

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

**aetna**<sup>®</sup>

## Member handbook and consumer disclosures

### **Important information about your health benefits**

For these health benefits and insurance plans:

- Aetna Open Access<sup>®</sup> Elect Choice<sup>®</sup> EPO
- Open Choice<sup>®</sup> PPO
- Aetna Open Access Managed Choice<sup>®</sup> POS



Aetna Open Access<sup>®</sup> Elect Choice<sup>®</sup>, Open Choice<sup>®</sup> and Aetna Open Access Managed Choice<sup>®</sup> health insurance plans are underwritten by Aetna Life Insurance Company, which is a licensed health insurance company in Texas.

[www.aetna.com](http://www.aetna.com)

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### **Aetna Open Access® Elect Choice® is an exclusive provider organization (EPO) plan**

This plan only provides benefits for services received from doctors, hospitals and other health care provider that participate in the plan's network. It does not cover services received from health care providers who do not participate in the network. Some exceptions apply. They are described in your policy and this booklet.

### **Open Choice®, a preferred provider organization (PPO) plan Aetna Open Access Managed Choice®, a point of service (POS) plan**

These plans provide benefits for services received from doctors, hospitals and other health care providers who participate in the plan's network. The plans also provide benefits for services received from health care providers who do not participate in the network. Some exceptions apply. They are described in your policy and this booklet.

### **Have a Med Premier or Student Plan?**

If you have a Student Accident and Sickness plan, please visit [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com) for questions or call Aetna Student Health at the toll-free number on your ID card for more information. For appeals, please forward your request to the address shown on your Explanation of Benefits statement or adverse determination letter. Fully insured student health insurance plans are underwritten by Aetna Life Insurance Company (Aetna), which is a licensed health insurance company in Texas. Aetna Student Health<sup>SM</sup> is the brand name used for products and services provided by Aetna Life Insurance Company and its applicable affiliated companies (Aetna).

If you have a Med Premier major medical plan and have questions, please call The Boon Group® at the toll-free number on your ID card for more information. The Med Premier plan is a fully insured health insurance plan underwritten by Aetna Life Insurance Company. Administrative services are provided by Aetna Life Insurance Company and Boon Administrative Services, Inc., a licensed Third Party Administrator and a wholly owned subsidiary of The Boon Group, Inc.

## **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 you will pay for services. Plan document names vary. They may include a Schedule of Benefits, Booklet-certificate, Group Agreement, Group Insurance Certificate, Group Insurance Policy and/or any riders and updates that come with them. If you can't find your plan documents, 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 are already an enrolled member of an Aetna health insurance 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](http://www.aetna.com) and click “Log In/Register.” Follow the prompts to complete the one-time registration.

Then you can log in any time to:

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

### **2. Use your mobile device to access a streamlined version of Aetna Navigator**

Go to your Play Store (Android) or App Store (iPhone) and search for Aetna Mobile. You can also text **APPS** to **23862** to download.

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

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

### **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 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
- Get help using our cost-of-care tools or ask for a payment estimate
- 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

## Preferred and nonpreferred benefits differ by plan

### Network-only plans

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

### Plans that cover out-of-network services

With Open Choice and Open Access Managed Choice plans, you may choose a doctor in our network (preferred). You may choose to visit an out-of-network doctor (nonpreferred). We cover the cost of care based on if the provider, such as a doctor or hospital, is “in network” or “out of network.” See the “What you pay” section for details.

## Medically necessary covered benefits

As an Aetna member, you will be entitled to the medically necessary covered benefits as listed in the Booklet-certificate, 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.

In order for services 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.

*Note: Consumer Choice health benefits plans issued pursuant to the Texas Consumer Choice of Benefits Health Insurance Plan Act do not include all state mandated health insurance benefits. Benefits provided under a Consumer Choice Benefits plan are provided at a reduced level from what is mandated or are excluded completely from the plan. The covered benefits listed below may not be available under a Consumer Choice health benefits plan.*

### Medically necessary covered services include:

- Primary care physician and specialist physician outpatient and inpatient visits
- Evidence-based items or services that have a rating of “A” or “B” in effect in the current recommendations of the United States Preventive Services Task Force (USPSTF)
- Routine adult physical examinations (including immunizations, routine vision and hearing screenings)
- Routine well-child care (including immunizations)
- Certain tests for the early detection of cardiovascular disease

## 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.

- Routine cancer screenings (which include screening mammograms; prostate specific antigen (PSA) tests; digital-rectal exams (DRE); fecal occult blood tests (FOBT); sigmoidoscopies; double contrast barium enemas (DCBE); and colonoscopies)
- Routine gynecological exams, including routine Pap smears, the CA 125 blood test or liquid-based cytology methods for detection of human papillomavirus and cervical or ovarian cancer
- Routine vision, speech and hearing screenings (including newborns)
- Injections, including allergy desensitization injections
- Diagnostic, laboratory, X-ray services
- Cancer chemotherapy and cancer hormone treatments and services that have been approved by the United States Food and Drug Administration for general use in treatment of cancer
- Diagnosis and treatment of gynecological or infertility problems by participating gynecologists or participating infertility specialists. Benefits for infertility treatment are limited, and you should call **1-800-575-5999** for more information about coverage under your specific health plan.
- Outpatient and inpatient prenatal and postpartum care and obstetrical services
- Inpatient hospital 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 by a participating behavioral health provider for diagnostic, medical or therapeutic rehabilitation services for chemical dependency.
- Inpatient rehabilitation benefits are covered for medical, nursing, counseling or therapeutic rehabilitation services in an appropriately licensed participating facility.
- Mental health benefits. A member is covered for services for the treatment of mental or behavioral conditions provided through participating behavioral health providers.
- Short-term, outpatient evaluative and crisis intervention and home health mental health services.
- Serious mental illness: diagnosis and medical treatment of a serious mental illness. Serious mental illness means the following psychiatric illnesses (as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM)III-R): schizophrenia; paranoid and other psychotic disorders; bipolar disorders (hypomanic; mixed, manic and depressive); major depressive disorders (single episode or recurrent); schizoaffective disorders (bipolar or depressive); pervasive developmental disorders; obsessive-compulsive disorders and depression in childhood and adolescence.
- Emergency medical services, including screening/ evaluation to determine whether an emergency medical condition exists, and for emergency medical transportation. See the "Emergency and urgent care and care after office hours" section for more information. As a reminder, a referral from your PCP is not required for this service.(b)(5)
- Urgent, non-emergent care services obtained from a licensed physician or facility outside the service area if (i) the service is a covered benefit; (ii) the service is medically necessary and immediately required because of unforeseen illness, injury or condition. As a reminder, a referral from your PCP is not required for this service.
- Inpatient and outpatient physical, occupational and speech rehabilitation services when they are medically necessary and meet or exceed the treatment goals established for the patient.
- We will not exclude coverage for cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing or treatment, neurofeedback therapy, remediation, postacute transition services or community reintegration services necessary as a result of and related to an acquired brain injury.

- Cardiac rehabilitation benefits following an inpatient hospital stay. A limited course of outpatient cardiac rehabilitation is covered following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction.
- Home health benefits rendered by a participating home health care agency. Preauthorization must be obtained from the member's attending participating physician. Home health benefits are not covered if Aetna determines the treatment setting is not appropriate or if there is a more cost-effective setting in which to provide appropriate care.
- Hospice care medical benefits when preauthorized
- Initial provision of prosthetic appliances. Covered prosthetic appliances generally include those items covered by Medicare unless otherwise excluded under your specific health plan.
- Certain injectable medications when an oral alternative drug is not available and when preauthorized, unless excluded under your specific health plan
- Mastectomy-related services including reconstructive breast surgery, prostheses and lymphedema, as described in your specific health plan
- Inpatient care for a minimum of 48 hours after a mastectomy or for 24 hours after a lymph node dissection
- Voluntary sterilizations
- Administration, processing of blood, processing fees, and fees related to autologous blood donations only
- Diagnostic and surgical treatment of the temporomandibular joint that is medically necessary as a result of an accident, a trauma, a congenital defect, a developmental defect or a pathology
- Diabetic outpatient self-management training and education (including medical nutrition therapy for the treatment of diabetes), equipment and supplies (including blood glucose monitors and monitor-related supplies including test strips and lancets; injection aids; syringes and needles; insulin infusion devices; and insulin and other pharmacological agents for controlling blood sugar)
- Certain infertility services. Refer to the "What the Medical Benefit Covers" section of the Policy for detailed information. Benefits for infertility treatment are limited. Call **1-800-575-5999** for more information about coverage under your specific health plan.
- Coverage is provided for formulas necessary for the treatment of phenylketonuria or other heritable diseases to the same extent as for drugs available only on the orders of a physician
- Orthotic and prosthetic devices
- Routine patient care costs associated with approved clinical trials

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

## Prescription drug benefit

Check your plan documents to see if your plan includes prescription drug benefits. You will be responsible for any deductible, copayments or coinsurance shown on your Schedule of Benefits.

### Some plans encourage generic drugs over brand-name drugs

A generic drug is the same as a brand-name drug in dose, use and form. They are FDA approved and safe to use. Generic drugs usually sell for less; so many plans give you incentives to use generics. That doesn't mean you can't use a brand-name drug, but you'll pay more for it. You'll pay your normal share of the cost, and you'll also pay the difference in the two prices.

### We may also encourage you to use certain drugs

Some plans encourage you to buy certain prescription drugs over others. The plan may even pay a larger share for those drugs. We list those drugs in the Aetna Preferred Drug Guide (also known as a "drug formulary"). This guide shows which prescription drugs are covered on a preferred basis. It also explains how we choose medications to be in the guide.

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

### Drug companies may give us rebates when our members buy certain drugs

Rebates usually apply to drugs on the preferred drug guide. They may also apply to drugs not in the guide. In plans where you pay a percentage of the cost, your share of the cost is based on the price of the drug before Aetna receives any rebate. Sometimes, in plans where you pay a percentage of the cost instead of a flat dollar amount, you may pay more for a drug in the preferred drug guide than for a drug not in the guide.

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

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

### You might not have to stick to the preferred drug guide

Sometimes your doctor might recommend a drug that's not in the preferred drug guide. If it is medically necessary for you to use that drug, you, someone helping you or your doctor can ask us to make an exception. Your pharmacist can also ask for an exception for antibiotics and pain 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 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/](http://www.aetna.com/formulary/). You can call the toll-free number on your Aetna ID card to ask for a printed copy. We frequently add new drugs to the guide. Look online or call Member Services for the latest updates.

**Have questions? Get answers.**

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

**Emergency and urgent care and care after office hours**

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

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

- Call **911** or go to the nearest emergency room. If you have time, call your doctor or PCP.
- Tell your doctor or PCP as soon as possible afterward. A friend or family member may call on your behalf.
- You do not have to get approval for emergency services.

**You are covered for emergency care**

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

Sometimes you don't have a choice about where you go for care, like if you go to the emergency room for chest pain 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. You pay your plan's copayments, coinsurance and deductibles for your in-network level of benefits.

We'll review the information when the claim comes in. If we think the situation was not urgent, we might ask you for more information and may send you a form to fill out. Please complete the form, or call Member Services to give us the information over the phone.

**After-hours care – available 24/7**

Call your doctor when you have medical questions or concerns. Your doctor should have an answering service if you call after the office closes. You can also go to an urgent care center, which may have limited hours. To find a center near you, log in to [www.aetna.com](http://www.aetna.com) and search our list of doctors and other health care providers. Check your plan documents to see how much you must pay for urgent care services.

**Out-of-area services and benefits**

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



## What you pay

Besides paying your health insurance premium, you will share in the cost of your health care. These are called “out-of-pocket” costs. Your plan documents show the amounts that apply to your specific plan. Those costs may include:

- **Copay** – A fixed amount (for example, \$25) you pay for a covered health care services. You usually pay this when you receive the service. The amount can vary by the type of service. For example, the copay for your primary doctor’s office visit may be different than a specialist’s office visit.
- **Coinsurance** – Your share of the costs of a covered service. Coinsurance is calculated as a percentage — 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** – Some plans include a deductible. This is the amount you owe for health care services before your health plan begins to pay. For example, if your deductible is \$1,000, your plan won’t pay anything until you have paid \$1,000 for any covered health care services that are subject to the deductible. The deductible may not apply to all services.
  - **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 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.

### Your financial responsibility

You are responsible for all applicable copayments and premiums under your particular plan. This information is included, with specific amounts, in your enrollment kit. You are also financially responsible for all non-covered services and, in some cases, out-of-area expenses. Out-of-area hospital emergency facility, freestanding emergency medical care facility or urgent care expenses are reimbursed by the health plan.

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

## Your costs for emergency care and approved out-of-area services

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

In these cases, we will reimburse the out-of-network provider at our usual and customary charge. Please contact Member Services if you receive a bill from the out-of-network provider. We will work to resolve the outstanding balance so that all you pay is the appropriate network deductible, coinsurance or copayments under your plan.
- **PPO plans:** When you are treated by an out-of-network provider when a network provider is not reasonably available or for an emergency medical condition, we will reimburse the out-of-network provider at our usual and customary charge. Please contact Member Services if you receive a bill from the out-of-network provider. We will work to resolve the outstanding balance so that all you pay is the appropriate network deductible, coinsurance or copayments under your plan.

## What you pay when you go outside the network

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

“**Out of network**” (nonpreferred benefits) 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 voluntarily 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 voluntarily choose to use an out-of-network doctor. If you have an emergency or you are referred to an out-of-network provider by an in-network provider, your claim will be considered in-network and paid accordingly.

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

When you voluntarily 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.

Your plan will define the methodology we use to determine the recognized charge. Your plan may base the recognized charge on the:

- **Reasonable Amount Rate:** The Reasonable Amount Rate is generally based upon the 80<sup>th</sup> percentile value reported in a database prepared by FAIR Health, a nonprofit company. FAIR Health changes these rates periodically.
- **Medicare Rates:** CMS develops rates for specific services based on the time, effort and expertise needed to perform that service and other relevant factors. More specifically, CMS rates take into account three factors: (1) the time or effort to provide the service; (2) provider administrative costs in the relevant geographic area; and (3) malpractice insurance costs by specialty in the relevant geographic area. CMS reflects these factors in Relative Value Units (RVUs) for each service. CMS assigns the RVU values based on recommendations of a committee composed of physicians. Providers widely accept Medicare patients and are reimbursed at the Medicare rates.
- **Aetna Facility Fee Schedule:** Our Aetna Facility Fee Schedule is based upon all of Aetna’s out-of-network claim experience.

We update our information annually and the data we use are not more than three years old. We utilize Claim Check, which is a nationally recognized and generally accepted database containing bundling edits and logic.

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 get an estimate of your share of the cost for out-of-network services you are planning. See “Get plan information online or by phone” to learn how.

Our way of paying out-of-network doctors and hospitals, described above, applies when you voluntarily choose to get care out of network. See “Emergency and urgent care” for information about how we pay providers when you have no choice in where you go for care.

## Exclusions and limitations

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 plan documents from your employer. If you’re already a member, you may call us at the toll-free number on your Aetna ID card.

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 plan documents 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, 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.
- Charges for a service or supply furnished by a network provider in excess of the negotiated charge or an out-of-network provider in excess of the recognized charge

- 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, developmental and learning disorders, behavioral training, and cognitive rehabilitation. This includes services, treatment or educational testing and training related to behavioral (conduct) problems, learning disabilities or developmental delays. Special education, including lessons in sign language to instruct a member whose ability to speak has been lost or impaired to function without that ability, 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.
- 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. 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 Food and Drug Administration (FDA) and the National Institutes of Health (NIH); needles, syringes and other injectable aids (except diabetic supplies); drugs related to the treatment of non-covered services; and drugs related to contraception (unless covered by a prescription drug rider), the treatment of infertility and performance enhancing steroids
- 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 for 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
- 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: Getting approvals for services

Sometimes we will pay for care only if we have given an approval before you get it. We call that “preauthorization.”

Preauthorization is usually limited to more serious care like surgery or being admitted to a hospital or skilled nursing facility. 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.

### 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 if you get your care outside our network, you must call us for preauthorization when it's required.

Call the number 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

<b>If the reason for your request is:</b>	<b>You should request preauthorization:</b>
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 (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	<ul style="list-style-type: none"><li>• As soon as possible after your doctor confirms pregnancy, and</li><li>• Within 24 to 96 hours of birth or as soon as possible thereafter</li></ul> 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 are 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.

“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 external review” section to learn more.

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

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

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

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

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

## What happens if your doctor leaves the health plan

If your doctor or other health care provider leaves the plan, you may be able to continue to see that doctor for a limited time. This will allow you extra time to finish your course of treatment or find a replacement doctor you're comfortable with.

This “continuation of care” provision applies as follows:

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

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

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

## Complaints, appeals and external review

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.

The complaint and appeal processes can be different depending on your plan and where you live. Some states have laws that include their own processes, but these state laws don't apply to many plans we administer. So, it's best to check your plan documents or talk to someone in Member Services to see how it works for you.

### 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 e-mail Member Services through the secure member website at [www.aetna.com](http://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.

### 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. You may write the Texas Department of Insurance at:

PO Box 149104  
Austin, TX 78714-9104  
Fax: **(512) 490-1007**  
Web: [www.tdi.texas.gov](http://www.tdi.texas.gov)  
E-mail: [ConsumerProtection@tdi.texas.gov](mailto:ConsumerProtection@tdi.texas.gov)  
Toll-free phone: **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 poststabilization care after emergency treatment no later than one hour after the time your physician requests the care. We will also notify you of a denial for continued hospital stay within 24 hours of your request.

### Get a review from someone outside Aetna

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

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

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

## Doctors, hospitals and other health care providers

### Search our network

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](http://www.aetna.com) and log in. From your secure member website home page, select “Find a Doctor” from the top menu bar and start your search.

**Considering enrollment:** Visit [www.aetna.com](http://www.aetna.com) and scroll down to “Find a doctor, dentist, facility or vision provider” from the home page. You’ll need to select the plan you’re interested in from the drop-down box.

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

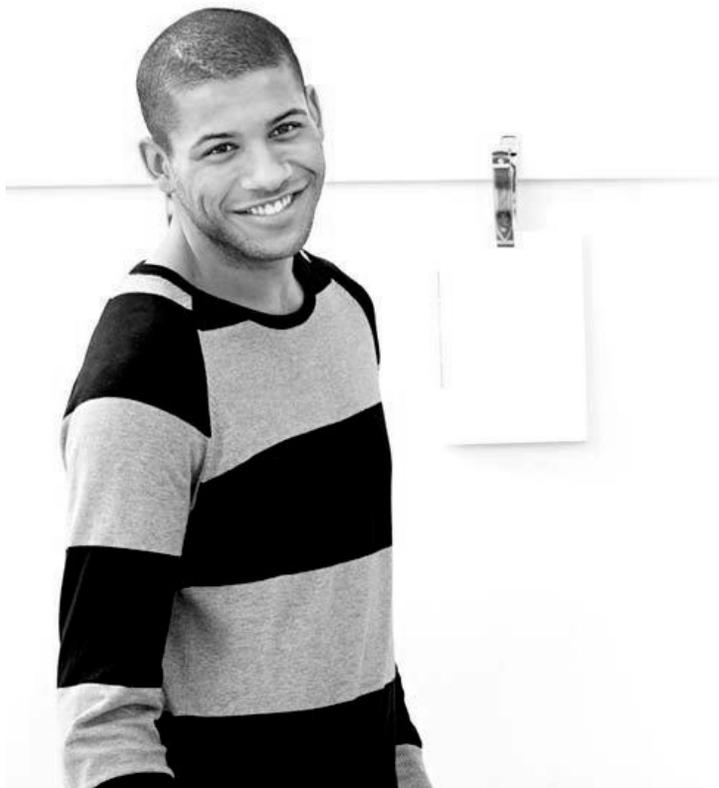
- Where the physician attended medical school
- Board certification status
- Language spoken
- Hospital affiliations
- Gender
- Driving directions

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

### Get a FREE printed directory

Our provider directories are updated four times each year. To get a free printed list of doctors and hospitals, call the toll-free number on your Aetna ID card. If you’re not yet a member, call **1-888-982-3862**. You may also write to: Aetna, PO Box 569441, Dallas, TX, 75356-9441.

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



## Information about doctors who participate in the Aetna network

Participating doctors, specialists and other health care providers are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. We cannot guarantee that any particular provider will be available or is accepting new patients. Our network of doctors may change without notice.

### The status of the doctor's practice may have changed

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

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

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

## How we pay doctors

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

One of the goals of managed care is to reduce and control the costs of health care. We offer financial incentives in compensation arrangements with doctors in an attempt to reduce and control the costs of health care.

Appropriate financial incentives are intended to:

- Reduce waste in the application of medical resources
- Eliminate inefficiencies that can lead to artificial inflation of health care costs
- Encourage doctors to practice preventive medicine and focus on improving the long-term health of patients
- Direct attention to patient satisfaction
- Improve the efficient delivery of quality health care services without compromising the quality and integrity of the physician-patient relationship

Only appropriate financial incentives will be used to compensate physicians and providers treating Aetna members.

Capitation is an example of a financial incentive arrangement 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.

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

If you are considering enrolling in our plan, you are entitled to ask if the plan or any provider group serving Aetna members, has compensation arrangements with participating doctors that can create a financial incentive to reduce or control the costs of providing medically necessary covered services.

Upon request, we will send you a summary of the compensation arrangements known to us relating to a particular doctor. To request this summary, call the Member Services telephone number on your ID card. Or, you may contact the provider group directly to find out about compensation arrangements between the provider group and any participating doctor. You may also wish to ask your doctor about what financial incentive arrangements are included in his or her compensation.

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

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

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

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

\* The specific goals will vary from network to network.

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

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

You can see which health care providers are part of an accountable care organization when you use our 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.

## Aetna service areas

### Dallas/Fort Worth Texas



# Central/South Texas



## Houston/Southeast Texas



## Calhoun/Victoria Texas



## West and Northwest Texas



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

We annually report health plan data and information to the Texas Department of Insurance (TDI) to assist the TDI in evaluating the adequacy of our networks. If a waiver or a local market access plan applies to facility services or to internal medicine, family or general practice, pediatric practitioner practice, obstetrics and gynecology, anesthesiology, psychiatry, or general surgery services, you may view the plan information on our website at [http://www.aetna.com/docfind/cms/assets/pdf/TX\\_NonContracted\\_Privr\\_Rprt.pdf](http://www.aetna.com/docfind/cms/assets/pdf/TX_NonContracted_Privr_Rprt.pdf). If you do not have Internet access or prefer a printed copy of the results, contact Member Services.

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

### Aetna Open Choice PPO and Open Access Managed Choice POS 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 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](http://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 the directory is materially inaccurate, you may be entitled to have an out-of-network claim paid at the in-network level of benefits.

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) for services received in a network hospital, 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/cpmmmediation.html](http://www.tdi.texas.gov/consumer/cpmmmediation.html).

## Exclusive Provider Organization Disclosure

### *Texas Department of Insurance Notice*

An exclusive provider benefit plan provides no benefits for services you receive from out-of-network providers, with specific exceptions as described in your policy and below.

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

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

You may obtain a current directory of preferred providers at the following website: [www.aetna.com/docfind](http://www.aetna.com/docfind) or by calling **1-800-My Health (1-800-694-3258)** for assistance in finding available preferred providers.

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

## Other benefits and programs

### 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](http://www.aetna.com/docfind) and click the "Quality and Cost Information" link. No Internet? Call Member Services instead. Use the toll-free number on your Aetna ID card to ask for a printed copy.

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

- **Beginning Right® Depression Program:** Perinatal and Postpartum Depression Education, Screening and Treatment Referral
- **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](http://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](http://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.

## How we determine what is covered

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

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

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

The product or service:

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

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

If we deny coverage, we'll send you and your doctor a letter. The letter will explain how to appeal the denial. You have the same right to appeal if a physician's group denied coverage. You can call Member Services to ask for a free copy of the materials we use to make coverage decisions. Or visit [www.aetna.com/about/cov\\_det\\_policies.html](http://www.aetna.com/about/cov_det_policies.html) to read our policies. Doctors can write or call our Patient Management department with questions. Contact Member Services either online or at the phone number on your Aetna ID card for the appropriate address and phone number.

### We study the latest medical technology

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

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

- Read medical journals to see the research. We want to know how safe and effective it is.
- See what other medical and government groups say about it. That includes the federal Agency for 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](http://www.aetna.com)

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

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

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

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

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



## 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](http://www.aetna.com/individuals-families/member-rights-resources.html) to view the list. You can also call Member Services at the number on your ID card to ask for a printed copy.

### Making medical decisions before your procedure

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

There are three types of advance directives:

- Durable power of attorney – Name the person you want to make medical decisions for you
- Living will – Spells out the type and extent of care you want to receive
- Do-not-resuscitate order – States 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](http://www.aetna.com). Enter “commitment to quality” in the search bar. You can also call Member Services to ask for a printed copy. The toll-free number is on your Aetna ID card.

## **We protect your privacy**

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

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

### **Summary of the Aetna Privacy Policy**

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

- Your doctors, dentists, pharmacies, hospitals and other caregivers
- Other insurers
- Vendors
- Government departments
- Third-party administrators (TPAs), (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](http://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 contributing to the other coverage).

#### **When you have a new dependent**

Getting married? Having a baby? A new dependent changes everything. And you can change your mind. You can enroll within 31 days after a life event if you chose not to enroll during the normal open enrollment period. Life events include:

- Marriage
- Birth
- Adoption
- Placement for adoption

In Texas, an adopted child can be added when you are a party to a suit to adopt the child.

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.**