Quality health plans & benefits
Healthier living
Financial well-being
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aetna®

# Member handbook and consumer disclosures

## Important information about your health benefits

**Quality Point of Service® (QPOS®)**

**www.aetna.com**

**This Consumer Choice of Benefits Health Insurance Plan or Health Maintenance Organization health care plan, either in whole or in part, does not provide state-mandated health benefits normally required in accident and sickness policies or evidences of coverages in Texas. This standard health benefit plan may provide a more affordable health plan for you, although, at the same time, it may provide you with fewer health benefits than those normally included as state mandated health benefits in plans in Texas. Please consult with your insurance agent to discover which state-mandated health benefits are excluded in this policy or evidence of coverage.**

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# Get plan information online and by phone

## Your "plan documents" list all the details for the plan you chose

That information includes what's covered, what's not covered and the specific amounts that you will pay for services. Plan document names vary. They may include a Schedule of Benefits, Certificate of Coverage, Evidence of Coverage and/or any riders and updates that come with them. If you can't find your plan documents, you can get a copy online or by calling Member Services. See below for details.

For more information, including information about participating health care providers, you may call **1-888-982-3862** or write to: **Aetna, PO Box 569441, Dallas, TX, 75356-9441**. For help understanding how a particular medical plan works, you can also review your Summary of Benefits and Coverage document or contact your employer or benefits administrator.

## If you're already enrolled in an Aetna health plan

You have three convenient ways to get plan information anytime, day or night:

1. **Log in to your secure Aetna Navigator® member website**
   You can get coverage information for your plan online. You can also get details about any programs, tools and other services that come with your plan. Just register once to create a user name and password.

   Have your Aetna ID card handy to register. Then visit **www.aetna.com** and click "Log In/Register." Follow the prompts to complete the one-time registration.

   Then you can log in any time to:

   - Verify who's covered and what's covered
   - Access your "plan documents"
   - Track claims or view past copies of Explanation of Benefits statements
   - Use the DocFind® search tool to find in-network care
   - Use our Cost of Care tools so you can *know before you go*
   - Learn more about and access any wellness programs that come with your plan

2. **Use your mobile device to access a streamlined version of Aetna Navigator**
   Go to your Play Store (Android) or App Store (iPhone) and search for Aetna Mobile. You can also text **APPS** to **23862** to download.

   Here's just some of what you can do from Aetna Mobile:

   - Find a doctor or facility
   - View alerts and messages
   - View your claims, coverage and benefits
   - View your ID card information
   - Use the Member Payment Estimator
   - Contact us by phone or email

3. **Call Member Services at the toll-free number on your Aetna ID card**
   As an Aetna member you can use the Aetna Voice Advantage self-service options 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 out other ways to contact Aetna
   - Order a replacement Aetna ID card
   - Be transferred to behavioral health services (if included in your plan)

   You can also speak with a representative to:

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

**QPOS referred in-network benefits are provided by Aetna Health Inc., which is licensed by the Texas Department of Insurance to operate as a Health Maintenance Organization (HMO) within an approved service area. QPOS self-referred network and out-of-network benefits are underwritten by Aetna Health Insurance Company.**

# Medically necessary covered benefits

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

This plan does not cover all health care expenses and includes exclusions and limitations. Benefits exclusions and limitations are outlined in your plan documents. Read your plan documents carefully to determine which health care services are covered benefits and to what extent.

You'll also find a summary of exclusions and limitations within this document. To find out before you enroll whether your plan documents contain exclusions and limitations different from those listed in this document, contact your employer's benefits manager. You may also request a sample copy of the Aetna Certificate of Coverage from your employer.

If you're already a member, you may call us toll-free at **1-888-257-3241**.

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

To get the highest level of coverage (referred benefits), except for certain specialist benefits (referred to as "direct access" benefits) or in a medical emergency or an urgent care situation outside the service area, you must access covered benefits through your primary care physician (PCP) either directly or with a PCP referral. If you do not get a PCP referral to go to a network or out-of-network provider, benefits will be paid at the lower benefit (self-referred) level.

Although listed as covered below, benefits are subject to the exclusions and limitations as listed in the Certificate of Coverage. You are also responsible for cost sharing as outlined in your Certificate of Coverage.

**This is a general list of benefits that may be covered. Your employer or plan sponsor decides specifically which to cover and which to omit. That's why it's important to review your official plan documents for the list specific to your group plan.**

**Medically necessary covered services include:**

- Primary care physician and specialist physician (upon referral) outpatient and inpatient visits
- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF)
- Routine adult physical examinations (including immunizations, routine vision and hearing screenings)
- Routine well-child care (including immunizations)
- Certain tests for the early detection of cardiovascular disease
- Routine cancer screenings (which include screening mammograms; prostate specific antigen (PSA) tests; digital-rectal exams (DRE); fecal occult blood tests (FOBT); sigmoidoscopies; double contrast barium enemas (DCBE) and colonoscopies)
- Routine gynecological exams, including routine Pap smears, or liquid-based cytology methods for detection of human papillomavirus and cervical or ovarian cancer
- For women age 18 and older, annual examination for ovarian cancer including at a minimum a CA 125 blood test
- Osteoporosis: Medically accepted bone mass measurement for to detect low bone mass and to determine the person's risk of osteoporosis and fractures associated with osteoporosis
- Routine vision, speech and hearing screenings (including newborns)
- Injections, including allergy desensitization injections
- Diagnostic, laboratory, X-ray services
- Cancer chemotherapy, oral cancer drugs and cancer hormone treatments and services that have been approved by the United States Food and Drug Administration for general use in treatment of cancer
- Diagnosis and treatment of gynecological or infertility problems by participating gynecologists or participating infertility specialists. Benefits for infertility treatment are limited and you should call **1-800-575-5999** for more information about coverage under your specific health plan.
- Outpatient and inpatient prenatal and postpartum care and obstetrical services, including Inpatient care for a minimum of 48 hours after an uncomplicated vaginal delivery or for 96 hours after a uncomplicated delivery by cesarean section
- Complications of pregnancy:
  - Conditions, requiring hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsis, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and
  - Non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible.
- Contraceptive drugs and devices

- Voluntary sterilizations
- Inpatient hospital and skilled nursing facility benefits, including inpatient physician care. Except in an emergency, all services are subject to preauthorization by Aetna. Coverage for skilled nursing facility benefits is subject to the maximum number of days, if any, listed in your specific health plan.
- Transplants that are nonexperimental or noninvestigational. Covered transplants must be approved by an Aetna medical director before the surgery. The transplant must be performed at a hospital specifically approved and designated by Aetna to perform these procedures. If we deny coverage of a transplant based on lack of medical necessity, the member may request a review by an independent review organization (IRO). More information can be found in the "Complaints, Appeals and Independent Review" section of the plan documents.
- Outpatient surgical services and supplies in connection with a covered surgical procedure. Nonemergency services and supplies are subject to preauthorization by Aetna.
- Chemical dependency/substance abuse benefits
- Outpatient and inpatient care benefits are covered for detoxification.
- Outpatient rehabilitation visits are covered to a participating behavioral health provider upon referral by the PCP for diagnostic, medical or therapeutic rehabilitation services for chemical dependency.
- Inpatient rehabilitation benefits are covered for medical, nursing, counseling or therapeutic rehabilitation services in an appropriately licensed participating facility upon referral by the member's participating behavioral health provider for chemical dependency.
- Mental health benefits: A member is covered for services for the treatment of mental or behavioral conditions provided through participating behavioral health providers.
- Short-term, outpatient evaluative and crisis intervention or home health mental health services.
- Serious mental illness: diagnosis and medical treatment of a serious mental illness. Serious mental illness means the following psychiatric illnesses (as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM)III-R): schizophrenia; paranoid and other psychotic disorders; bipolar disorders (hypomanic; mixed, manic and depressive); major depressive disorders (single episode or recurrent); schizoaffective disorders (bipolar or depressive); pervasive developmental disorders; obsessive-compulsive disorders and depression in childhood and adolescence.
- Autism spectrum disorders: a neurological disorder that includes autism, Asperger's syndrome, or Pervasive Development Disorder.
- Emergency medical services, including screening/evaluation to determine whether an emergency medical condition exists, and for emergency medical transportation. See the "Emergency and urgent care and care after office hours" section for more information. As a reminder, a referral from your PCP is not required for this service.
- Urgent, nonemergent care services obtained from a licensed physician or facility outside the service area if (i) the service is a covered benefit; (ii) the service is medically necessary and immediately required because of unforeseen illness, injury, or condition; and (iii) it was not reasonable, given the circumstances, for the member to return to the Aetna HMO service area for treatment. As a reminder, a referral from your PCP is not required for this service.
- Inpatient and outpatient physical, occupational and speech rehabilitation services when they are medically necessary and meet or exceed the treatment goals established for the patient.
- Cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing or treatment, neurofeedback therapy, remediation, postacute transition services, or community reintegration services, including outpatient day treatment services, or other post-acute care treatment services necessary as a result of and related to an acquired brain injury.
- Cardiac rehabilitation benefits following an inpatient hospital stay. A limited course of outpatient cardiac rehabilitation is covered following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction.
- Home health benefits rendered by a participating home health care agency. Preauthorization must be obtained from the member's attending participating physician. Home health benefits are not covered if Aetna determines the treatment setting is not appropriate or if there is a more cost-effective setting in which to provide appropriate care.
- Hospice care medical benefits when preauthorized.
- Initial provision of prosthetic appliances. Covered prosthetic appliances generally include those items covered by Medicare unless otherwise excluded under your specific health plan.
- Certain injectable medications when an oral alternative drug is not available and when preauthorized, unless excluded under your specific health plan
- Mastectomy-related services including reconstructive breast surgery, prostheses and lymphedema, as described in your specific health plan
- Inpatient care for a minimum of 48 hours after a mastectomy or for 24 hours after a lymph node dissection

- Administration, processing of blood, processing fees, and fees related to autologous blood donations only
- Diagnostic and surgical treatment of the temporomandibular joint that is medically necessary as a result of an accident, a trauma, a congenital defect, a developmental defect or a pathology
- Coverage for diabetes includes, but is not limited to: Diabetic outpatient self-management training and education (including medical nutrition therapy for the treatment of diabetes), equipment and supplies (including blood glucose monitors and monitor-related supplies including test strips and lancets; injection aids; syringes and needles; insulin infusion devices; and insulin and other pharmacological agents for controlling blood sugar)
- Coverage is provided for amino-acid based elemental formulas necessary for the diagnosis, treatment or administration of the following to the same extent as for drugs available only on the orders of a physician:
  - Immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins
  - Severe food protein-induced enterocolitis syndrome
  - Eosinophilic disorders, as evidenced by the results of a biopsy
  - Impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length and motility of the gastrointestinal tract
- Coverage is provided for formulas necessary for the treatment of phenylketonuria or other heritable diseases to the same extent as for drugs available only on the orders of a physician
- Orthotic and prosthetic devices
- Routine patient care costs associated with approved clinical trials
- Reconstructive surgery for craniofacial abnormalities for a child who is younger than 18 years of age.
- Coverage for telemedicine medical services and telehealth services
- Diagnostic or surgical treatment of conditions affecting the temporomandibular joint (including the jaw and the craniomandibular joint) if the treatment is medically necessary as a result of an accident; a trauma; a congenital defect; a developmental defect; or a pathology

See also Exclusions and limitations section in this document.

## 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 and

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

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

## Important benefits for women

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

Please contact Member Services for more information, or visit the U.S. Department of Health and Human Services website, **www.cms.gov/HealthInsReformforConsume/Downloads/WHCRA_Helpful_Tips_2010_06_14.pdf**, and the U.S. Department of Labor website, **www.dol.gov/ebsa/consumer_info_health.html**.

## Transplants and other complex conditions

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

## Prescription drug benefit

The plan covers drugs prescribed to treat a chronic, disabling, or life-threatening illness, when the illness is also a covered condition under the plan. The drug must be:

1. Approved by the United States Food and Drug Administration (FDA) for at least one indication; and
2. Recognized for treatment of the indication for which the drug is prescribed by:
   - a prescription drug reference compendium approved by the commissioner for purposes of this section; or
   - substantially accepted peer-reviewed medical literature.

This includes coverage of medically necessary services associated with the administration of the drug.

Based on "medical necessity," we may not deny coverage of such drugs unless the reason for the denial is unrelated to the legal status of the drug use.

The plan does not cover experimental drugs that are not otherwise approved by the FDA for any disease or condition that is excluded from coverage under the plan, or that the FDA has determined to be contraindicated for treatment of the current indication.

**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. If a generic drug is not available, we will cover a brand-name prescription drug.

**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 manufacturers may give us rebates when you buy certain drugs**
While rebates apply mostly to drugs on the preferred drug list, they may apply to nonpreferred drugs as well. However, your share of the cost is based on the price of the drug before any rebate.

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

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

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

**You may have to try one drug before you can try another**
"Step therapy" means you may have to try one or more less-expensive or more common drugs before a drug on the step-therapy list will be covered. Your doctor might want you to skip one of these drugs for medical reasons. If so, you, someone helping you or your doctor can ask for a medical exception. Your pharmacist can also ask for an exception for antibiotics and pain medicines.

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

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

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

## Have questions? Get answers.

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

## Emergency and urgent care and care after office hours

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

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

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

**You are covered for emergency care**
You have this coverage while you are traveling or if you are near your home. That includes students who are away at school.

Sometimes you don't have a choice about where you go for care, like if you go to the emergency room for chest pain or after 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.

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.

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

**After-hours care — available 24/7**
Call your doctor anytime if you have medical questions or concerns. Your doctor should have an answering service if you call after the office closes. You can also go to an urgent care center, which may have limited hours. To find a center near you, log on to **www.aetna.com** 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.

# What you pay

## Your costs when you don't get a referral or you go outside the network

You may choose a doctor in our network with or without a referral from your primary care physician (PCP). You may also choose to visit an out-of-network doctor. We cover the cost of care based on your choices.

"**Referred**" benefits means you must get a PCP referral to in-network doctors to receive the highest level of benefits for specialty care. (See the "Choose a primary care physician" and "Referrals" sections for more about this.) If you don't get a referral, your benefit will be paid at the "nonreferred" level. This is the same level of benefits as if you went to an out-of-network doctor.

"**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. For emergency and urgent care, and when a network provider is not reasonably available within the service area (when preapproved), we will pay for services as if you received them from a network provider.

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 that 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 that you are fully responsible for paying everything above the amount that 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 or your employer chooses. 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 and urgent care" to learn more; these services are treated as in-network benefits.

## 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.

### How we pay claims when the services you need are not available within the network

If you cannot find a network doctor or hospital to provide a medically necessary service or a network provider is not reasonably available, call Member Services at the toll-free number on your Aetna ID card for help. If the Member Services representative cannot find a network provider, he or she can get authorization for an out-of-network provider to perform the service.

In this case, your share of the cost will be the same as if you received care in network. We will credit your out-of-pocket costs to your out-of-pocket maximums accordingly. We will protect you from any balance billing.

### Your network doctor will bill the plan for covered services

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

### Your financial responsibility

You are responsible for all applicable copayments, coinsurance, deductibles and premiums under your particular plan. This information is included, with specific amounts, in your enrollment kit. You are also financially responsible for all noncovered services.

- **Copay for PCP referred in-network services** – This could be a percentage of the cost (for example you pay 25 percent and the plan pays 75 percent). Copays apply when you go to your PCP or when your PCP refers you to other network providers. It could also be a set amount (for example, $25) you pay for covered health care service. You usually pay this at the time you receive 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.
- **Coinsurance for self-referred network and out-of-network services** – Coinsurance applies when you refer yourself to a network doctor or if you go outside the network for covered services. Coinsurance does not apply when you go to your PCP or when your PCP refers you to other network providers. Coinsurance is calculated as a percent — such as 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 for self-referred network and out-of-network services** – Some plans include a deductible when you refer yourself to a network doctor or if you go outside the network for covered services. Deductible does not apply when you go to your PCP or when your PCP refers you to other network providers. This is the amount you owe for health care services before your health plan begins to pay. For example, if your deductible is $1,000, your plan won't pay anything until you have paid $1,000 for any covered health care services that are subject to the deductible. The deductible may not apply to all services.
  - **Inpatient Hospital Deductible** – This deductible applies when you are a patient in a hospital.
  - **Emergency Room Deductible** – This is the amount you pay when you go to the emergency room. If you are admitted to the hospital within 24 hours, you won't have to pay it.

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

## Exclusions and limitations

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

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

- Acupuncture and acupuncture therapy, except when performed by a participating physician as a form of anesthesia in connection with covered surgery
- Ambulance or medical transportation services for nonemergency transportation
- Bereavement counseling, funeral arrangements, pastoral counseling, financial or legal counseling, homemaker or caretaker services, respite care, and any service not solely related to the care of the member, including but not limited to, sitter or companion services for the member or other members of the family, transportation, house cleaning and maintenance of the house
- Biofeedback
- Blood and blood plasma, including provision of blood, blood plasma, blood derivatives, synthetic blood or blood products other than blood-derived clotting factors, the collection or storage of blood plasma, the cost of receiving the services of professional blood donors, apheresis (removal of the plasma) or plasmapheresis (cleaning and filtering of the plasma). Only administration, processing of blood and blood plasma, processing fees, and fees related to autologous blood donations are covered.
- Care for conditions that state or local law requires to be treated in a public facility, including but not limited to mental illness commitments
- Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury. Examples include asbestos removal, air filtration, and special ramps or doorways.
- Cosmetic surgery, or treatment relating to the consequences of, or as a result of, cosmetic surgery, including but not limited to surgery to correct gynecomastia, breast augmentation, and otoplasties. This exclusion does not apply to (i) surgery to restore normal bodily functions, including but not limited to, cleft lip and cleft palate or as a continuation of a staged reconstruction procedure, or congenital defects; (ii) breast reconstruction following a mastectomy, including the breast on which mastectomy surgery has been performed and the breast on which mastectomy surgery has not been performed; and (iii) reconstructive surgery performed on a member who is less than 18 years of age to improve the function of or to attempt to create a normal appearance of a craniofacial abnormality.
- Costs for court-ordered services, or those required by court order as a condition of parole or probation
- Custodial care
- Dental services, including false teeth. This exclusion does not apply to: the removal of bone fractures, tumors, and orthodontogenic cysts; diagnostic and medical/surgical treatment of the temporomandibular joint disorder; or medical services required when the dental services cannot be safely provided in a dentist's office due to the member's physical, mental or medical condition.
- Durable medical equipment and household equipment, including but not limited to crutches, braces, the purchase or rental of exercise cycles, water purifiers, hypo-allergenic pillows, mattresses or waterbeds, whirlpool or swimming pools, exercise and massage equipment, central or unit air conditioners, air purifiers, humidifiers, dehumidifiers, escalators, elevators, ramps, stair glides, emergency alert equipment, handrails, heat appliances, improvements made to a member's house or place of business and adjustments made to vehicles
- Educational services and treatment of behavioral disorders and services for remedial education including evaluation or treatment of learning disabilities, minimal brain dysfunction, and behavioral training. This includes services, treatment or educational testing and training related to behavioral (conduct) problems, learning disabilities, or developmental delays unless specifically listed in the Covered Benefits section or by a rider or amendment attached to the plan documents. Special education, including lessons in sign language to instruct a member, whose ability to speak has been lost or impaired, to function without that ability, are not covered.

- Experimental or investigational procedures or ineffective surgical, medical, psychiatric or dental treatments or procedures, research studies, or other experimental or investigational health care procedures or pharmacological regimes as determined by Aetna, unless preauthorized by Aetna.

  This exclusion will not apply to:

  - Drugs
    (i) that have been granted treatment investigational new drug (IND) or Group c/ treatment IND status;

    (ii) that are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; or

    (iii) when we have determined that available scientific evidence demonstrates that the drug is effective or the drug shows promise of being effective for the disease.
  - Procedures or services required to be covered as a result of an independent review decision upon appeal.
- Hair analysis
- Health services, including those related to pregnancy, rendered before the effective date or after the termination of the member's coverage
- Hearing aids
- Home births
- Home uterine activity monitor
- Hypnotherapy
- Infertility services not otherwise covered, including injectable infertility drugs, charges for the freezing and storage of cryopreserved embryos, charges for storage of sperm, and donor costs, including but not limited to: the cost of donor eggs and donor sperm, ovulation predictor kits, and donor egg program or gestational carriers, ZIFT, GIFT or in-vitro fertilization unless specifically covered by a rider or an amendment to the plan documents. Call **1-800-575-5999** for more information about exclusions.
- Injectable drugs as follows: experimental drugs or medications, or drugs or medications that have not been proven safe and effective for a specific disease or approved for a mode of treatment by the U.S. Food and Drug Administration (FDA) and the National Institutes of Health (NIH); needles, syringes and other injectable aids (except for diabetic supplies.); drugs related to the treatment of non-covered services; and drugs related to contraception, the treatment of infertility and performance enhancing steroids. Contraceptive drugs and devices are covered when prescription drugs are covered.
- Inpatient care for serious mental illness that is not provided in a hospital or mental health treatment facility; non-medical ancillary services and rehabilitation services in excess of the number of days described in the Schedule of Benefits for serious mental illness
- Inpatient treatment for mental or behavioral conditions, except for serious mental illness (unless covered by a rider to your plan)
- Military service-related diseases, disabilities or injuries for which the member is legally entitled to receive treatment at government facilities and which facilities are reasonably available to the member
- Missed appointment charges
- Non-diagnostic and non-medical/surgical treatment of temporomandibular joint disorder (TMJ)
- Oral or topical drugs used for sexual dysfunction or performance
- Orthoptic therapy (vision exercises)
- Outpatient medical consumable or disposable supplies such as syringes, incontinence pads, elastic stockings and reagent strips. This exclusion does not apply to diabetic supplies.
- Performance, athletic performance or lifestyle enhancement drugs and supplies
- Personal comfort or convenience items
- Prescription or nonprescription drugs and medicines, except as provided on an inpatient basis (unless covered by a prescription drug rider). This exclusion does not apply to diabetes supplies, including but not limited to insulin.
- Private-duty or special-nursing care (unless medically necessary and preauthorized by Aetna)
- Recreational, educational and sleep therapy, including any related diagnostic testing
- Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling and sex therapy
- Reversal of voluntary sterilizations
- Routine foot/hand care
- Services for which a member is not legally obligated to pay in the absence of this coverage
- Services for the treatment of sexual dysfunctions or inadequacies, including therapy, supplies, or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis
- The following services or supplies:
  - Those that do not require the technical skills of a medical, mental health or a dental professional
  - Those furnished mainly for the personal comfort or convenience of the member, or any person who cares for the member, or any person who is part of the member's family, or any provider
  - Those furnished solely because the member is an inpatient on any day in which the member's disease or injury could safely and effectively be diagnosed or treated while the member is not an inpatient

- Those furnished in a particular setting that could safely and effectively be furnished in a physician's or a dentist's office or other less costly setting consistent with the applicable standard of care

- Services performed by a relative of a member for which, in the absence of any health benefits coverage, no charge would be made
- Services rendered for the treatment of delays in speech development, unless resulting from disease, injury, or congenital defects
- Services required by third parties, including but not limited to, physical examinations, diagnostic services and immunizations in connection with obtaining or continuing employment, insurance, travel, school admissions or attendance, including examinations required to participate in athletics, except when such examinations are considered to be part of an appropriate schedule of wellness services
- Specific non-standard allergy services and supplies, including but not limited to, skin titration (wrinkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine auto-injections
- Special medical reports, including those not directly related to treatment of the member (i.e., reports prepared in connection with litigation)
- Spinal manipulation for subluxation
- Surgical operations, procedures or treatment of obesity
- Therapy or rehabilitation as follows: primal therapy (intense non-verbal expression of emotion expected to result in improvement or cure of psychological symptoms), chelation therapy (removal of excessive heavy metal ions from the body), rolfing, psychodrama, megavitamin therapy, purging, bio-energetic therapy, vision perception training, carbon dioxide and other therapy or rehabilitation not supported by medical and scientific evidence. This exclusion does not apply to rehabilitative services such as physical, speech and occupational therapy.
- Transsexual surgery, sex change or transformation, including any procedure or treatment or related service designed to alter a member's physical characteristics from the member's biologically determined sex to those of another sex, regardless of any diagnosis of gender role or psychosexual orientation problems
- Treatment in a federal, state, or governmental entity, including care and treatment provided in a nonparticipating hospital owned or operated by any federal, state or other governmental entity, except to the extent required by applicable laws
- Treatment of mental retardation, defects, and deficiencies
- Treatment of occupational injuries and occupational diseases
- Unauthorized services, including any nonemergency service obtained by or on behalf of a member without prior referral by the member's PCP or certification by Aetna
- Vision care services and supplies, including orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision) and radial keratotomy, including related procedures designed to surgically correct refractive errors. Eye exams for children through age 17 are covered.
- Weight reduction programs or dietary supplements

**No coverage based on U.S. sanctions**

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

# Preauthorization: Getting approvals for services

Preauthorization is required for hospital care, surgical procedures, and certain outpatient services. Preauthorization is not required for PCP visits, emergency services, or to go to an urgent care center or after-hours clinic.

Your plan documents list all the services that require you to get preauthorization. If you don't, you will have to pay for all or a larger share of the cost of the service. For example, you may pay a higher share (such as, 50 percent) or a specific penalty (such as, $400). These costs will not apply to your deductible or out-of-pocket limits. Penalties apply to out-of-network services only in plans that include out-of-network benefits.

**How to request preauthorization**

When you get care from a doctor in the Aetna network, your doctor or hospital staff will request preauthorization for you. But, except in an emergency, if you get your care outside our network, you must call us for preauthorization when it's required.

Call the number shown on your Aetna ID card to begin the process. You must get the approval before you receive the care. Preauthorization is not required for emergency services.

| When to request preauthorization | If the reason for your request is: | You should request preauthorization: |
|---|---|---|
| | **Nonemergency admissions** | At least 1 to 14 days (see your plan documents) before the date you are scheduled to be admitted |
| | Emergency medical condition | If possible, before receiving outpatient care, treatment or procedure, or as soon as reasonably possible |
| | Emergency admission | Within 24 to 96 hours or as soon as reasonably possible after you have been admitted |
| | Urgent admission<br>(a hospital admission due to the onset of or change in an illness, diagnosis of an illness, or injury) | Before you are scheduled to be admitted. |
| | Additional days during an inpatient stay | At least 1 day before you are scheduled to be discharged |
| | Outpatient nonemergency medical services that require preauthorization | At least 1 to 14 days (see your plan documents) before the outpatient care is provided, or the treatment is scheduled |
| | Prenatal care and delivery | • As soon as possible after your doctor confirms pregnancy, and<br>• Within 24 to 96 hours of birth or as soon as possible thereafter<br>Penalty will not apply for first 48 hours after routine delivery or 96 hours after cesarean delivery. |

**What we look for when reviewing a preauthorization request**

First, we check to see that you are still a member. And we make sure the service is considered medically necessary for your condition. We also check that the service and place requested to perform the service is cost effective. If we know of a treatment or place of service that is just as effective but costs less, we may talk to you or your doctor about it. Our decisions are based entirely on appropriateness of care and service and the existence of coverage, using nationally recognized guidelines and resources.

We also look to see if you qualify for one of our case management programs. If so, one of our nurses may call to tell you about it and help you understand your upcoming procedure. Preauthorization does not, however, verify if you have reached any plan dollar limits or visit maximums for the service requested. That means preauthorization is not a guarantee that the service will be covered.

"Preauthorization," when used in this document, means the utilization review process to determine whether the requested service, procedure, prescription drug or medical device meets our clinical criteria for coverage.

Preauthorization does not mean verification, which is defined by Texas law as a reliable representation of payment of care or services to fully insured HMO members.

**We will notify you and your doctor of our decision**

Preauthorization is good for 30 to 90 days depending on the type of service requested, as long as you are still a plan member. For an inpatient admission, our letter will include the length of stay that we approved. Your doctor can request authorization for more days if recommended.

If we deny the requested coverage, the letter will explain why and that you can appeal our decision. See the "Complaints, appeals and independent review" section to learn more.

**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.

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

## What happens if your doctor leaves the health plan

For network-only plans, if your doctor or other health care provider leaves the plan, you may be able to continue to see that doctor for a limited time.

To be eligible, your doctor cannot have left the network for any of these reasons:

- Imminent harm to your health
- Action against the doctor's professional license
- Provider fraud
- Failure to satisfy credentialing criteria

| Continuation of Care applies as follows: | If you have this condition: | You can be covered with this doctor for an extra: |
|---|---|---|
| | A disability, acute condition, life threatening illness or special circumstances | 90 days |
| | A terminal illness | 9 months |
| | Past the 24th week of pregnancy | Through delivery of the child, immediate postpartum care and follow-up checkup within the first 6 weeks after delivery |

# Complaints, appeals and independent review

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

Aetna
PO Box 14586
Lexington, KY 40512-1486

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

We are interested in hearing all comments, questions, complaints or appeals from customers, members and doctors. We do not retaliate against any of those individuals or groups for initiating a complaint or appeal.

Only medical professionals can deny coverage if the reason is medical necessity. We do not give financial incentives or otherwise to Aetna employees for denying coverage. Sometimes a physicians' 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 physicians' group denied coverage for medical necessity. You can call Member Services to ask for a free copy of the criteria we use to make coverage decisions. Or visit **www.aetna.com/about/cov_det_policies.html** 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.

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

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

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

For more information about your right to an appeal, contact the Texas Department of Insurance. The website for the Texas Department of Insurance is **www.tdi.texas.gov**. Their toll-free telephone number is **1-800-252-3439**.

**A "rush" review may be possible**

If your doctor thinks you cannot wait 30 days, ask for an "expedited review." Examples include denials for emergency care and for continued hospital stays. We will respond as soon as is practicable, but not later than within one working day. We will give your provider a notice of denial of coverage for post-stabilization care after emergency treatment no later than one hour after the time your physician requests the care. We will also notify you of a denial for continued hospital stay within 24 hours of your request.

**Get a review from someone outside Aetna**

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

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

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

**Voluntary Arbitration**

You, your plan sponsor and the plan may agree to binding arbitration to resolve any controversy, dispute or claim between is arising out of or relating to your plan, whether stated in tort, contract, statute, claim for benefits, bad faith, professional liability or otherwise ("Claim"). Arbitration will be administered pursuant to the Texas Arbitration Act before a sole arbitrator ("Arbitrator").

Judgment on the award rendered by the Arbitrator ("Award") may be entered by any court having jurisdiction thereof. If administrator declines to oversee the case and the parties do not agree on an alternative administrator, a sole neutral Arbitrator will be appointed upon petition to a court having jurisdiction.

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

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

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

**Existing members**: Visit **www.aetna.com** and log in. From your secure member website home page, select "Find a Doctor" from the top menu bar and start your search.

**Considering enrollment**: Visit **www.aetna.com** and scroll down to "Find a doctor, dentist, facility or vision provider" from the home page. You'll need to select the plan you're interested in from the drop-down box.

Our online search tool is more than just a list of doctors' names and addresses. It also includes information about:

- Where the physician attended medical school
- Board certification status
- Language spoken
- Hospital affiliations
- Gender
- Driving directions

## Get a FREE printed directory

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 **1-888-982-3862**.

Our provider directory will identify hospitals that have contractually agreed to facilitate the use of preferred doctors. Our network hospitals will exercise good faith effort to accommodate your request to use a network doctor. If you are assigned a facility based physician or physician group at least 48 hours prior to the services being rendered, the hospital will provide you with information at least 24 hours prior to services being rendered enough information for you to determine if the assigned facility based physician or physician group is a preferred/network provider.

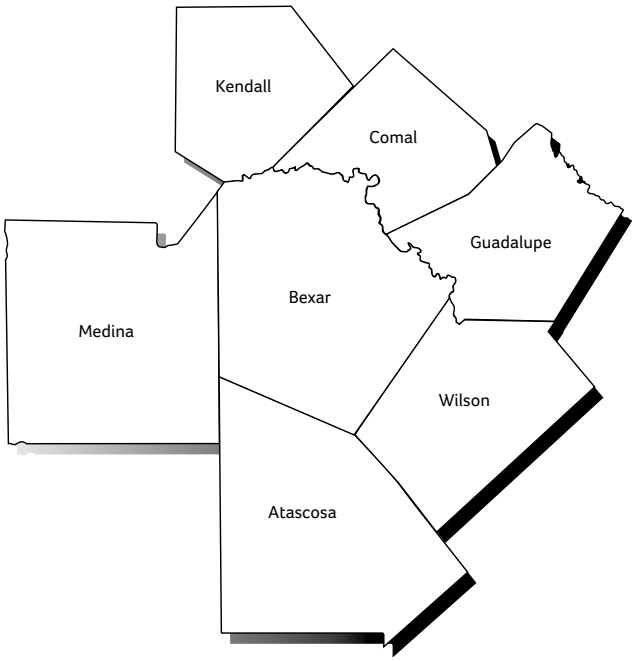
# Aetna QPOS service areas

### Houston / Southeast Texas

Counties: Austin, Brazoria, Chambers, Colorado, Fort Bend, Galveston, Grimes, Hardin, Harris, Liberty, Jefferson, Matagorda, Montgomery, Orange, San Jacinto, Walker, Waller, and Wharton

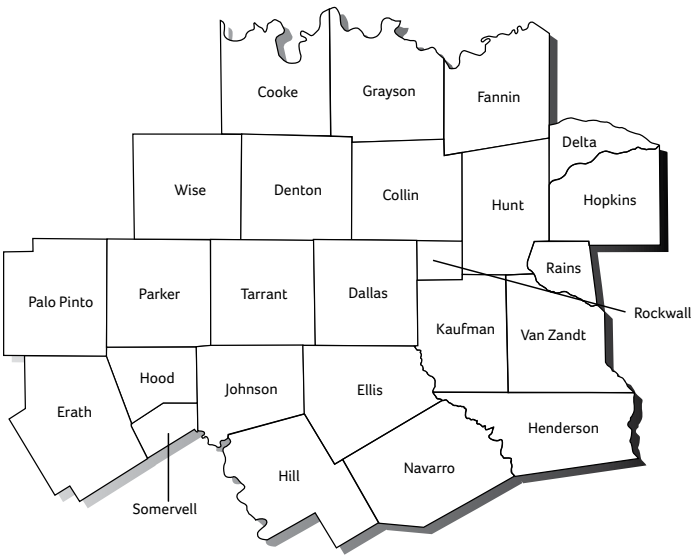
### San Antonio

Counties: Atascosa, Bexar, Comal, Guadalupe, Kendall, Medina, Wilson



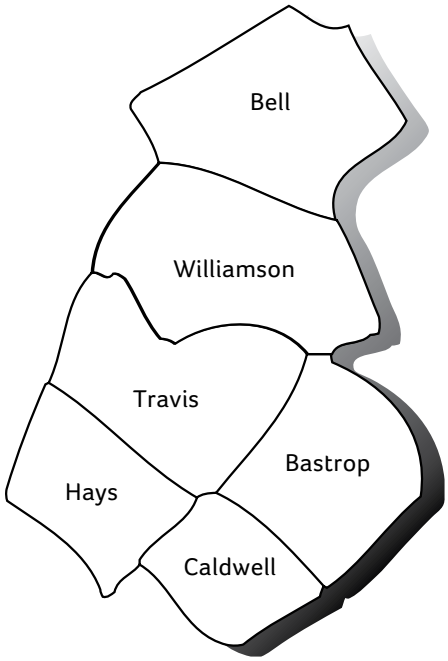

### Dallas/Fort Worth

Counties: Collin, Cooke, Dallas, Delta, Denton, Ellis, Erath, Fannin, Grayson, Henderson, Hill, Hood, Hopkins, Hunt, Johnson, Kaufman, Navarro, Palo Pinto, Parker, Rains, Rockwall, Somervell, Tarrant, Van Zandt, Wise




### Austin / Central Texas

Counties: Bastrop, Bell, Caldwell, Hays, Travis, Williamson

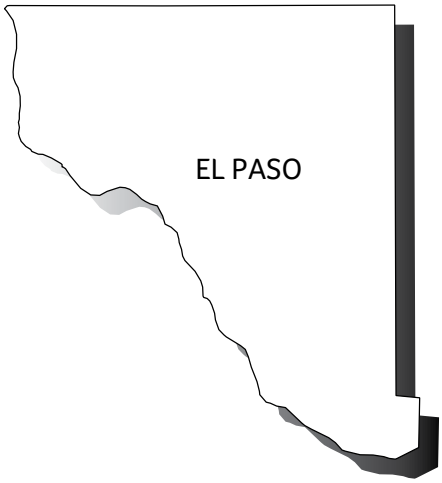


**Corpus Christi**

Counties: Aransas, Bee, Duval, Jim Wells, Kleberg, Live Oak, Nueces, San Patricio

**El Paso**

Counties: El Paso




# You have the right to an adequate network of preferred providers

## Quality Point of Service (QPOS) Disclosure

***Texas Department of Insurance Notice***

You have the right to an adequate network of preferred providers (also known as "network providers"). If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance.

If you relied on materially inaccurate directory information, you may be entitled to have an out-of-network claim paid at the in-network percentage level of reimbursement and your out-of-pocket expenses counted toward your in-network deductible and out-of-pocket maximum.

You have the right, in most cases, to obtain estimates in advance:

- From out-of-network providers of what they will charge for their services; and
- From your insurer of what it will pay for the services.

You may obtain a current directory of preferred providers at the following website: **www.aetna.com/docfind/** or by calling the number on your Aetna ID card (if you're not yet enrolled, call **1-888-982-3862**) for assistance in finding available preferred providers.

If you are treated by a provider or hospital that is not a preferred provider, you may be billed for anything not paid by the insurer.

If the amount you owe to an out-of-network hospital-based radiologist, anesthesiologist, pathologist, emergency department physician, assistant surgeon or neonatologist is greater than $500 (not including your copayment, coinsurance, and deductible responsibilities), you may be entitled to have the parties participate in a teleconference, and, if the result is not to your satisfaction, in a mandatory mediation at no cost to you.

You can learn more about mediation at the Texas Department of Insurance website:
**www.tdi.texas.gov/consumer/cpmmediation.html**.

# Texas Department of Insurance

If you have a dispute concerning your premium or about a claim you should contact the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance. You may contact the Texas Department of Insurance for information on companies, coverages, rights or complaints at **1-800-252-3439**.

You may also write the Texas Department of Insurance:

PO Box 149104
Austin, TX 78714-9104
Fax: **(512) 490-1007**
Web: **www.tdi.texas.gov**
Email: **ConsumerProtection@tdi.texas.gov**

## If you are admitted to a hospital

Your coverage does not require that your PCP use a hospitalist when you are hospitalized. However, your PCP may not oversee your care if you are admitted to a hospital, skilled nursing facility or other inpatient facility and you may be seen by a doctor who works in the hospital and will direct your care. These doctors are called "hospitalists." The choice is between you and your PCP. Read "Choose a primary care physician (PCP)" in this booklet to learn more about the role of a PCP.

## How we contract with doctors

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

One of the goals of managed care is to reduce and control the costs of health care. We offer financial incentives in some compensation arrangements with doctors in an attempt to reduce and control the costs of health care. Only appropriate financial incentives will be used to compensate physicians and providers treating Aetna members.

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

Fee for service is a different method of payment. A doctor charges a fee for each patient visit, medical procedure, or medical service provided. For example, Mrs. Smith, an Aetna member, goes to Dr. Jones for maternity care. Mrs. Smith's baby is delivered by Cesarean section. Dr. Jones' contract with us states she will be paid a fee for each patient visit and each service she provides. The amount of payment Dr. Jones receives will depend on the number, types and complexity of services, and the time she spends providing services to Mrs. Smith. Because Cesarean deliveries are more complicated than vaginal deliveries, Dr. Jones is paid more to deliver Mrs. Smith's baby than she would be paid for a vaginal delivery. Mrs. Smith may be responsible for paying some portion of Dr. Jones' bill.

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

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

### 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.

# Choose a primary care physician

With an Aetna Point of Service (POS) plan, you are covered at different levels depending on whether you visit your chosen primary care provider (PCP), or if you go directly to any licensed physician without seeing your PCP first. Your PCP can coordinate all your health care. If it's an emergency, you don't have to call your PCP first. Your PCP will perform physical exams, order tests and screenings and help you when you're sick. Your PCP will also refer you to a specialist when needed.

If you visit any licensed physician without going to your PCP first, your out-of-pocket costs are generally higher.

## Female members may choose an Ob/Gyn

You have the right to select an Ob/Gyn to whom you have access without obtaining a referral from your PCP. You are not required to select an Ob/Gyn. You may elect to receive your Ob/Gyn services from your PCP.

## Tell us who you chose to be your PCP

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

# Limited provider networks

## Choosing your doctor

Your primary care physician (PCP) will be the one you call when you need medical advice, when you are sick and when you need preventive care such as immunizations. Your PCP may be part of a practice group or association of health professionals who work together to provide a full range of health care services. That means when you choose your PCP, you are also choosing that association.

Usually, you cannot receive services from any doctor or health care professional, including your obstetrician-gynecologist (Ob/Gyn), who is not also part of your PCP's group or association. You will not be able to select doctors outside of your PCP's group, even if that doctor is listed with your health plan's network. The association to which your PCP belongs will provide or arrange for all of your care, so make sure that your PCP's association includes the specialists and hospitals that you prefer.

PCPs who are part of a limited provider network will have that designation shown in the physician directory immediately following their name (for example, Dr. John Smith, XYZ IPA). If you have questions about whether a PCP is a member of a limited provider network, please call the Member Services toll-free telephone number on your ID card.

## Information about doctors who participate in the Aetna network

Participating doctors, specialists and other health care providers are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. We cannot guarantee that any particular doctor will be available or is accepting new patients.

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

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

Accountable care organizations (ACOs) 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. For the purpose of cost-sharing, ACOs are considered network providers.

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.

If you receive care through an accountable care network, your share of the cost will be the same as if you received care in network. These doctors and hospitals are in-network service providers. We will credit your out-of-pocket costs to your out-of-pocket maximums accordingly. We will protect you from any balance billing.

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

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

*The specific goals will vary from network to network.

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

A "referral" is a written request for you to see another doctor. Some doctors can send the referral right to your specialist for you. There's no paper involved.

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

**Remember these points about referrals:**

You do not need a referral for emergency care.

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

## Referrals within physician groups

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

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

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

## Female members

In selecting a PCP, remember that your PCP's limited provider network affects your choice of an Ob/Gyn. You have the right to designate an Ob/Gyn to whom you have access without first obtaining referral from a PCP. However, the designated Ob/Gyn must belong to the same limited provider network as your PCP. This is another reason to be sure your PCP's limited provider network includes the specialist (particularly the Ob/Gyn) and hospitals you prefer. You do not have to designate an Ob/Gyn; instead, you may elect to receive Ob/Gyn services from your PCP.

## PCP and referral rules for Ob/Gyns

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

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

# How we determine what is covered

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

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

## We check if it's "medically necessary"

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

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

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

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

The determination of medically necessary care is an analytical process applied on a case-by-case basis by qualified professionals who have the appropriate training, education, and experience and who possess the clinical judgment and case-specific information necessary to make these decisions.

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

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

## We study the latest medical technology

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

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

- Read medical journals to see the research. We want to know how safe and effective it is.
- See what other medical and government groups say about it. That includes the federal Agency for 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 ID card. Ask for a copy of a CPB for any product or service.

# 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, including our Member Rights and Responsibilities.

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

## Making medical decisions before your procedure

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

There are three types of advance directives:

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

You can create an advance directive in several ways:

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

*Source: American Academy of Family Physicians. 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 January 12, 2015.*

## Learn about our quality management programs

We make sure your doctor provides quality care for you and your family. To learn more about these programs, go to our website at **www.aetna.com**. 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), (this includes plan sponsors and/or employers)

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, sexual orientation, health, ethnicity, creed, age or national origin when giving you access to care. Network providers are contractually obligated to the same.

We must comply with these laws:

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

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

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

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

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

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

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

To refine your search, we suggest you search these areas:

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

See "Other Reports on Health Care Quality" in the drop-down menu for Managed Behavioral Healthcare Organizations – for behavioral health accreditation and Credentials Verifications Organizations – for credentialing certification.

**If you need this material translated into another language, please call Member Services at 1-888-982-3862.**
**Si usted necesita este material en otro lenguaje, por favor llame a Servicios al Miembro al 1-888-982-3862.**

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