thok ë Thuonjǎŋ cɔl 855.208.4606 kecin ayöc. (Nilotic-Dinka)

For språkassistanse på norsk, ring 855 208 4606 kostnadsfritt. (Norwegian)

(Panjabi) ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 855.208.4606 'ਤੇ ਮੁਫਤ ਕਾਲ ਕਰੋ।

Fer Hefle in Deitsch, ruf: 855.208.4606 aa. Es Aaruf koschtet nix. (Pennsylvanian Dutch)

برای راهنمایی به زبان فارسی با شماره 855.208.4606 بدون هیچ هزینه ای تماس بگیرید. انگلیسی (Persian)

Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 855.208.4606. (Polish)

Para obter assistência linguística em português ligue para o 855.208.4606 gratuitamente. (Portuguese)

Pentru asistență lingvistică în românește telefonați la numărul gratuit 855.208.4606 (Romanian)

Fún ìrànlowọ nípa èdè (Yorùbá) pe 855.208.4606 láí san owó kankan rárá. (Yoruba)

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:



Your doctors

Just use our tools to find your doctor or a new one in your area. Your doctor will help you get the most out of your benefits.



Your prescriptions

All of our plans include prescription drug coverage and medical care.



A plan that works for you

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.



Your confidence

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.

For 2017 benefits, the open enrollment period is November 1, 2016, through January 31, 2017.

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 www.healthcare.gov.

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 their 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. 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 claims 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 can contribute \$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.

Case management/disease management

Once you are a member, you can check to see if you qualify for our chronic disease or case management programs by calling the number on your ID card.

*Referrals are required for health maintenance organization (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, go to **www.aetnaindividual.com**.



By mail

Applies only if you are applying for off-exchange plans.



By phone

Call us toll-free at **1-844-829-8875**.

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.

Material name	Description	Delivery	When to expect
Welcome letter	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 Navigator® secure member website.	 	7 – 10 days
Quick start guide	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.	 	7 – 10 days
Summary of Benefits and Coverage (SBC)	An easy-to-read summary of the benefits for the plan you selected.	 	7 days
Plan documents	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.	 	30 days

Health care reform — What you need to know

Since President Obama signed the Affordable Care Act, 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. For more information about how much the fine will be in 2017, visit **www.healthcare.gov**.
- 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 parent's plan.

Learn more about health care reform.

Visit **www.aetna.com/health-reform-connection/index.html**.



Health care focused on you: accountable care plan options

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 www.aetna.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 more 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 www.myaetnawholehealth.com to see what it's like to be an accountable care plan member. There you'll find a 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 **1-844-829-8875**. You can also visit us online at 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 significant — 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 network doctors and hospitals using our online provider directory. It’s a good idea to check every time you make an appointment.

Visit **www.aetnaindividualdocfind.com**. Then select your primary state of residence.

Or call **1-844-829-8875** 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.

Office visit		In network	Out of network
Doctor bill	Amount billed	\$150	\$150
Amount Aetna uses to calculate payment	Aetna’s rate* in network	\$90*	
	Recognized amount** out of network		\$90**
What we’ll pay	Aetna’s negotiated rate/recognized amount	\$90	\$90
	Percent your plan pays	80%	60%
	Amount of Aetna’s negotiated rate/recognized amount covered under plan	\$72*	\$54**
What you owe	Your coinsurance responsibility	\$18	\$36
	Amount that can be balance billed to you	\$0	\$60
Your total responsibility		\$18***	\$96***

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.

Outpatient surgery

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

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.

Five-day hospital stay

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

*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:

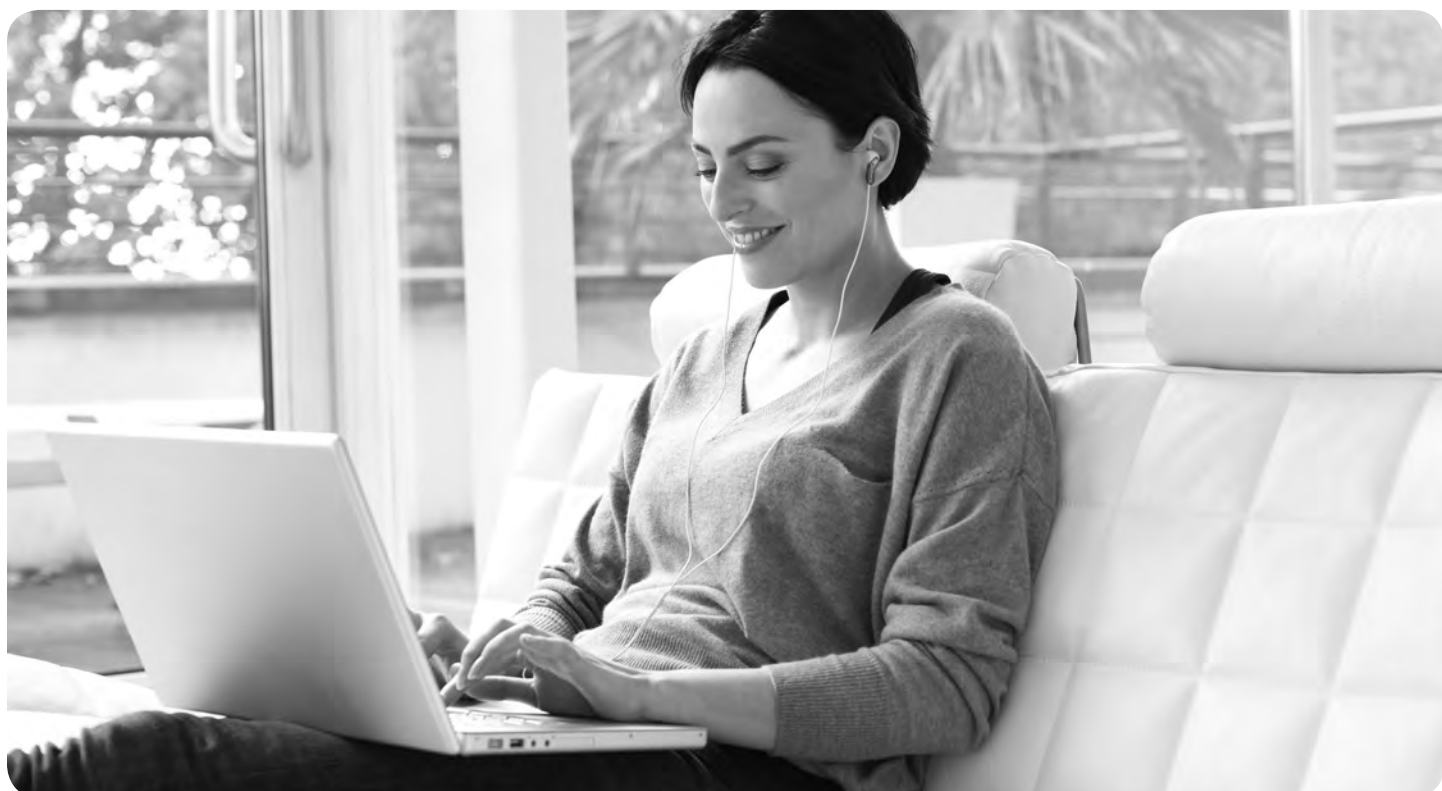
- Your Aetna health benefits or insurance plan may pay part of the doctor's bill. But it pays less of the bill than if you get care from a network doctor.
- Some plans may not pay any benefits if you go out of network. Some plans cover out of network only in an emergency.

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.

Plan type	Monthly premium	Costs you pay out of pocket
Bronze	\$	\$\$\$
Silver	\$\$	\$\$
Gold	\$\$\$	\$

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 Maine

These plans include pediatric dental (PD).

ME Aetna Whole Health Bronze \$40 Copay PD

Member benefits	In network you pay	Non-designated you pay
Deductible (ded) individual/family¹ (applies to out-of-pocket maximum)	\$6,400/\$12,800	\$7,100/\$14,200
Member coinsurance	0%	40%
Out-of-pocket maximum individual/family¹ (maximum you will pay for all covered services)	\$7,150/\$14,300	\$7,150/\$14,300
Primary care visit	\$40 copay; ded waived	40% after ded
Specialist visit	Covered in full after ded	40% after ded
Hospital stay	Covered in full after ded	40% after ded
Outpatient surgery (ambulatory surgical center/hospital)	Covered in full after ded	40% after ded
Emergency room	Covered in full after ded	Paid at the designated level
Urgent care	\$60 copay; ded waived	\$100 copay after ded
Preventive care/screening/immunization (age and frequency visit limits apply)	Covered in full; ded waived	Covered in full; ded waived
Annual routine gyn exam (annual pap/mammogram)	Covered in full; ded waived	Covered in full; ded waived
Diagnostic lab	Covered in full after ded	Paid at the designated level
Diagnostic X-ray	Covered in full after ded	40% after ded
Imaging (CT/PET scans, MRIs)	Covered in full after ded	40% after ded
Vision		
Pediatric eye exam (1 visit per year)	Covered in full; ded waived	Paid at the designated level
Pediatric glasses/contacts (coverage is limited to 1 set of frames and 1 set of contact lenses or eyeglass lenses per calendar year)	Covered in full; ded waived	Paid at the designated level
Pediatric dental		
Dental checkup/preventive dental care (2 visits per year)	Covered in full; ded waived	Paid at the designated level
Basic dental care	30% after ded	Paid at the designated level
Major dental care	50% after ded	Paid at the designated level
Orthodontia (medically necessary only)	50% after ded	Paid at the designated level
Pharmacy		
Pharmacy deductible	Integrated with medical ded	Integrated with medical ded
Preferred generic drugs	Generic: \$20 copay after ded	Generic: \$20 copay after ded
Preferred brand drugs	\$75 copay after ded	\$75 copay after ded
Nonpreferred drugs	Generic & Brand: 50% after ded	Generic & Brand: 50% after ded
Specialty drugs*	P: 50% after ded NP: 50% after ded	P: 50% after ded NP: 50% after ded

¹The 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 ded and/or out-of-pocket limit.

*P=Preferred specialty drugs; NP=Nonpreferred specialty drugs.

Aetna individual health benefits and health insurance plans are offered and/or underwritten by Aetna Health Inc. and/or Aetna Life Insurance Company (Aetna). Each insurer has sole financial responsibility for its own products.

ME Aetna Whole Health Silver \$10 Copay PD

In network you pay	Non-designated you pay
\$4,000/\$8,000	\$5,750/\$11,500
20%	40%
\$6,000/\$12,000	\$6,850/\$13,700
\$10 copay; ded waived	\$50 copay after ded
\$60 copay; ded waived	\$75 copay after ded
20% after ded	40% after ded
\$100 copay plus 20% after ded	\$500 copay plus 40% after ded
\$250 copay after ded	Paid at the designated level
\$75 copay; ded waived	40% after ded
Covered in full; ded waived	Covered in full; ded waived
Covered in full; ded waived	Covered in full; ded waived
20% after ded	Paid at the designated level
20% after ded	40% after ded
\$100 copay plus 20% after ded	\$500 copay plus 40% after ded
Covered in full; ded waived	Paid at the designated level
Covered in full; ded waived	Paid at the designated level
Covered in full; ded waived	Paid at the designated level
30% after ded	Paid at the designated level
50% after ded	Paid at the designated level
50% after ded	Paid at the designated level
\$500 per member	\$500 per member
Low Cost Generic: \$3 copay; ded waived Generic: \$10 copay; ded waived	Low Cost Generic: \$3 copay; ded waived Generic: \$10 copay; ded waived
\$40 copay after ded	\$40 copay after ded
Generic & Brand: \$50 copay after ded	Generic & Brand: \$50 copay after ded
P: 40% after ded NP: 50% after ded	P: 40% after ded NP: 50% after ded

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>. Then,

- 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. Information is believed to be accurate as of the production date; however, it is subject to change.

Aetna Health Plan options in Maine (continued)

These plans include pediatric dental (PD).

ME Aetna Whole Health Gold \$5 Copay PD

Member benefits	In network you pay	Non-designated you pay
Deductible (ded) individual/family¹ (applies to out-of-pocket maximum)	\$1,500/\$3,000	\$3,750/\$7,500
Member coinsurance	20%	40%
Out-of-pocket maximum individual/family¹ (maximum you will pay for all covered services)	\$4,500/\$9,000	\$6,000/\$12,000
Primary care visit	\$5 copay; ded waived	\$30 copay; ded waived
Specialist visit	\$40 copay; ded waived	\$75 copay after ded
Hospital stay	20% after ded	40% after ded
Outpatient surgery (ambulatory surgical center/hospital)	20% after ded	40% after ded
Emergency room	\$250 copay after ded	Paid at the designated level
Urgent care	\$75 copay; ded waived	\$150 copay; ded waived
Preventive care/screening/immunization (age and frequency visit limits apply)	Covered in full; ded waived	Covered in full; ded waived
Annual routine gyn exam (annual pap/mammogram)	Covered in full; ded waived	Covered in full; ded waived
Diagnostic lab	20% after ded	Paid at the designated level
Diagnostic X-ray	20% after ded	40% after ded
Imaging (CT/PET scans, MRIs)	20% after ded	\$100 copay plus 40% after ded
Vision		
Pediatric eye exam (1 visit per year)	Covered in full; ded waived	Paid at the designated level
Pediatric glasses/contacts (coverage is limited to 1 set of frames and 1 set of contact lenses or eyeglass lenses per calendar year)	Covered in full; ded waived	Paid at the designated level
Pediatric dental		
Dental checkup/preventive dental care (2 visits per year)	Covered in full; ded waived	Paid at the designated level
Basic dental care	30% after ded	Paid at the designated level
Major dental care	50% after ded	Paid at the designated level
Orthodontia (medically necessary only)	50% after ded	Paid at the designated level
Pharmacy		
Pharmacy deductible	None	None
Preferred generic drugs	Low Cost Generic: \$3 copay Generic: \$10 copay	Low Cost Generic: \$3 copay Generic: \$10 copay
Preferred brand drugs	\$30 copay	\$30 copay
Nonpreferred drugs	Generic & Brand: \$50 copay	Generic & Brand: \$50 copay
Specialty drugs*	P: 40% NP: 50%	P: 40% NP: 50%

¹The 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 ded and/or out-of-pocket limit.

*P=Preferred specialty drugs; NP=Nonpreferred specialty drugs.

Aetna individual health benefits and health insurance plans are offered and/or underwritten by Aetna Health Inc. and/or Aetna Life Insurance Company (Aetna). Each insurer has sole financial responsibility for its own products.

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>. Then,

- 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. Information is believed to be accurate as of the production date; however, it is subject to change.

Things to think about when choosing your 2017 health 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 2017, your insurance company may automatically enroll you in the same or a similar plan. You can change your plan during Open Enrollment.

Rating areas*

Maine

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 **1-844-829-8875**.

Area 1

Cumberland
Sagadahoc
York

Area 2

Knox
Lincoln
Oxford

Area 3

Androscoggin
Franklin
Waldo



*Networks may not be available in all ZIP codes and are subject to change.

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 Florida, we offer dependent coverage up to age 30, with certain eligibility requirements. In New Jersey, we offer dependent coverage up to age 31, with certain eligibility requirements.

10-day right to review*

Don't cancel your current insurance until we let you know we've 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.

*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.

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 who is 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.

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 for 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



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 ages 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, nonprescription lenses and nonprescription contact lenses that are for individuals ages 19 and older or are for 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.
- Nonmedically 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, and 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 are limited or excluded by, your plan documents, 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.

Important information about your health benefits

For Open Choice® PPO and these Aetna Open Access® plans: Open Access Managed Choice® and Aetna Health Network OnlySM

Understanding your plan of benefits

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

Warning: If you or your family members are covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and hospitals, and it may be impossible to comply with both plans at the same time. Before you enroll in this plan, read all of the rules very carefully and compare them with the rules of any other plan that covers you or your family.

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

Most of the information in this booklet applies to all plans. But some does not. For example, not all plans have a deductible.

State-specific information throughout this booklet does not apply to all plans. To be sure, review your plan documents, ask your benefits administrator, or call Aetna Member Services. Some states may also have differences that are not reflected in this document.

Where to find information about your specific plan

Your “plan documents” list all the details for the plan you choose. This includes what’s covered, what’s not covered and what you will pay for services. Plan document names vary. They may include a Booklet-certificate, Schedule of Benefits, Certificate of Coverage, and/or any riders and updates that come with them.

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

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 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. Then visit www.aetna.com and click “Log In/Register.” Follow the prompts to complete the one-time registration.

Then you can log in anytime 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 online provider search tool to find 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 your secure member website

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 Aetna member ID card information
- Use the Member Payment Estimator
- Contact us by phone or email

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.

Aetna individual health benefits and health insurance plans are underwritten by Aetna Life Insurance Company and/or by Aetna Health Inc. (Aetna). Each insurer has sole financial responsibility for its own products.

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

As an Aetna member you can use the voice response self-service options to:

- 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 other ways to contact Aetna
- Order a replacement Aetna member ID card
- Be transferred to behavioral health services

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
- Find specific health information
- Learn more about our Quality Management program

Not yet a member?

For help understanding how a particular medical plan works, you should review your Summary of Benefits and Coverage document. You can also call us with questions.

- If you purchased your health plan through an agent or directly from Aetna, you can call **1-866-565-1236**.
- If you purchased your health plan through the public exchange (**www.healthcare.gov**), you can call **1-855-586-6960**.

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

Use our online 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 **www.aetna.com** and log in. From your secure member website home page, select "Find a Doctor, Dentist or Facility" and start your search.
- **Considering enrollment:** Visit **www.aetna.com** and select "Find a Doctor" from the top menu bar. 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

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 **www.healthcare.gov**, call us at **1-855-586-6960** instead.)

If you live in **Georgia**, you can call toll-free at **1-844-289-4503** to confirm that the preferred provider in question is in the network and/or accepting new patients.

Michigan members may contact the Michigan Office of Financial and Insurance Services at **517-373-0220** to:

- Verify participating providers' licenses
- Access information on formal complaints and disciplinary actions filed or taken against a health care provider in the immediate preceding three years.

For more information on your health plan, call Member Services at **1-844-289-4503** or refer to your plan documents.

A provider's right to join the network — Kentucky

Any health care provider who meets our enrollment criteria and who is willing to meet the terms and conditions for participation has a right to become a participating provider in our network.

Customary waiting times — Kentucky

- Routine — within 7 days
- Preventive care — within 8 weeks
- Symptomatic, nonurgent — within 3 days
- Urgent complaint — same day/within 24 hours
- Emergency — immediately or referred to ER

Accountable care organizations—physician networks that help to improve care while lowering costs

Accountable care organizations 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 online search tool. See "Search our network for doctors, hospitals and other health care providers" in this booklet for details. After entering your search criteria, look for the specific network logo.

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 marcar **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.

Costs and rules for using your plan

What you pay

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

Copay — A 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.

Coinsurance — Your share of the costs for a covered service. This is usually a percentage (for example, 20 percent 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 percent 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 for some services. Other deductibles may apply at the same time.

*The specific goals will vary from network to network.

Your costs when you go outside the network

Network-only plans

Aetna Health Network Only is a network-only plan.

That means the plan covers health care services only when provided by a doctor who participates in the Aetna network. Not every hospital, health care facility, physician or other types of providers participate in the network. If you receive services from an out-of-network doctor or other health care provider, you will have to pay all of the costs for the services. See also “Emergency care.”

Plans that cover out-of-network services

With Open Choice and Open Access Managed Choice plans, you may choose a doctor in our network. You may choose to visit an out-of-network doctor. We cover the cost of care based on if the provider, such as a doctor or hospital, is “in network” or “out of network.” We want to help you understand how much we will pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this care. The following are examples for when you see a doctor:

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

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

Your out-of-network doctor or hospital sets the rate to charge you. It may be higher — sometimes much higher — than what your Aetna plan “recognizes” or “allows.” Your doctor may bill you for the dollar amount the plan doesn’t “recognize.” You’ll also pay higher copayments, coinsurance and deductibles under your plan. No dollar amount above the “recognized charge” counts toward your deductible or out-of-pocket limits. This means you are fully responsible for paying everything above the amount the plan allows for a service or procedure.

When you choose to see an out-of-network doctor, we pay for your health care depending on the plan you selected. Some of our plans pay for out-of-network services by looking at what Medicare would pay and adjusting that amount up or down. Our plans range from paying 90 percent of Medicare (that is, 10 percent less than Medicare would pay) to 300 percent of Medicare (the Medicare rate multiplied by three). Some plans pay for out-of-network services based on what is called the “usual and customary” charge or “reasonable amount” rate. These plans use information from FAIR Health, Inc., a not-for-profit company, that reports how much providers charge for services in any ZIP code.

You can call Member Services at the toll-free number on your Aetna ID card to find out the method your plan uses to reimburse out-of-network doctors. You can also ask for an estimate of your share of the cost for out-of-network services you are planning. The way of paying out-of-network doctors and hospitals applies when you choose to get care out of network. See “Emergency care” to learn more.

Going in network just makes sense

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

To learn more about how we pay out-of-network benefits, visit **www.aetna.com**. Type “how Aetna pays” in the search box.

Surprise bills — Connecticut

A surprise bill is a bill you get for eligible health services that were not emergency services. The bill is from an out-of-network provider who performed services while you were in a network hospital or facility.

- These services were in addition to those performed by a network provider.
- You may have precertified the procedure or service, but you did not knowingly choose to receive services from an out-of-network provider.

A surprise bill is not a bill for services received when a network provider was available and you knowingly choose to use an out-of-network provider.

Contact Member Services if you receive a surprise bill. You only have to pay the same coinsurance, copayment, deductible or other out-of-pocket expense you would pay if you had used a network provider.

You never need referrals with open access plans

As an Aetna Open Access or PPO plan member, you do not need a referral from your regular doctor to see a specialist. You may need to select a primary care physician (PCP) depending on your state. Even if you don't have to, we encourage you to do so. A PCP can help you navigate the health care system.

Some states also require us to tell you about certain open access benefits:

Delaware

- **Ob/Gyn** — Female members have direct access to an Ob/Gyn of their choice. They do not need a referral from their PCP to visit their Ob/Gyn for covered services.

Florida

- **Chiropractor and podiatrist** — You have direct access to a participating primary care chiropractic and podiatric provider of your choice and do not need a referral from your PCP to access these benefits covered under your health benefits plan.
- **Dermatologist** — You have direct access to a participating dermatologist of your choice and do not need a referral from your PCP to access these benefits covered under your health benefits plan.

Georgia

- **Ob/Gyn** — Female members have direct access to the participating primary Ob/Gyn provider of their choice and do not need a referral from their PCP for a routine well-woman exam, including a Pap smear when appropriate and an unlimited number of visits for gynecologic problems and follow-up care.
- **Dermatologist** — You have direct access to the participating dermatologist of your choice and do not need a referral from your primary care physician(s) to access dermatologic benefits covered under your health plan.

Kentucky

Participating primary chiropractic providers — If you live in Kentucky, you have direct access to the participating primary chiropractic provider of your choice. You do not need a referral from your PCP to access chiropractic benefits covered under your benefits plan.

Tennessee

Routine vision care — You are covered for routine vision exams from participating providers without a referral from your PCP. Copayments may apply. For routine eye exams, you can visit a participating optometrist or ophthalmologist without a referral, once every 12 months. A contact lens fitting exam is not covered.

Precertification: getting approvals for services

Sometimes we will pay for care only if we have given an approval before you get it. We call that “precertification.” You usually only need precertification for more serious care like surgery or being admitted to a hospital. Your plan documents list all the services that require this approval. Your PCP or network specialist will get this approval for you.

You do not have to get precertification for emergency services.

What we look for when reviewing a request

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

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

Our review process after precertification (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.

If you have a chronic condition or an upcoming hospital stay, you may qualify for one of our care management programs. An Aetna nurse can be the extra support you need. After you enroll, just call the number on your ID card to learn more.

Information about specific benefits

No coverage based on U.S. Sanctions

If U.S. trade sanctions consider you a blocked person, the plan cannot provide benefits or coverage to you. Also if you travel to a country sanctioned by the United States, the plan in most cases cannot provide benefits or coverage to you. Also, if your health care provider is a blocked person or is in a sanctioned country, we cannot pay for services from that provider. For example, if you receive care while traveling in another country and the health care provider is a blocked person or is in a sanctioned country, the plan cannot pay for those services. For more information on U.S. Trade sanctions, visit www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

Emergency care

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 he or she 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.

In **Kentucky**, the definition for Emergency Medical Condition is, *"A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson would reasonably have cause to believe constitutes a condition that the absence of immediate medical attention could reasonably be expected to result in: placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part; or with respect to a pregnant woman who is having contractions, a situation in which there is inadequate time to effect a safe transfer to another hospital before delivery; or a situation in which transfer may pose a threat to the health or safety of the woman or the unborn child."*

You are covered for emergency care

You have emergency 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 a heart attack 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.

Urgent care

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 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.

Prescription drug benefit

Some plans encourage generic drugs over brand-name drugs

A generic drug is the same as a brand-name drug in dose, use and form. They are FDA approved and safe to use. Generic drugs usually sell for less; so many plans give you incentives to use generics. That doesn't mean you can't use a brand-name drug, but you'll pay more for 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. Check your plan documents to see how much you will pay. You can use those drugs if your plan has an "open formulary," but you'll pay the highest copay under the plan. 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 percentage 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 percentage 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.

Home delivery and specialty-drug services from Aetna owned pharmacies

Home delivery and specialty drug services are from pharmacies 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 medicine. 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 medicine.

You may request an exception for some drugs that are not covered

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

Get a copy of the preferred drug guide

You can find the Aetna Preferred Drug Guide on our website at 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.

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 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
- **SASADA program:** Substance Abuse Screening for Adolescents with Depression and/or Anxiety

Call Member Services for more information on either of these programs.

Transplants and other complex conditions

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

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.

Please contact Member Services for more information. For more information, you can visit the U.S. Department of Health and Human Services website, www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/whcra_factsheet.html, and the U.S. Department of Labor website, www.dol.gov/ebsa/consumer_info_health.html.

Delaware — scalp hair prosthesis benefit

Aetna plans cover the cost of scalp hair prosthesis worn for hair loss suffered as a result of alopecia areata, resulting from an autoimmune disease. The same limitations and guidelines that apply to other prosthesis as outlined in your plan documents will apply. But this benefit is also limited to \$500 per year.

How we determine what's covered

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. It might be to treat an injury or illness.

The product or service:

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

Only medical professionals can decide if a treatment or service is not medically necessary. We do not reward Aetna employees for denying coverage. Sometimes a physician's group will determine medical necessity. Those groups might use different resources than we do.

If we deny coverage, we'll send you and your doctor a letter. The letter will explain how to appeal the denial. You have the same right to appeal if a physician's group denied coverage. You can call Member Services to ask for a free copy of the materials we use to make coverage decisions. Or visit www.aetna.com/about/cov_det_policies.html to read our 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 Healthcare Research and Quality.
- Ask experts.
- Check how often and how successfully it has been used.

We publish our decisions in our Clinical Policy Bulletins.

We post our findings on www.aetna.com

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

CPBs help us decide whether to approve a coverage request. Your plan may not cover everything our CPBs say is medically necessary. Each plan is different, so check your plan documents.

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

You and your doctor can read our CPBs on our website at **www.aetna.com**. You can find them under “Individuals & Families.” No Internet? Call Member Services at the toll-free number on your Aetna member ID card. Ask for a copy of a CPB for any product or service.

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 email Member Services through the secure member website. 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.

Get a review from someone outside Aetna

If the denial is based on a medical judgment, you may be able to get an outside review if you're not satisfied with your appeal (in most cases you will need to finish all of your internal appeals first). Follow the instructions on our response to your appeal. Call Member Services to ask for an External Review Form. You can also visit **www.aetna.com**. Enter “external review” into the search bar.

An independent review organization (IRO) will assign your case to one of their experts. The expert will be a doctor or other professional who specializes in that area or type of appeal. You should have a decision within 45 calendar days of the request. The outside reviewer's decision is final and binding; we will follow the outside reviewer's decision and you will not have to pay anything unless there was a filing fee.

Some states have their own external review process and you may need to pay a small filing fee as part of the state mandated program. In other states external review is still available but follows federal rules. Visit your state's government website to learn more. You can find a link at **www.usa.gov/Agencies/State-and-Territories.shtml** or call Member Services at the toll-free number on your Aetna ID card for help.

Connecticut external review — You must exhaust the Aetna internal appeal process described above before requesting an outside review. You have the right to appeal to the Connecticut Insurance Department if we have denied coverage because the services are not medically necessary, experimental or investigational, cosmetic or custodial under the terms of your plan. You may also give consent to your doctor to file an appeal for you. You or your doctor must file this appeal with the Connecticut Insurance Department within 120 days after you receive our final determination.

In an emergency or life-threatening situation, you or your doctor can ask the Connecticut Insurance Department for an expedited external appeal without exhausting our internal appeal process.

A “rush” review may be possible

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

Member rights and responsibilities

Know your rights as a member

You have many legal rights as a member of a health plan. You also have many responsibilities. You have the right to suggest changes in our policies and procedures. This includes our member rights and responsibilities.

Some of your rights are explained below. We also publish a list of rights and responsibilities on our website. Visit **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 procedure¹

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 — names 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 Care Management and Quality Management Programs

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

Anyone can get health care

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

We must comply with these laws:

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

¹American Academy of Family Physicians. Advance Directives and Do Not Resuscitate Orders. January 2012. Available at <http://familydoctor.org/familydoctor/en/healthcare-management/end-of-life-issues/advance-directives-and-do-not-resuscitate-orders.html>. Accessed June 10, 2016.

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

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

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

When you lose your other coverage

You might choose not to enroll now because you already have health insurance. You may be able to enroll later if you lose that other coverage. This includes enrolling your spouse or children and other dependents. If that happens, you must apply within 60 days before you expect to lose coverage and 60 days after your coverage 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 60 days after certain life events if you chose not to enroll during the normal open enrollment period. These life events include:

- Marriage
- Birth
- Adoption
- Placement for adoption

Talk to your benefits administrator for more information or to request special enrollment.

Additional disclosures by state

Connecticut:

Connecticut law allows you to keep dependent children on the plan even if they are no longer eligible for coverage because they:

- Become covered under a group health plan through his or her own employment
- Attain the age of 26

If your dependent child is handicapped on the date coverage would otherwise terminate, he/she may be able to continue coverage. You must provide documentation of this status within 31 days of the date on which the child's coverage would have terminated in the absence of the handicap.

You can get the forms you need to continue coverage by calling Member Services at the toll-free number on your member ID card. Complete and return the forms within 31 days of the date on which the child's coverage would have terminated in the absence of the handicap. If we don't receive the form within that time frame, your dependent's coverage will end.

If your dependent is not handicapped and you would like information on continuing coverage for him or her within our service area, please contact your benefits administrator.

Medical loss ratios

The medical loss ratio is the ratio of incurred claims to earned premium for the prior calendar year for managed care plans issued in Connecticut.

It includes claims for medical expenses for services and supplies provided to enrollees. It does not include expenses for stop loss, reinsurance, enrollee educational programs or other cost-containment programs or features.

Aetna Health Inc.: 88.3%

Aetna Life Insurance Company (ALIC): 81.0%

Federal Medical Loss Ratio: 80% – 85%

Georgia: Consumer Choice Option

The Consumer Choice Option is available for Georgia residents enrolled in certain Aetna managed care plans. Under this option, with certain restrictions required by law and an additional monthly premium cost, members of certain Aetna managed care plans may nominate an out-of-network health care provider to provide covered services, for themselves and their covered family members. The out-of-network provider you nominate must agree to accept the Aetna compensation, to adhere to the plan's quality assurance requirements, and to meet all other reasonable criteria required by the plan of its in-network participating providers

It is possible the provider you nominate will not agree to participate. If the out-of-network provider you nominate agrees to participate, your benefits and any applicable copayments will be the same as for in-network providers. It will be available for an increased premium in addition to the premium you would otherwise pay. Your increased premium responsibility will vary depending on whether you have a single plan or family coverage, and on the type of insurance, riders, and coverage. Call **1-844-289-4503** for exact pricing and other information. Please have your Aetna member ID card available when you call.

More information is available

Georgia

A summary of any agreement or contract between Aetna and any health care provider will be made available upon request by calling the Member Services telephone number listed on your ID card. The summary will not include financial agreements as to actual rates, reimbursements, charges, or fees negotiated by Aetna and the provider. The summary will include a category or type of compensation paid by Aetna to each class of health care provider under contract with Aetna.

Kentucky

Kentucky law requires Aetna to provide, upon enrollment and upon request, the following information: (1) a current participating provider directory with information on access to primary care providers and available providers; (2) general information on the type of financial incentives between contracted participating providers including any incentives and bonuses; and (3) our standard customary waiting times for appointments for urgent and routine care. Additionally, upon request, we will make available information about the provider network, including hospital affiliations and whether

a particular network provider is board certified and whether a provider is currently accepting new patients. Members may contact Member Services at the toll-free number on their ID card for more information; all others contact your benefits administrator.

Ohio

Ohio law requires us to provide, upon request, a list of the top 20 percent of services and your expected contribution for each service.

West Virginia Patient Bill of Rights

1. You have the right to a description of your rights and responsibilities, plan benefits, benefit limitations, premiums, and individual cost-sharing requirements.
2. You have the right to a description of the HMO's grievance and hearing procedures and the right to pursue grievance and hearing procedures without reprisal from the health maintenance organization (HMO).
3. You have the right to a description of the method in which you can obtain a list of the plan's provider network, including the names and credentials of all participating providers, and the method by which you may choose providers within the plan.
4. You have the right to choose an available participating primary care physician (PCP), and with proper referrals, the right to a participating specialist.
5. You have the right to privacy and confidentiality with regard to your personal information.
6. You have the right to full disclosure from your health care provider of any information relating to your medical condition or treatment plan and the ability to examine and offer corrections to your own medical records.
7. You have the right to be informed of plan policies and any charges for which you will be responsible.
8. You have the right to a description of the procedures for obtaining out-of-area services.
9. You have the right to a description of the method by which you can obtain access to a summary of the plan's accreditation report.
10. You have the right to have medical advice or options communicated to you without any limitations or restrictions being placed upon the provider or PCP by the HMO.
11. You have the right to have all coverage denials reviewed by appropriate medical professionals consistent with the HMO's review procedure.
12. You have the right to have coverage denials involving medical necessity or experimental treatment reviewed, after exhaustion of the HMO's internal grievance procedure, by appropriate medical professionals who are knowledgeable about the recommended or requested health care service, as part of an external review.
13. You have the right to emergency services without prior authorization if a prudent layperson acting reasonably would have believed that an emergency medical condition existed, and the right to a description of procedures to obtain emergency services.
14. A woman has the right to direct access, annually, to her Ob/Gyn for the purpose of a well-woman examination without a referral from her PCP, and no woman shall be required to obtain a referral from her PCP as a condition to coverage of prenatal or obstetrical care.
15. A woman whose plan provides coverage for surgical services in an inpatient or outpatient setting has the right to reconstruction of the breast following mastectomy and reconstructive or cosmetic surgery required as a result of an injury caused by the act of a person convicted of a crime involving family violence.
16. A woman whose plan provides coverage for laboratory or X-ray services has a right to the following when performed for cancer screening or diagnostic purposes: (1) a baseline mammogram for women age thirty-five to thirty-nine, inclusive; (2) a mammogram for women age forty to forty-nine, inclusive, at least every two years; (3) a mammogram every year for women age fifty and over; (4) a Pap smear at least annually for women age 18 and over.
17. A nonsymptomatic person over 50 years of age and a symptomatic person under 50 years of age has the right to colorectal cancer examinations and laboratory tests for colorectal cancer.
18. You have the right to rehabilitation services.
19. You have the right to child immunization services, which shall not be subject to payment of any deductible, per-visit charge and/or copayment.
20. A diabetic whose health benefits policy includes eye care benefits, has the right to direct access to an optometrist or ophthalmologist of their choice from the panel without referral from their PCP for an annual diabetic retinal examination. When the diabetic retinal examination reveals the beginning stages of an abnormal condition, access to future examinations shall be subject to prior authorization from a primary care physician.

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

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

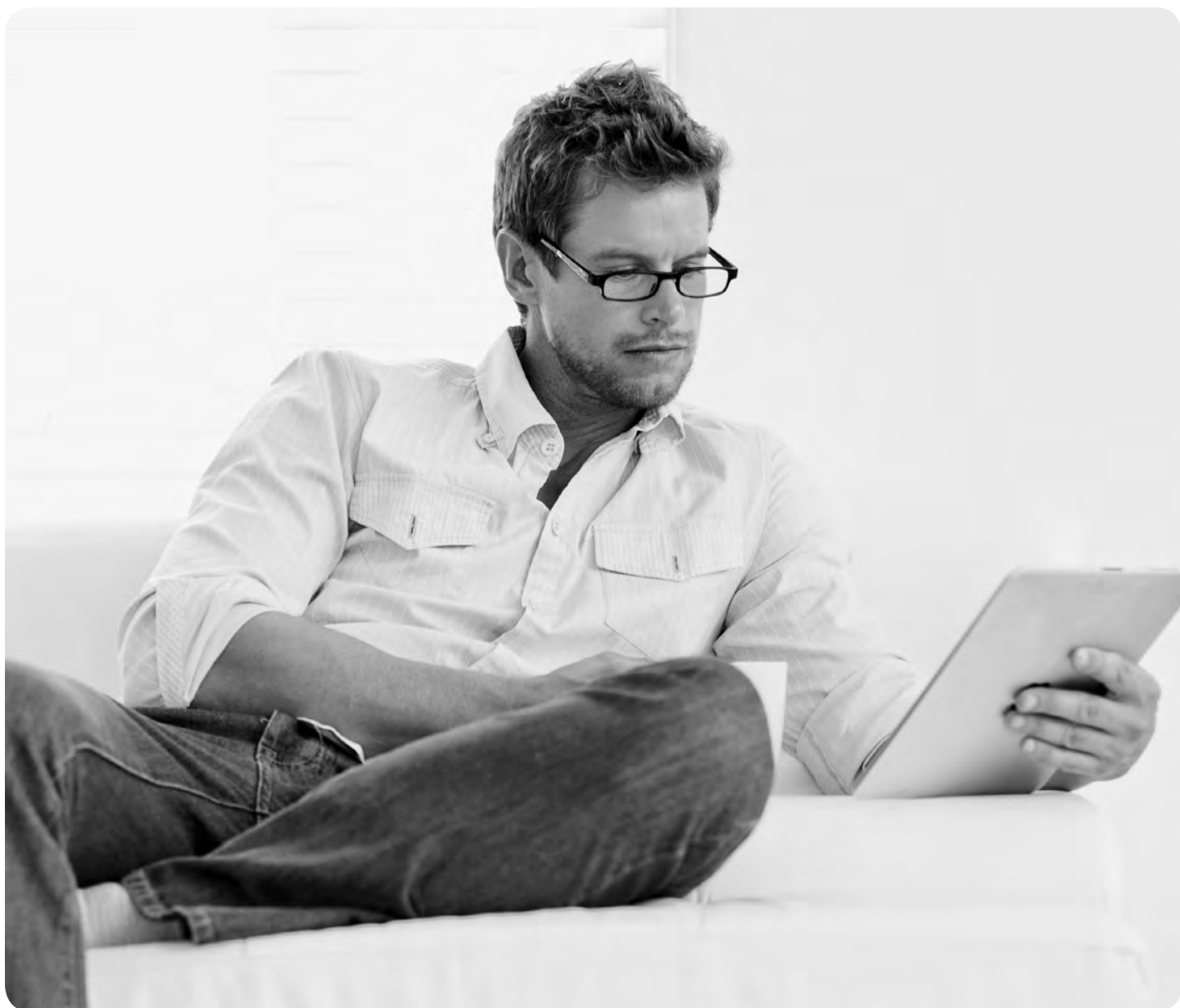
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