TAKE CHARGE OF YOUR HEALTH.

CHOOSE AETNA,
CHOOSE AFFORDABLE COVERAGE

The information you need to choose quality and affordable health benefits and insurance coverage.

Aetna®

63.43.300.1 (1/11)

LEARN ABOUT YOUR PLAN CHOICES

AETNA ADVANTAGE PLANS FOR INDIVIDUALS, FAMILIES AND THE SELF-EMPLOYED

Aetna Advantage Plans for Individuals, Families and the Self-Employed are underwritten by Aetna Life Insurance Company directly and/or through an out-of-state blanket trust or Aetna Health Inc. (together, "Aetna") In some states, individuals may qualify as a business group of one and may be eligible for guaranteed issue, small group health plans. To the extent permitted by law, these plans are medically underwritten and you may be declined coverage in accordance with your health condition

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HEALTH CARE REFORM — **WHAT YOU NEED TO KNOW**

THE FEDERAL HEALTH CARE REFORM LEGISLATION, KNOWN AS THE PATIENT PROTECTION AND AFFORDABLE CARE ACT, WAS SIGNED INTO LAW ON MARCH 23, 2010 BY PRESIDENT OBAMA.

Since then, Aetna has periodically updated the Aetna Advantage Plans for Individuals, Families and the Self-Employed to include any necessary changes. It is important for you to know that your Aetna Advantage Plan will always comply with all of the federal health care reform legislation.

WOMEN'S PREVENTIVE HEALTH BENEFITS – NEW CHANGES EFFECTIVE AUGUST 1, 2012

As you may know, the legislation includes changes that are being phased in over a number of years. The latest set of changes now includes coverage of Women's Preventive Health Benefits.

As of August 1, 2012, all of the following women's health services are considered preventive and therefore generally covered at no cost share, when provided in-network:

- Well-woman visits (annual routine physical, annual routine GYN exam and prenatal visits)
- Screening for gestational diabetes
- Human Papillomavirus (HPV) DNA testing
- Counseling for sexually transmitted infections
- Counseling and screening for human immunodeficiency virus (HIV)
- Screening and counseling for interpersonal and domestic violence
- Breastfeeding support, supplies and counseling
- Contraceptive methods and counseling

IF YOU WOULD LIKE TO COMPARE ADDITIONAL PLANS, OR FOR MORE DETAILED PLAN INFORMATION, YOU MAY ALSO VISIT **WWW.HEALTHCARE.GOV.**

THANK YOU

FOR CONSIDERING THE AETNA ADVANTAGE PLANS FOR INDIVIDUALS, FAMILIES AND THE SELF-EMPLOYED. WE ARE PLEASED TO PRESENT THIS INFORMATION KIT, WHICH YOU CAN USE TO FIND A HEALTH INSURANCE PLAN THAT'S RIGHT FOR YOU.

APPLY/ENROLL INSTRUCTIONS

Once you choose a plan, there are two options for you to apply/enroll.

1) If you are working with a broker:

BROKER

You have an ally in the process. Get personalized assistance from your broker, who can answer your questions, help you choose the plan that's right for you and guide you through the application process.

2) If you are applying/enrolling on your own:

ONLINE

You can visit us online at **www.AetnaIndividual.com**. This website offers easy ways to find the plan that is best for you. You can browse our DocFind® online provider directory and apply online.

MAIL

Complete and mail the enclosed application/ enrollment form, in the envelope provided, with one form of payment selected.

PHONE

Any questions? Just call 1-800-MY-HEALTH (1-800-694-3258) and we'll be happy to answer your questions as well as help you complete the application.

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TOP REASONS TO **CHOOSE AETNA**

ROBUST COVERAGE, COMPETITIVE COSTS

We offer plans with valuable features, which may include:

- An excellent combination of quality coverage and competitively priced premiums
- The freedom to see doctors whenever you need to – without referrals
- Coverage for preventive care, prescription drugs, doctor visits, hospitalization and immunizations
- No copayments for well-women exams when you visit a network provider
- No claim forms to fill out when you use a network provider
- National provider networks offer you a vast selection of participating physicians and hospitals

COVERAGE WHEN YOU TRAVEL

Like to travel? You have access to covered services from a national network of doctors and hospitals that accept our negotiated fees.

FAMILY COVERAGE

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

TAX ADVANTAGES

We also offer high-deductible plans that are compatible with tax-advantaged health savings accounts (HSAs). You can contribute money to your HSA tax free. That money earns interest tax free. And qualified withdrawals for medical expenses are tax free, too.

ONLINE HEALTH TOOLS AND RESOURCES

Need health information fast? We offer secure Internet access to reliable health information tools and resources through our secure member website. Also, here are three examples of our online tools that will help make it easier for you to make informed decisions about your health care:

- **Member Payment Estimator**
  Our group of Web-based decision-support tools is designed to help you plan for your health care expenses by giving you health care costs and other information you need to make better decisions. For tools that provide both in- and out-of-network cost information, you can see the potential cost savings when a participating in-network provider (physician, dentist and facility) is used.
- **Aetna SmartSource℠**
  Aetna SmartSource will change the way you research conditions, symptoms and more. Unlike most search engines and general health websites, Aetna SmartSource delivers information that is specific to you based on where you live, your selected Aetna insurance plan and other information.
- **Mobile Web**
  Mobile access to the most popular and useful features of Aetna.com is simplified for on-the-go use. Our health-related mobile applications can help you save money and easily access health information.

LET'S TALK

HAVE QUESTIONS?

Call
your broker

or

Email
AetnaAdvantagePlans@aetna.com

WANT A QUOTE NOW?

Visit
www.AetnaIndividual.com

or

Call
1-800-MY-HEALTH
(1-800-694-3258)

MORE REASONS TO CHOOSE AN AETNA ADVANTAGE PLAN

AFFORDABLE QUALITY AND CHOICES

Our plans are designed to offer you quality coverage at an excellent value. You can choose from a wide range of health insurance plans that offer varying amounts of coverage depending on you or your family's specific needs.

Generally speaking, the lower your "premiums," or monthly payments, the higher your "deductible," which is the amount you pay out of pocket before the plan begins paying for covered expenses.

You'll pay less by using "in-network" doctors, hospitals, pharmacies and other health care providers who participate in the Aetna network than by using "out-of-network" providers.

This allows you to be in control of how much you spend by matching the type of coverage you desire with the premium that matches your budget.

ABOUT HEALTH SAVINGS ACCOUNTS (HSAs)

Many of our high-deductible plans are health savings account (HSA) compatible. That means you pay lower premiums and get tax-advantaged savings. An HSA is a personal account that lets you pay for qualified medical expenses with tax-advantaged funds. You or an eligible family member make contributions to your HSA tax free, and those dollars earn interest tax free. Then, when you make withdrawals from your account to pay for qualified health care expenses, they're tax free, too.

OUR PLANS ARE DESIGNED TO OFFER YOU QUALITY COVERAGE AT AN EXCELLENT VALUE

FAMILY COVERAGE

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

IT'S EASY TO ESTABLISH AN HSA

Once you are enrolled in a qualifying High Deductible Health Plan, Aetna will send you a letter outlining how to enroll in an HSA with Bank of America.

There is no additional charge to you for opening up this account.

WHY CHOOSE AN AETNA HEALTHFUND HSA?

- No set-up fees
- No monthly administration fee
- No withdrawal forms required
- Convenient access to HSA funds via debit card or online payments
- Track HSA activity online

You can track your HSA activity through Bank of America, too. Bank of America is the HSA administrator. Just log in to **www.bankofamerica.com/benefitslogin**.

ADD DENTAL PPO

With the Aetna Advantage Dental PPO insurance plan, participating dentists provide covered services at negotiated rates and may also provide discounts on non-covered services such as cosmetic tooth whitening and orthodontic care, so you generally pay less out of pocket. You also have the flexibility to visit a dentist who does not participate in the Aetna network, though you will not have access to negotiated fees.

Note: Dental coverage is available only if you purchase medical coverage. Discounts for non-covered services may not be available in all states.

WHAT DOES THAT MEAN?

Here are a few definitions of terms you'll see throughout this brochure. For a more in-depth list of terms, please visit **www.planforyourhealth.com.***

Coinsurance – The dollar amount that the plan and you pay for covered benefits after the deductible is paid.

Copayment (Copay) – A fixed dollar amount that you must contribute toward the cost of covered medical services under a health plan. For HSA compatible plans, copayment will apply to your out-of-pocket max.

Deductible – A fixed yearly dollar amount you pay before the benefits of the plan policy start.

Exclusions and Limitations — Specific conditions or circumstances that are not covered under a plan.

Out-of-Pocket Maximum – The amounts such as coinsurance and deductibles that you are required to contribute toward the cost of health services covered by the benefits plan before the plan pays 100% of additional out-of-pocket costs.

Premium – The amount charged for a health insurance policy or health benefits plan on a monthly basis.

Pre-existing Condition – A health condition or medical problem that was diagnosed or treated (including the use of prescription drugs) before getting coverage under a new insurance health plan.

* Plan For Your Health is a public education program from Aetna and the Financial Planning Association.

VALUE-ADDED PROGRAMS

AETNA ADVANTAGE PLANS INCLUDE SPECIAL PROGRAMS[1] TO COMPLEMENT OUR HEALTH COVERAGE

These programs include health information programs and tools, and offer you access to substantial savings on products to help you stay healthy. These programs are offered in addition to your Aetna Advantage Plan and are NOT insurance.

Following is a description of some of the discount programs included with our plans. For more information on any of these programs, please visit us online at **www.aetna.com.**

DISCOUNT PROGRAMS

Aetna Fitness℠ Discount Program

Members can save with preferred rates on gym memberships and discounts on at-home weight-loss programs, home fitness options and one-on-one health coaching services through GlobalFit®.

Aetna Hearing℠ Discount Program

Offers members and their families savings on hearing exams, hearing aids and other hearing services.

Aetna Natural Products and Services℠ Discount Program

Members can access reduced rates on acupuncture, chiropractic care, massage therapy and dietetic counseling through the ChooseHealthy® program.** Members can also get discounts on over-the-counter vitamins, herbal and nutritional supplements, and natural products. Through Vital Health Network, members can receive a discount on online consultations and alternative remedies provided by medical doctors for a variety of conditions.

Aetna Vision℠ Discount Program

Offers discounts on vision exams, lenses and frames. A member must use a provider in the EyeMed Select Network. LASIK surgery discounts are also available.

Aetna Weight Management℠ Discount Program

Offers savings on the CalorieKing® Program and products, eDiets® diet plans and products, Jenny® weight loss programs and Nutrisystem® weight loss meal plans. Members can choose from a variety of programs and plans to meet their specific weight loss goals and save money.

HEALTH MANAGEMENT **TOOLS**

INFORMED HEALTH® LINE

Our 24-hour toll-free number that puts you in touch with experienced registered nurses and an audio library for information on thousands of health topics.

THE AETNA SECURE MEMBER WEBSITE

Register and log on to our secure member website to check claims status, contact Aetna Member Services, estimate the costs of health care services, and more. The secure member website provides a starting point to find answers about health care, types of treatment, cost of services and more to help members make more informed decisions. Plus, members have access to their own Personal Health Record*, a single, secure place where they can view their medical history and add other health information.

While only your doctor can diagnose, prescribe or give medical advice, the Informed Health Line nurses can provide information on more than 5,000 health topics. Contact your doctor first with any questions or concerns regarding your health care needs.

Discount programs provide access to discounted prices and are NOT insured benefits. The member is responsible for the full cost of the discounted services. Aetna may receive a percentage of the fee you pay to the discount vendor.

1 Availability varies by plan. Talk with your Aetna representative for details.

* The Aetna Personal Health Record should not be used as the sole source of information about your health conditions or medical treatment.

** The ChooseHealthy program is made available through American Specialty Health Systems, Inc. (ASH Systems), a subsidiary of American Specialty Health Incorporated (ASH). ChooseHealthy is a federally registered trademark of ASH and used with permission herein.

HOW CAN I SAVE MONEY ON MY HEALTH CARE BENEFITS EXPENSES?

It's a sign of the times — people are looking to trim household expenses wherever they can. Aetna is here to help. We've prepared special tips to help you save money on health care benefits — without compromising your health.

Healthy Savings from Aetna gives you eight ways to start saving now with your Aetna health insurance plan. Take advantage of easy-to-follow tips, tools and charts that show you how you may save. Check out all the ways you can save at **www.aetna.com/healthysavings.**

AETNA NETWORK PROVIDERS **SAVE YOU MONEY**

KEEP ACCESS TO QUALITY CARE AFFORDABLE WITH THE AETNA PROVIDER NETWORK

IS YOUR DOCTOR IN THE AETNA NETWORK?

Our provider network is quite extensive throughout the country, including your state. In fact, your doctor may already be part of the Aetna Advantage Plan network. To check which local physicians, hospitals, pharmacies and eyewear providers participate in your area, please visit **www.AetnaIndividual.com** and select "Find a Doctor", or call 1-800-694-3258 and ask for a directory of providers.

By using providers in the Aetna network, you can take advantage of the significant discounts we have negotiated to help lower your out-of-pocket costs for medically necessary care. This can help you get the care you need at an affordable price.

Let's look at some examples, so you can see your network savings in action.

These examples are based on the following Aetna plan features and assume you've already met your deductible (the fixed amount that you must pay for covered medical services before your plan will pay benefits):

What your plan pays (plan coinsurance):

80% in network / 60% out of network

What you pay (coinsurance):

20% in network / 40% out of network

IMPORTANT ADDITIONAL INFORMATION

The "recognized amount":

When you receive services from a provider who is not in the Aetna network, the plan pays based on the "recognized" amount/charge, which is described in your benefit plan. In these examples, if you use a health care provider who is not in the Aetna network, you may be responsible for the entire difference between what the provider bills and the recognized amount/charge. As the examples show, that difference can be large.

EXAMPLE 1

You have been getting care for an ongoing condition from a specialist who is not in the Aetna network. You are thinking about switching to a specialist in the Aetna network. This example illustrates what you may save if you switch.

OFFICE VISIT		In-Network	Out-of-Network+
Doctor bill	Amount billed	$150	$150
Amount Aetna uses to calculate payment	Aetna's rate* in-network	$90*	
	Recognized amount** out-of-network		$90**
What your plan will pay	Aetna's negotiated rate/ recognized amount	$90	$90
	Percent your plan pays	80%	60%
	Amount of Aetna's negotiated rate/recognized amount covered under plan	$72*	$54**
What you owe	Your coinsurance responsibility	$18	$36
	Amount that can be balance billed to you	$0	$60
YOUR TOTAL RESPONSIBILITY		**$18*** **	**$96*** **

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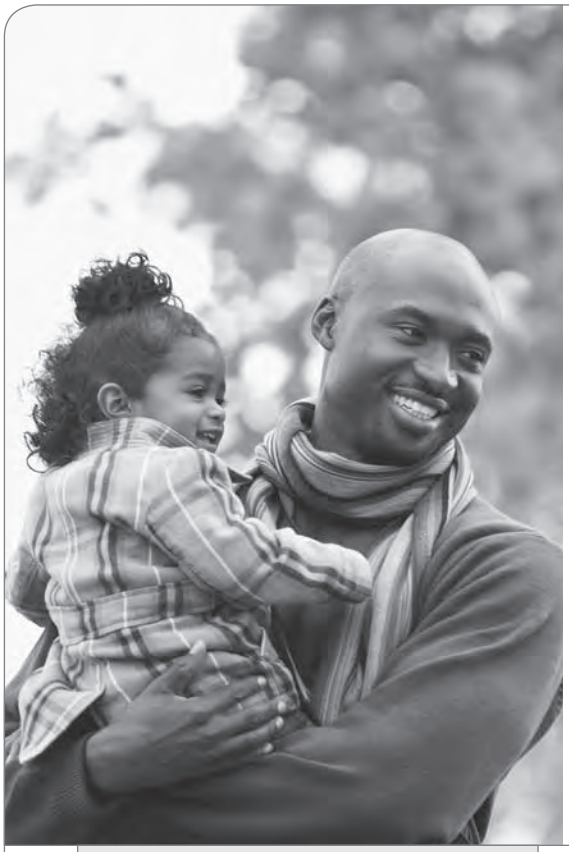

EXAMPLE 2

You need outpatient surgery for a simple procedure and are deciding if you will have it done by a physician in the Aetna network. This example gives you an idea of how much you might owe depending on your choice.

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

EXAMPLE 3

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

FIVE-DAY HOSPITAL STAY		In-Network	Out-of-Network+
Hospital bill	Amount billed	$25,000	$25,000
Amount Aetna uses to calculate payment	Aetna's rate* in-network	$8,750*	
	Recognized amount** out-of-network		$8,750**
What your plan will pay	Aetna's negotiated rate/ recognized amount	$8,750	$8,750
	Percent your plan pays	80%	60%
	Amount of Aetna's negotiated rate/recognized amount covered under plan	$7,000*	$5,250**
What you owe	Your coinsurance responsibility	$1,750	$3,500
	Amount that can be balance billed to you	$0	$16,250*
YOUR TOTAL RESPONSIBILITY		**$1,750*** **	**$19,750*** **

BY USING PROVIDERS IN THE AETNA NETWORK, YOU CAN TAKE ADVANTAGE OF THE SIGNIFICANT DISCOUNTS WE HAVE NEGOTIATED TO HELP LOWER YOUR OUT-OF-POCKET COSTS FOR MEDICALLY NECESSARY CARE.

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

SAVE EVEN MORE

MORE WAYS TO CONTROL HEALTH CARE COSTS

ENJOY THE VALUE OF GENERIC PRESCRIPTION DRUGS

Generic prescription drugs can save you money. They go through rigorous testing as required by the Food and Drug Administration. So you can be sure they are as safe and effective as their brand-name counterparts.

If a generic prescription drug is right for you, we offer many ways to help you access them:

- Tools to compare the costs of brand-name and generic drugs
- Outreach efforts that show how you can save with generic drugs
- Prescriptions filled with a generic, when appropriate
- Plan options that may include special terms about use of generics

AETNA RX HOME DELIVERY®

With this mail-order prescription drug program, order generic and brand prescription medications through our convenient and easy-to-use mail order pharmacy. To learn more or to download order forms, visit **www.AetnaRxHomeDelivery.com.**

SAVE ON LAB WORK

With your Aetna medical plan, you can save on testing and other lab services when you use Quest Diagnostics.

Here's how it works:

- If your doctor is collecting your sample in the office, ask him or her to send your testing to Quest.
- If your doctor is sending you outside the office to collect your sample, ask for a lab requisition form to Quest, and visit your nearest Quest office.

LOOK HOW MUCH YOU CAN SAVE!

	In-network lab	In-network hospital lab	Out-of-network lab
Cost of lab test	$30.00	$60.00	$300.00
Patient's copay	x20%	x20%	x40%
Patient pays	$6.00	$12.00	$120.00

BE A BETTER HEALTH CARE CONSUMER. ASK YOUR DOCTOR TO ONLY USE IN-NETWORK LABS, AND PAY LESS.

YOU'RE MOBILE. **SO ARE WE.**

Aetna Mobile puts our most popular online features at your fingertips. No matter where you are, you still want easy access to your health information to make the best decisions you can.

Want to look up a claim while you're waiting in line? Find a doctor and make an appointment while you're out shopping? Research the price of your medication during your train ride to work?

When you go to Aetna.com from your mobile phone's web browser, you can:

- Find a doctor, dentist or facility
- Buy health insurance
- Register for your secure member site
- Access your personal health record (PHR)
- View your member ID card
- Contact us by phone or email

Explore a smarter health plan.
Visit us at **www.aetna.com**.

RATING AREAS*

FLORIDA

YOUR RATES WILL DEPEND ON THE AREA IN WHICH YOUR COUNTY IS LOCATED. FOR MORE INFORMATION OR A QUOTE ON WHAT YOUR RATE WOULD BE, **CALL YOUR BROKER OR 1-800-MY-HEALTH.**

AREA 1

Alachua
Baker
Clay
Duval
Flagler
Marion
Nassau
Saint Johns

AREA 2

Lake
Orange
Osceola
Seminole

AREA 3

Charlotte
Hillsborough
Lee
Manatee
Pinellas
Sarasota

AREA 4

Broward
Miami-Dade
Palm Beach

AREA 5

Columbia
Sumter
Suwannee

AREA 6

Escambia
Holmes
Monroe
Okaloosa
Santa Rosa
Walton

AREA 7

Bay
Bradford
Gilchrist
Gulf
Levy
Putnam
Union
Washington

AREA 8

Martin
Okeechobee
Saint Lucie

AREA 9

Calhoun
De Soto
Dixie
Franklin
Gadsden
Glades
Hamilton
Hendry
Jackson
Jefferson
Lafayette
Liberty
Madison
Taylor
Wakulla

AREA 10

Leon

AREA 11

Brevard
Indian River
Volusia

AREA 12

Hernando
Pasco
Polk

AREA 13

Hardee
Highlands

AREA 14

Collier

AREA 15

Citrus

THE PRODUCTS OFFERED IN AREAS 1-4, 8 AND 10-15 ARE:

- Aetna Health Network Option℠ 1500
- Aetna Health Network Option℠ 2500
- Aetna Health Network Option℠ 5000
- Aetna Health Network Option℠ High Deductible 3500 (HSA Compatible)
- Aetna Health Network Option℠ High Deductible 5500 (HSA Compatible)
- Aetna Health Network Option℠ Value 5000
- Aetna Health Network Option℠ Value 7500
- Aetna Health Network Option℠ Value 10000
- Preventive and Hospital Care 3000 (HSA Compatible)
- Aetna Health Network Option℠ Savings Plus 3500
- Aetna Health Network Option℠ Savings Plus 6500

THE PRODUCTS OFFERED IN AREAS 5-7 AND 9 ARE:

- Aetna Open Access® Managed Choice® 1500
- Aetna Open Access® Managed Choice® 2500
- Aetna Open Access® Managed Choice® 5000
- Aetna Open Access® Managed Choice® High Deductible 3500 (HSA Compatible)
- Aetna Open Access® Managed Choice® High Deductible 5500 (HSA Compatible)
- Aetna Open Access® Managed Choice® Value 5000
- Aetna Open Access® Managed Choice® Value 7500
- Aetna Open Access® Managed Choice® Value 10000
- Preventive and Hospital Care 3000 (HSA Compatible)

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

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HOW DO I MAKE **SMART HEALTH CARE DECISIONS?**

Sure, health care options can sometimes be confusing. But it's important to understand your health and personal finance choices, so you can plan ahead and make wise decisions. **PlanforYourHealth.com** can help you choose the best health care alternatives for you and your family.

This website offers useful tips on different insurance products, plus interactive tools that show how big life changes will affect your health care options.

Visit **www.planforyourhealth.com**, and get guidance for different stages in your life — and in your health.

YOUR AETNA OPEN ACCESS® MANAGED CHOICE® **PLAN OPTION(S)**

ROBUST COVERAGE AND THE FLEXIBILITY OF LOWER MONTHLY PAYMENTS BALANCED WITH A DEDUCTIBLE... WHERE YOU DON'T PAY A LOT FOR FREQUENT DOCTOR VISITS

FEATURING:

- Robust coverage with a choice of varying deductible levels

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AETNA OPEN ACCESS® MANAGED CHOICE® 1500

FLORIDA

AETNA ADVANTAGE PLAN OPTIONS

MEMBER BENEFITS	In-Network	Out-of-Network+
Deductible Individual Family	 $1,500 $3,000	 $3,000 $6,000
Coinsurance (Member's responsibility)	25% after deductible up to out-of-pocket max.	50% after deductible up to out-of-pocket max.
	$0 once out-of-pocket max. is satisfied	
Coinsurance Maximum Individual Family	 $5,000 $10,000	 $7,000 $14,000
Out-of-Pocket Maximum Individual Family	 $6,500 $13,000	 $10,000 $20,000
	Includes deductible	
Non-Specialist Office Visit *Unlimited visits* General Physician, Family Practitioner, Pediatrician or Internist	$35 copay deductible waived	50% after deductible
Specialist Visit *Unlimited visits*	$75 copay deductible waived	50% after deductible
Hospital Admission	25% after deductible	50% after deductible
Outpatient Surgery	25% after deductible	50% after deductible
Urgent Care Facility	$75 copay deductible waived	50% after deductible
Emergency Room	$250 copay** (waived if admitted) after deductible	
Annual Routine Gyn Exam *No waiting period, no calendar year max.* Annual Pap/Mammogram	$0 copay deductible waived	50% after deductible
Maternity	Not covered *Except for pregnancy complications*	
Preventive Health — Routine Physical	$0 copay deductible waived	50% after deductible
	Includes lab work and X-rays	
Lab/X-Ray (Non- Preventive)	$50 copay per visit	50% after deductible
Complex Imaging	$500 copay per visit	50% after deductible
Skilled Nursing — instead of hospital *30 days per calendar year**	25% after deductible	50% after deductible
Physical/Occupational Therapy *24 visits per calendar year**	25% after deductible	50% after deductible
Home Health Care — instead of hospital *30 visits per calendar year**	25% after deductible	50% after deductible
Durable Medical Equipment *Aetna will pay up to $2,000 per calendar year**	25% after deductible	50% after deductible

PHARMACY	In-Network	Out-of-Network+
Pharmacy Deductible per individual	$500	$500
	Does not apply to generic	
Generic	$15 copay deductible waived	$15 copay plus 50% deductible waived
Preferred Brand	$40 copay after deductible	$40 copay plus 50% after deductible
Non-Preferred Brand	$65 copay after deductible	$65 copay plus 50% after deductible
Self-Injectables	30% after deductible	Not covered

* Maximum applies to combined in and out-of-network benefits.

** Copay is billed separately and not due at time of service. Copay does not count towards coinsurance or out-of-pocket maximum.

\+ For important information on your costs and how Aetna pays for out-of-network care, read "What you need to know about your out-of-network costs."

This material is for information only. A summary of exclusions is listed in the Aetna Advantage Plan brochure. For a full list of benefit coverage and exclusions refer to the plan documents. Plans may be subject to medical underwriting or other restrictions. Rates and benefits vary by location. Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Health insurance plans contain exclusions and limitations. Information is believed to be accurate as of the production date: however, it is subject to change.

Aetna Advantage Plans for Individuals, Families and the Self-Employed are underwritten by Aetna Life Insurance Company directly and/or through an out-of-state blanket trust or Aetna Health Inc. (together, "Aetna"). In some states, individuals may qualify as a business group of one and may be eligible for guaranteed issue, small group health plans. To the extent permitted by law, these plans are medically underwritten and you may be declined coverage in accordance with your health condition.

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Aetna®

AETNA OPEN ACCESS® MANAGED CHOICE® 2500

FLORIDA

AETNA ADVANTAGE PLAN OPTIONS

MEMBER BENEFITS	In-Network	Out-of-Network+
Deductible Individual Family	 $2,500 $5,000	 $5,000 $10,000
Coinsurance (Member's responsibility)	25% after deductible up to out-of-pocket max.	50% after deductible up to out-of-pocket max.
	$0 once out-of-pocket max. is satisfied	
Coinsurance Maximum Individual Family	 $5,000 $10,000	 $5,000 $10,000
Out-of-Pocket Maximum Individual Family	 $7,500 $15,000	 $10,000 $20,000
	Includes deductible	
Non-Specialist Office Visit *Unlimited visits* General Physician, Family Practitioner, Pediatrician or Internist	$35 copay deductible waived	50% after deductible
Specialist Visit *Unlimited visits*	$75 copay deductible waived	50% after deductible
Hospital Admission	25% after deductible plus $1,000 copay	50% after deductible
Outpatient Surgery	25% after deductible plus $250 copay	50% after deductible
Urgent Care Facility	$75 copay deductible waived	50% after deductible
Emergency Room	$250 copay** (waived if admitted) after deductible	
Annual Routine Gyn Exam *No waiting period, no calendar year max.* Annual Pap/Mammogram	$0 copay deductible waived	50% after deductible
Maternity	Not covered *Except for pregnancy complications*	
Preventive Health — Routine Physical	$0 copay deductible waived	50% after deductible
	Includes lab work and X-rays	
Lab/X-Ray (Non- Preventive)	$50 copay per visit	50% after deductible
Complex Imaging	$500 copay per visit	50% after deductible
Skilled Nursing — instead of hospital *30 days per calendar year**	25% after deductible	50% after deductible
Physical/Occupational Therapy *24 visits per calendar year**	25% after deductible	50% after deductible
Home Health Care — instead of hospital *30 visits per calendar year**	25% after deductible	50% after deductible
Durable Medical Equipment *Aetna will pay up to $2,000 per calendar year**	25% after deductible	50% after deductible

PHARMACY	In-Network	Out-of-Network+
Pharmacy Deductible per individual	$500	$500
	Does not apply to generic	
Generic	$15 copay deductible waived	$15 copay plus 50% deductible waived
Preferred Brand	$65 copay after deductible	$65 copay plus 50% after deductible
Non-Preferred Brand	$75 copay after deductible	$75 copay plus 50% after deductible
Self-Injectables	30% after deductible	Not covered

* Maximum applies to combined in and out-of-network benefits.

** Copay is billed separately and not due at time of service. Copay does not count towards coinsurance or out-of-pocket maximum.

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63.06.300.1-FL E (1/13)

Aetna®

AETNA OPEN ACCESS® MANAGED CHOICE® 5000

FLORIDA

AETNA ADVANTAGE PLAN OPTIONS

MEMBER BENEFITS	In-Network	Out-of-Network+
Deductible Individual Family	 $5,000 $10,000	 $10,000 $20,000
Coinsurance (Member's responsibility)	25% after deductible up to out-of pocket max	50% after deductible up to out-of pocket max.
	$0 once out-of-pocket max. is satisfied	
Coinsurance Maximum Individual Family	 $7,500 $15,000	 $2,500 $5,000
Out-of-Pocket Maximum Individual Family	 $12,500 $25,000	 $12,500 $25,000
	Includes deductible	
Non-Specialist Office Visit *Unlimited visits* General Physician, Family Practitioner, Pediatrician or Internist	$40 copay deductible waived	50% after deductible
Specialist Visit *Unlimited visits*	$75 copay deductible waived	50% after deductible
Hospital Admission	25% after deductible plus $1,000 copay	50% after deductible
Outpatient Surgery	25% after deductible plus $250 copay	50% after deductible
Urgent Care Facility	$75 copay deductible waived	50% after deductible
Emergency Room	$250 copay** (waived if admitted) after deductible	
Annual Routine Gyn Exam *No waiting period* Annual Pap/Mammogram	$0 copay deductible waived	50% after deductible
Maternity	Not covered *Except for pregnancy complications*	
Preventive Health — Routine Physical *No waiting period*	$0 copay deductible waived	50% after deductible
	Includes lab work and X-rays	
Lab/X-Ray (Non-Preventive)	$50 copay per visit	50% after deductible
Complex Imaging	$500 copay per visit	50% after deductible
Skilled Nursing — instead of hospital *30 days per calendar year**	25% after deductible	50% after deductible
Physical/Occupational Therapy *24 visits per calendar year**	25% after deductible	50% after deductible
Home Health Care — instead of hospital *30 visits per calendar year**	25% after deductible	50% after deductible
Durable Medical Equipment *Aetna will pay up to $2,000 per calendar year**	25% after deductible	50% after deductible

PHARMACY	In-Network	Out-of-Network+
Pharmacy Deductible per individual	$500	$500
	Does not apply to generic	
Generic	$15 copay deductible waived	$15 copay plus 50% deductible waived
Preferred Brand	$65 copay after deductible	$65 copay plus 50% after deductible
Non-Preferred Brand	$75 copay after deductible	$75 copay plus 50% after deductible
Self-Injectables	30% after deductible	Not covered

* Maximum applies to combined in and out-of-network benefits.

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63.06.300.1-FL E (1/13)

Aetna®

YOUR AETNA OPEN ACCESS® MANAGED CHOICE® HIGH DEDUCTIBLE **PLAN OPTION(S)**

LOWER PREMIUM COSTS ... AND A HEALTH SAVINGS ACCOUNT (HSA) COMPATIBLE PLAN THAT OFFERS TAX-ADVANTAGED SAVINGS

FEATURING:

- 0% or 10% coinsurance in network after your deductible is met, depending on which plan you choose

AETNA OPEN ACCESS® MANAGED CHOICE® HIGH DEDUCTIBLE 3500 (HSA COMPATIBLE)

FLORIDA

AETNA ADVANTAGE PLAN OPTIONS

MEMBER BENEFITS	In-Network	Out-of-Network+
Deductible Individual Family	$3,500 $7,000	$10,000 $20,000
Coinsurance (Member's responsibility)	10% up to out-of-pocket max.	50% after deductible
	$0 once out-of-pocket max. is satisfied	
Coinsurance Maximum Individual Family	$2,550 $5,100	$2,500 $5,000
Out-of-Pocket Maximum Individual Family	$6,050 $12,100	$12,500 $25,000
	Includes deductible	
Non-Specialist Office Visit *Unlimited visits* General Physician, Family Practitioner, Pediatrician or Internist	10% after deductible	50% after deductible
Specialist Visit *Unlimited visits*	10% after deductible	50% after deductible
Hospital Admission	10% after deductible	50% after deductible
Outpatient Surgery	10% after deductible	50% after deductible
Urgent Care Facility	10% after deductible	50% after deductible
Emergency Room	10% after deductible	
Annual Routine Gyn Exam *No waiting period* Annual Pap/Mammogram	$0 copay deductible waived	50% after deductible
Maternity	Not covered *Except for pregnancy complications*	
Preventive Health — Routine Physical *No waiting period*	$0 copay deductible waived	50% after deductible
	Includes lab work and X-rays	
Lab/X-Ray (Non-Preventive)	10% after deductible	50% after deductible
Complex Imaging	10% after deductible	50% after deductible
Skilled Nursing — instead of hospital *30 days per calendar year**	10% after deductible	50% after deductible
Physical/Occupational Therapy *24 visits per calendar year**	10% after deductible	50% after deductible
Home Health Care — instead of hospital *30 visits per calendar year**	10% after deductible	50% after deductible
Durable Medical Equipment *Aetna will pay up to $2,000 per calendar year**	10% after deductible	50% after deductible

PHARMACY	In-Network	Out-of-Network+
Pharmacy Deductible per individual	Integrated Medical/ Rx deductible	
Generic	10% after Medical/Rx deductible	50% after Medical/Rx deductible
Preferred Brand	10% after Medical/Rx deductible	50% after Medical/Rx deductible
Non-Preferred Brand	10% after Medical/Rx deductible	50% after Medical/Rx deductible
Self Injectables	10% after Medical/Rx deductible	Not covered

* Maximum applies to combined in and out-of-network benefits.

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63.06.300.1-FL E (1/13)

Aetna®

AETNA OPEN ACCESS® MANAGED CHOICE® HIGH DEDUCTIBLE 5500 (HSA COMPATIBLE)

FLORIDA

AETNA ADVANTAGE PLAN OPTIONS

MEMBER BENEFITS	In-Network	Out-of-Network+
Deductible Individual Family	$5,500 $11,000	$10,000 $20,000
Coinsurance (Member's responsibility)	0% after deductible	50% after deductible
	$0 once out-of-pocket max. is satisfied	
Coinsurance Maximum Individual Family	$0 $0	$2,500 $5,000
Out-of-Pocket Maximum Individual Family	$5,500 $11,000	$12,500 $25,000
	Includes deductible	
Non-Specialist Office Visit *Unlimited visits* General Physician, Family Practitioner, Pediatrician or Internist	0% after deductible	50% after deductible
Specialist Visit *Unlimited visits*	0% after deductible	50% after deductible
Hospital Admission	0% after deductible	50% after deductible
Outpatient Surgery	0% after deductible	50% after deductible
Urgent Care Facility	0% after deductible	50% after deductible
Emergency Room	0% after deductible	
Annual Routine Gyn Exam *No waiting period* Annual Pap/Mammogram	$0 copay deductible waived	50% after deductible
Maternity	Not covered *Except for pregnancy complications*	
Preventive Health — Routine Physical *No waiting period*	$0 copay deductible waived	50% after deductible
	Includes lab work and X-rays	
Lab/X-Ray (Non-Preventive)	0% after deductible	50% after deductible
Complex Imaging	0% after deductible	50% after deductible
Skilled Nursing — instead of hospital *30 days per calendar year**	0% after deductible	50% after deductible
Physical/Occupational Therapy *24 visits per calendar year**	0% after deductible	50% after deductible
Home Health Care — instead of hospital *30 visits per calendar year**	0% after deductible	50% after deductible
Durable Medical Equipment *Aetna will pay up to $2,000 per calendar year**	0% after deductible	50% after deductible

PHARMACY	In-Network	Out-of-Network+
Pharmacy Deductible per individual	Integrated Medical/ Rx deductible	
Generic	0% after Medical/ Rx Deductible	50% after Medical/ Rx Deductible
Preferred Brand	0% after Medical/ Rx Deductible	50% after Medical/ Rx Deductible
Non-Preferred Brand	0% after Medical/ Rx Deductible	50% after Medical/ Rx Deductible
Self Injectables	0% after Medical/ Rx Deductible	Not covered

* Maximum applies to combined in and out-of-network benefits.

** Copay is billed separately and not due at time of service. Copay does not count towards coinsurance or out-of-pocket maximum.

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63.06.300.1-FL E (1/13)

Aetna®

YOUR AETNA HEALTH NETWORK OPTION℠ **PLAN OPTION(S)**

THE AETNA HEALTH NETWORK OPTION℠ PLANS ARE HMO LICENSED PLANS WHICH PROVIDE IN-NETWORK AND OUT-OF-NETWORK BENEFITS.

ROBUST COVERAGE AND THE FLEXIBILITY OF LOWER MONTHLY PAYMENTS BALANCED WITH A DEDUCTIBLE... WHERE YOU DON'T PAY A LOT FOR FREQUENT DOCTOR VISITS

FEATURING:

- Robust coverage with a choice of varying deductible levels

AETNA HEALTH NETWORK OPTION℠ 1500

FLORIDA

AETNA ADVANTAGE PLAN OPTIONS

MEMBER BENEFITS	In-Network	Out-of-Network+
Deductible Individual Family	 $1,500 $3,000	 $3,000 $6,000
Coinsurance (Member's responsibility)	25% after deductible up to out-of-pocket max.	50% after deductible up to out-of-pocket max.
	$0 once out-of-pocket max. is satisfied	
Coinsurance Maximum Individual Family	 $5,000 $10,000	 $7,000 $14,000
Out-of-Pocket Maximum Individual Family	 $6,500 $13,000	 $10,000 $20,000
	Includes deductible	
Non-Specialist Office Visit *Unlimited visits* General Physician, Family Practitioner, Pediatrician or Internist	$35 copay deductible waived	50% after deductible
Specialist Visit *Unlimited visits*	$75 copay deductible waived	50% after deductible
Hospital Admission	25% after deductible	50% after deductible
Outpatient Surgery	25% after deductible	50% after deductible
Urgent Care Facility	$75 copay deductible waived	50% after deductible
Emergency Room	$250 copay** (waived if admitted) after deductible	
Annual Routine Gyn Exam *No waiting period, no calendar year max.* Annual Pap/Mammogram	$0 copay deductible waived	50% after deductible
Maternity	Not covered *Except for pregnancy complications*	
Preventive Health — Routine Physical	$0 copay deductible waived	50% after deductible
	Includes lab work and X-rays	
Lab/X-Ray (Non- Preventive)	$50 copay per visit	50% after deductible
Complex Imaging	$500 copay per visit	50% after deductible
Skilled Nursing — instead of hospital *30 days per calendar year**	25% after deductible	50% after deductible
Physical/Occupational Therapy *24 visits per calendar year**	25% after deductible	50% after deductible
Home Health Care — instead of hospital *30 visits per calendar year**	25% after deductible	50% after deductible
Durable Medical Equipment *Aetna will pay up to $2,000 per calendar year**	25% after deductible	50% after deductible

PHARMACY	In-Network	Out-of-Network+
Pharmacy Deductible per individual	$500	$500
	Does not apply to generic	
Generic	$15 copay deductible waived	$15 copay plus 50% deductible waived
Preferred Brand	$40 copay after deductible	$40 copay plus 50% after deductible
Non-Preferred Brand	$65 copay after deductible	$65 copay plus 50% after deductible
Self-Injectables	30% after deductible	Not covered

* Maximum applies to combined in and out-of-network benefits.

** Copay is billed separately and not due at time of service. Copay does not count towards coinsurance or out-of-pocket maximum.

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63.06.300.1-FL E (1/13)

Aetna®

AETNA HEALTH NETWORK OPTION℠ 2500

FLORIDA

AETNA ADVANTAGE PLAN OPTIONS

MEMBER BENEFITS	In-Network	Out-of-Network+
Deductible Individual Family	 $2,500 $5,000	 $5,000 $10,000
Coinsurance (Member's responsibility)	25% after deductible up to out-of-pocket max.	50% after deductible up to out-of-pocket max.
	$0 once out-of-pocket max. is satisfied	
Coinsurance Maximum Individual Family	 $5,000 $10,000	 $5,000 $10,000
Out-of-Pocket Maximum Individual Family	 $7,500 $15,000	 $10,000 $20,000
	Includes deductible	
Non-Specialist Office Visit *Unlimited visits* General Physician, Family Practitioner, Pediatrician or Internist	$35 copay deductible waived	50% after deductible
Specialist Visit *Unlimited visits*	$75 copay deductible waived	50% after deductible
Hospital Admission	25% after deductible plus $1,000 copay	50% after deductible
Outpatient Surgery	25% after deductible plus $250 copay	50% after deductible
Urgent Care Facility	$75 copay deductible waived	50% after deductible
Emergency Room	$250 copay** (waived if admitted) after deductible	
Annual Routine Gyn Exam *No waiting period, no calendar year max.* Annual Pap/Mammogram	$0 copay deductible waived	50% after deductible
Maternity	Not covered *Except for pregnancy complications*	
Preventive Health — Routine Physical	$0 copay deductible waived	50% after deductible
	Includes lab work and X-rays	
Lab/X-Ray (Non- Preventive)	$50 copay per visit	50% after deductible
Complex Imaging	$500 copay per visit	50% after deductible
Skilled Nursing — instead of hospital *30 days per calendar year**	25% after deductible	50% after deductible
Physical/Occupational Therapy *24 visits per calendar year**	25% after deductible	50% after deductible
Home Health Care — instead of hospital *30 visits per calendar year**	25% after deductible	50% after deductible
Durable Medical Equipment *Aetna will pay up to $2,000 per calendar year**	25% after deductible	50% after deductible

PHARMACY	In-Network	Out-of-Network+
Pharmacy Deductible per individual	$500	$500
	Does not apply to generic	
Generic	$15 copay deductible waived	$15 copay plus 50% deductible waived
Preferred Brand	$65 copay after deductible	$65 copay plus 50% after deductible
Non-Preferred Brand	$75 copay after deductible	$75 copay plus 50% after deductible
Self-Injectables	30% after deductible	Not covered

* Maximum applies to combined in and out-of-network benefits.

** Copay is billed separately and not due at time of service. Copay does not count towards coinsurance or out-of-pocket maximum.

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63.06.300.1-FL E (1/13)

Aetna®

AETNA HEALTH NETWORK OPTION℠ 5000

FLORIDA

AETNA ADVANTAGE PLAN OPTIONS

MEMBER BENEFITS	In-Network	Out-of-Network+
Deductible Individual Family	 $5,000 $10,000	 $10,000 $20,000
Coinsurance (Member's responsibility)	25% after deductible up to out-of-pocket max.	50% after deductible up to out-of-pocket max.
	$0 once out-of-pocket max. is satisfied	
Coinsurance Maximum Individual Family	 $7,500 $15,000	 $2,500 $5,000
Out-of-Pocket Maximum Individual Family	 $12,500 $25,000	 $12,500 $25,000
	Includes deductible	
Non-Specialist Office Visit *Unlimited visits* General Physician, Family Practitioner, Pediatrician or Internist	$40 copay deductible waived	50% after deductible
Specialist Visit *Unlimited visits*	$75 copay deductible waived	50% after deductible
Hospital Admission	25% after deductible plus $1,000 copay	50% after deductible
Outpatient Surgery	25% after deductible plus $250 copay	50% after deductible
Urgent Care Facility	$75 copay deductible waived	50% after deductible
Emergency Room	$250 copay** (waived if admitted) after deductible	
Annual Routine Gyn Exam *No waiting period* Annual Pap/Mammogram	$0 copay deductible waived	50% after deductible
Maternity	Not covered *Except for pregnancy complications*	
Preventive Health — Routine Physical *No waiting period*	$0 copay deductible waived	50% after deductible
	Includes lab work and X-rays	
Lab/X-Ray (Non-Preventive)	$50 copay per visit	50% after deductible
Complex Imaging	$500 copay per visit	50% after deductible
Skilled Nursing — instead of hospital *30 days per calendar year**	25% after deductible	50% after deductible
Physical/Occupational Therapy *24 visits per calendar year**	25% after deductible	50% after deductible
Home Health Care — instead of hospital *30 visits per calendar year**	25% after deductible	50% after deductible
Durable Medical Equipment *Aetna will pay up to $2,000 per calendar year**	25% after deductible	50% after deductible

PHARMACY	In-Network	Out-of-Network+
Pharmacy Deductible per individual	$500	$500
	Does not apply to generic	
Generic	$15 copay deductible waived	$15 copay plus 50% deductible waived
Preferred Brand	$65 copay after deductible	$65 copay plus 50% after deductible
Non-Preferred Brand	$75 copay after deductible	$75 copay plus 50% after deductible
Self-Injectables	30% after deductible	Not covered

* Maximum applies to combined in and out-of-network benefits.

** Copay is billed separately and not due at time of service. Copay does not count towards coinsurance or out-of-pocket maximum.

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63.06.300.1-FL E (1/13)

Aetna®

YOUR AETNA HEALTH NETWORK OPTION℠ HIGH DEDUCTIBLE **PLAN OPTION(S)**

THE AETNA HEALTH NETWORK OPTION℠ PLANS ARE HMO LICENSED PLANS WHICH PROVIDE IN-NETWORK AND OUT-OF-NETWORK BENEFITS.

LOWER PREMIUM COSTS ... AND A HEALTH SAVINGS ACCOUNT (HSA) COMPATIBLE PLAN THAT OFFERS TAX-ADVANTAGED SAVINGS

FEATURING:

- 0% or 10% coinsurance in network after your deductible is met, depending on which plan you choose

AETNA HEALTH NETWORK OPTION℠
HIGH DEDUCTIBLE 3500 (HSA COMPATIBLE)
FLORIDA
AETNA ADVANTAGE PLAN OPTIONS

MEMBER BENEFITS	In-Network	Out-of-Network+
Deductible Individual Family	$3,500 $7,000	$10,000 $20,000
Coinsurance (Member's responsibility)	10% after deductible	50% after deductible
	$0 once out-of-pocket max. is satisfied	
Coinsurance Maximum Individual Family	$2,550 $5,100	$2,500 $5,000
Out-of-Pocket Maximum Individual Family	$6,050 $12,100	$12,500 $25,000
	Includes deductible	
Non-Specialist Office Visit *Unlimited visits* General Physician, Family Practitioner, Pediatrician or Internist	10% after deductible	50% after deductible
Specialist Visit *Unlimited visits*	10% after deductible	50% after deductible
Hospital Admission	10% after deductible	50% after deductible
Outpatient Surgery	10% after deductible	50% after deductible
Urgent Care Facility	10% after deductible	50% after deductible
Emergency Room	10% after deductible	
Annual Routine Gyn Exam *No waiting period, no calendar year max.* Annual Pap/Mammogram	$0 copay deductible waived	50% after deductible
Maternity	Not covered *Except for pregnancy complications*	
Preventive Health — Routine Physical	$0 copay deductible waived	50% after deductible
	Includes lab work and X-rays	
Lab/X-Ray (Non-Preventive)	10% after deductible	50% after deductible
Complex Imaging	10% after deductible	50% after deductible
Skilled Nursing — instead of hospital *30 days per calendar year**	10% after deductible	50% after deductible
Physical/Occupational Therapy *24 visits per calendar year**	10% after deductible	50% after deductible
Home Health Care — instead of hospital *30 visits per calendar year**	10% after deductible	50% after deductible
Durable Medical Equipment *Aetna will pay up to $2,000 per calendar year**	10% after deductible	50% after deductible

PHARMACY	In-Network	Out-of-Network+
Pharmacy Deductible per individual	Integrated Medical/Rx Deductible	Integrated Medical/Rx Deductible
Generic	10% after Medical/Rx Deductible	50% after Medical/Rx Deductible
Preferred Brand	10% after Medical/Rx Deductible	50% after Medical/Rx Deductible
Non-Preferred Brand	10% after Medical/Rx Deductible	50% after Medical/Rx Deductible
Self-Injectables	10% after Medical/Rx Deductible	Not covered

* Maximum applies to combined in and out-of-network benefits.

** Copay is billed separately and not due at time of service. Copay does not count towards coinsurance or out-of-pocket maximum.

\+ For important information on your costs and how Aetna pays for out-of-network care, read "What you need to know about your out-of-network costs."

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

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63.06.300.1-FL E (1/13)

Aetna®

AETNA HEALTH NETWORK OPTION℠
HIGH DEDUCTIBLE 5500 (HSA COMPATIBLE)
FLORIDA
AETNA ADVANTAGE PLAN OPTIONS

MEMBER BENEFITS	In-Network	Out-of-Network+
Deductible Individual Family	 $5,500 $11,000	 $10,000 $20,000
Coinsurance (Member's responsibility)	0% after deductible up to out-of-pocket max.	50% after deductible up to out-of-pocket max.
	$0 once out-of-pocket max. is satisfied	
Coinsurance Maximum Individual Family	 $0 $0	 $2,500 $5,000
Out-of-Pocket Maximum Individual Family	 $5,500 $11,000	 $12,500 $25,000
	Includes deductible	
Non-Specialist Office Visit *Unlimited visits* General Physician, Family Practitioner, Pediatrician or Internist	0% after deductible	50% after deductible
Specialist Visit *Unlimited visits*	0% after deductible	50% after deductible
Hospital Admission	0% after deductible	50% after deductible
Outpatient Surgery	0% after deductible	50% after deductible
Urgent Care Facility	0% after deductible	50% after deductible
Emergency Room	0% after deductible	
Annual Routine Gyn Exam *No waiting period* Annual Pap/Mammogram	$0 copay deductible waived	50% after deductible
Maternity	Not covered *Except for pregnancy complications*	
Preventive Health — Routine Physical	$0 copay deductible waived	50% after deductible
	Includes lab work and X-rays	
Lab/X-Ray (Non-Preventive)	0% after deductible	50% after deductible
Complex Imaging	0% after deductible	50% after deductible
Skilled Nursing — instead of hospital *30 days per calendar year**	0% after deductible	50% after deductible
Physical/Occupational Therapy *24 visits per calendar year**	0% after deductible	50% after deductible
Home Health Care — instead of hospital *30 visits per calendar year**	0% after deductible	50% after deductible
Durable Medical Equipment *Aetna will pay up to $2,000 per calendar year**	0% after deductible	50% after deductible

PHARMACY	In-Network	Out-of-Network+
Pharmacy Deductible per individual	Integrated Medical/Rx Deductible	Integrated Medical/Rx Deductible
Generic	0% after Medical/Rx Deductible	50% after Medical/Rx Deductible
Preferred Brand	0% after Medical/Rx Deductible	50% after Medical/Rx Deductible
Non-Preferred Brand	0% after Medical/Rx Deductible	50% after Medical/Rx Deductible
Self-Injectables	0% after Medical/Rx Deductible	Not covered

* Maximum applies to combined in and out-of-network benefits.

** Copay is billed separately and not due at time of service. Copay does not count towards coinsurance or out-of-pocket maximum.

\+ For important information on your costs and how Aetna pays for out-of-network care, read "What you need to know about your out-of-network costs."

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63.06.300.1-FL E (1/13)

Aetna®

YOUR AETNA OPEN ACCESS® MANAGED CHOICE® VALUE **PLAN OPTION(S)**

AFFORDABILITY — A BALANCE OF LOWER MONTHLY PREMIUMS AND GREATER COST SHARING WITH QUALITY COVERAGE

FEATURING:

- Coverage for routine and major services with lower monthly premiums (that's the "Value" part)

AETNA OPEN ACCESS® MANAGED CHOICE® VALUE 5000

FLORIDA

AETNA ADVANTAGE PLAN OPTIONS

MEMBER BENEFITS	In-Network	Out-of-Network+
Deductible Individual Family	 $5,000 $10,000	 $10,000 $20,000
Coinsurance (Member's responsibility)	20% / 40% after deductible up to out-of-pocket max.	50% after deductible up to out-of-pocket max.
	$0 once out-of-pocket max. is satisfied	
Coinsurance Maximum Individual Family	 $7,500 $15,000	 $2,500 $5,000
Out-of-Pocket Maximum Individual Family	 $12,500 $25,000	 $12,500 $25,000
	Includes deductible	
Non-Specialist Office Visit General Physician, Family Practitioner, Pediatrician or Internist	Visits 1-5: $40 copay, deductible waived; Visit 6+: No Coverage Non Specialist and Specialist share visit max.	50% after deductible
Specialist Visit	Visits 1-5: $50 copay, deductible waived; Visit 6+: No Coverage Non Specialist and Specialist share visit max.	50% after deductible
Hospital Admission	40% after deductible	50% after deductible
Outpatient Surgery	40% after deductible	50% after deductible
Urgent Care Facility	$100 copay deductible waived	50% after deductible
Emergency Room	$250 copay** (waived if admitted) after deductible	
Annual Routine Gyn Exam *No waiting period* Annual Pap/Mammogram	$0 copay deductible waived	50% after deductible
Maternity	Not covered *Except for pregnancy complications*	
Preventive Health — Routine Physical *No waiting period*	$0 copay deductible waived	50% after deductible
	Includes lab work and X-rays	
Lab/X-Ray (Non-Preventive)	20% after deductible	50% after deductible
Complex Imaging	40% after deductible	50% after deductible
Skilled Nursing — instead of hospital *30 days per calendar year**	40% after deductible	50% after deductible
Physical/Occupational Therapy *24 visits per calendar year**	20% after deductible	50% after deductible
Home Health Care — instead of hospital *30 visits per calendar year**	20% after deductible	50% after deductible
Durable Medical Equipment *Aetna will pay up to $2,000 per calendar year**	40% after deductible	50% after deductible

PHARMACY	In-Network	Out-of-Network+
Pharmacy Deductible per individual	Not Applicable	Not Applicable
Generic	$20 copay deductible waived	$20 copay plus 50% deductible waived
Preferred Brand	Not covered	Not covered
Non-Preferred Brand	Not covered	Not covered
Self-Injectables	Not covered	Not covered

* Maximum applies to combined in and out-of-network benefits.

** Copay is billed separately and not due at time of service. Copay does not count towards coinsurance or out-of-pocket maximum.

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63.06.300.1-FL E (1/13)

Aetna®

AETNA OPEN ACCESS® MANAGED CHOICE® VALUE 7500

FLORIDA

AETNA ADVANTAGE PLAN OPTIONS

MEMBER BENEFITS	In-Network	Out-of-Network+
Deductible Individual Family	 $7,500 $15,000	 $10,000 $20,000
Coinsurance (Member's responsibility)	20% / 40% after deductible up to out-of-pocket max.	50% after deductible up to out-of-pocket max.
	$0 once out-of-pocket max. is satisfied	
Coinsurance Maximum Individual Family	 $5,000 $10,000	 $2,500 $5,000
Out-of-Pocket Maximum Individual Family	 $12,500 $25,000	 $12,500 $25,000
	Includes deductible	
Non-Specialist Office Visit General Physician, Family Practitioner, Pediatrician or Internist	Visits 1-5: $40 copay, deductible waived; Visit 6+: No Coverage Non Specialist and Specialist share visit max.	50% after deductible
Specialist Visit	Visits 1-5: $50 copay, deductible waived; Visit 6+: No Coverage Non Specialist and Specialist share visit max.	50% after deductible
Hospital Admission	40% after deductible	50% after deductible
Outpatient Surgery	40% after deductible	50% after deductible
Urgent Care Facility	$100 copay deductible waived	50% after deductible
Emergency Room	$250 copay** (waived if admitted) after deductible	
Annual Routine Gyn Exam *No waiting period* Annual Pap/Mammogram	$0 copay deductible waived	50% after deductible
Maternity	Not covered *Except for pregnancy complications*	
Preventive Health — Routine Physical *No waiting period*	$0 copay deductible waived	50% after deductible
	Includes lab work and X-rays	
Lab/X-Ray (Non-Preventive)	20% after deductible	50% after deductible
Complex Imaging	40% after deductible	50% after deductible
Skilled Nursing — instead of hospital *30 days per calendar year**	40% after deductible	50% after deductible
Physical/Occupational Therapy *24 visits per calendar year**	20% after deductible	50% after deductible
Home Health Care — instead of hospital *30 visits per calendar year**	20% after deductible	50% after deductible
Durable Medical Equipment *Aetna will pay up to $2,000 per calendar year**	40% after deductible	50% after deductible

PHARMACY	In-Network	Out-of-Network+
Pharmacy Deductible per individual	Not Applicable	Not Applicable
Generic	$20 copay deductible waived	$20 copay plus 50% deductible waived
Preferred Brand	Not covered	Not covered
Non-Preferred Brand	Not covered	Not covered
Self-Injectables	Not covered	Not covered

* Maximum applies to combined in and out-of-network benefits.

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63.06.300.1-FL E (1/13)

Aetna®

AETNA OPEN ACCESS® MANAGED CHOICE® VALUE 10000

FLORIDA

AETNA ADVANTAGE PLAN OPTIONS

MEMBER BENEFITS	In-Network	Out-of-Network+
Deductible Individual Family	 $10,000 $20,000	 $10,000 $20,000
Coinsurance (Member's responsibility)	20% / 40% after deductible up to out-of-pocket max.	50% after deductible up to out-of-pocket max.
	$0 once out-of-pocket max. is satisfied	
Coinsurance Maximum Individual Family	 $2,500 $5,000	 $2,500 $5,000
Out-of-Pocket Maximum Individual Family	 $12,500 $25,000	 $12,500 $25,000
	Includes deductible	
Non-Specialist Office Visit General Physician, Family Practitioner, Pediatrician or Internist	Visits 1-5: $40 copay, deductible waived; Visit 6+: No Coverage Non Specialist and Specialist share visit max.	50% after deductible
Specialist Visit	Visits 1-5: $50 copay, deductible waived; Visit 6+: No Coverage Non Specialist and Specialist share visit max.	50% after deductible
Hospital Admission	40% after deductible	50% after deductible
Outpatient Surgery	40% after deductible	50% after deductible
Urgent Care Facility	$100 copay deductible waived	50% after deductible
Emergency Room	$250 copay** (waived if admitted) after deductible	
Annual Routine Gyn Exam *No waiting period* Annual Pap/Mammogram	$0 copay deductible waived	50% after deductible
Maternity	Not covered *Except for pregnancy complications*	
Preventive Health — Routine Physical *No waiting period*	$0 copay deductible waived	50% after deductible
	Includes lab work and X-rays	
Lab/X-Ray (Non-Preventive)	20% after deductible	50% after deductible
Complex Imaging	40% after deductible	50% after deductible
Skilled Nursing — instead of hospital *30 days per calendar year**	40% after deductible	50% after deductible
Physical/Occupational Therapy *24 visits per calendar year**	20% after deductible	50% after deductible
Home Health Care — instead of hospital *30 visits per calendar year**	20% after deductible	50% after deductible
Durable Medical Equipment *Aetna will pay up to $2,000 per calendar year**	40% after deductible	50% after deductible

PHARMACY	In-Network	Out-of-Network+
Pharmacy Deductible per individual	Not Applicable	Not Applicable
Generic	$20 copay deductible waived	$20 copay plus 50% deductible waived
Preferred Brand	Not covered	Not covered
Non-Preferred Brand	Not covered	Not covered
Self-Injectables	Not covered	Not covered

* Maximum applies to combined in and out-of-network benefits.

** Copay is billed separately and not due at time of service. Copay does not count towards coinsurance or out-of-pocket maximum.

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63.06.300.1-FL E (1/13)

Aetna®

YOUR AETNA HEALTH NETWORK OPTION℠ VALUE **PLAN OPTION(S)**

THE AETNA HEALTH NETWORK OPTION℠ PLANS ARE HMO LICENSED PLANS WHICH PROVIDE IN-NETWORK AND OUT-OF-NETWORK BENEFITS.

AFFORDABILITY — A BALANCE OF LOWER MONTHLY PREMIUMS AND GREATER COST SHARING WITH QUALITY COVERAGE

FEATURING:

- Coverage for routine and major services with lower monthly premiums (that's the "Value" part)

AETNA HEALTH NETWORK OPTION℠ VALUE 5000

FLORIDA

AETNA ADVANTAGE PLAN OPTIONS

MEMBER BENEFITS	In-Network	Out-of-Network+
Deductible Individual Family	 $5,000 $10,000	 $10,000 $20,000
Coinsurance (Member's responsibility)	20% / 40% after deductible up to out-of-pocket max.	50% after deductible up to out-of-pocket max.
	$0 once out-of-pocket max. is satisfied	
Coinsurance Maximum Individual Family	 $7,500 $15,000	 $2,500 $5,000
Out-of-Pocket Maximum Individual Family	 $12,500 $25,000	 $12,500 $25,000
	Includes deductible	
Non-Specialist Office Visit General Physician, Family Practitioner, Pediatrician or Internist	Visits 1-5: $40 copay, deductible waived; Visit 6+: No Coverage Non Specialist and Specialist share visit max.	50% after deductible
Specialist Visit	Visits 1-5: $50 copay, deductible waived; Visit 6+: No Coverage Non Specialist and Specialist share visit max.	50% after deductible
Hospital Admission	40% after deductible	50% after deductible
Outpatient Surgery	40% after deductible	50% after deductible
Urgent Care Facility	$100 copay deductible waived	50% after deductible
Emergency Room	$250 copay** (waived if admitted) after deductible	
Annual Routine Gyn Exam *No waiting period* Annual Pap/Mammogram	$0 copay deductible waived	50% after deductible
Maternity	Not covered *Except for pregnancy complications*	
Preventive Health — Routine Physical *No waiting period*	$0 copay deductible waived	50% after deductible
	Includes lab work and X-rays	
Lab/X-Ray (Non-Preventive)	20% after deductible	50% after deductible
Complex Imaging	40% after deductible	50% after deductible
Skilled Nursing — instead of hospital *30 days per calendar year**	40% after deductible	50% after deductible
Physical/Occupational Therapy *24 visits per calendar year**	20% after deductible	50% after deductible
Home Health Care — instead of hospital *30 visits per calendar year**	20% after deductible	50% after deductible
Durable Medical Equipment *Aetna will pay up to $2,000 per calendar year**	40% after deductible	50% after deductible

PHARMACY	In-Network	Out-of-Network+
Pharmacy Deductible per individual	Not Applicable	Not Applicable
Generic	$20 copay deductible waived	$20 copay plus 50% deductible waived
Preferred Brand	Not covered	Not covered
Non-Preferred Brand	Not covered	Not covered
Self-Injectables	Not covered	Not covered

* Maximum applies to combined in and out-of-network benefits.

** Copay is billed separately and not due at time of service. Copay does not count towards coinsurance or out-of-pocket maximum.

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63.06.300.1-FL E (1/13)

Aetna®

AETNA HEALTH NETWORK OPTION℠ VALUE 7500

FLORIDA

AETNA ADVANTAGE PLAN OPTIONS

MEMBER BENEFITS	In-Network	Out-of-Network+
Deductible Individual Family	 $7,500 $15,000	 $10,000 $20,000
Coinsurance (Member's responsibility)	20% / 40% after deductible up to out-of-pocket max.	50% after deductible up to out-of-pocket max.
	$0 once out-of-pocket max. is satisfied	
Coinsurance Maximum Individual Family	 $5,000 $10,000	 $2,500 $5,000
Out-of-Pocket Maximum Individual Family	 $12,500 $25,000	 $12,500 $25,000
	Includes deductible	
Non-Specialist Office Visit General Physician, Family Practitioner, Pediatrician or Internist	Visits 1-5: $40 copay, deductible waived; Visit 6+: No Coverage Non Specialist and Specialist share visit max.	50% after deductible
Specialist Visit	Visits 1-5: $50 copay, deductible waived; Visit 6+: No Coverage Non Specialist and Specialist share visit max.	50% after deductible
Hospital Admission	40% after deductible	50% after deductible
Outpatient Surgery	40% after deductible	50% after deductible
Urgent Care Facility	$100 copay deductible waived	50% after deductible
Emergency Room	$250 copay** (waived if admitted) after deductible	
Annual Routine Gyn Exam *No waiting period* Annual Pap/Mammogram	$0 copay deductible waived	50% after deductible
Maternity	Not covered *Except for pregnancy complications*	
Preventive Health — Routine Physical *No waiting period*	$0 copay deductible waived	50% after deductible
	Includes lab work and X-rays	
Lab/X-Ray (Non-Preventive)	20% after deductible	50% after deductible
Complex Imaging	40% after deductible	50% after deductible
Skilled Nursing — instead of hospital *30 days per calendar year**	40% after deductible	50% after deductible
Physical/Occupational Therapy *24 visits per calendar year**	20% after deductible	50% after deductible
Home Health Care — instead of hospital *30 visits per calendar year**	20% after deductible	50% after deductible
Durable Medical Equipment *Aetna will pay up to $2,000 per calendar year**	40% after deductible	50% after deductible

PHARMACY	In-Network	Out-of-Network+
Pharmacy Deductible per individual	Not Applicable	Not Applicable
Generic	$20 copay deductible waived	$20 copay plus 50% deductible waived
Preferred Brand	Not covered	Not covered
Non-Preferred Brand	Not covered	Not covered
Self-Injectables	Not covered	Not covered

* Maximum applies to combined in and out-of-network benefits.

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63.06.300.1-FL E (1/13)

Aetna®

AETNA HEALTH NETWORK OPTION℠ VALUE 10000

FLORIDA

AETNA ADVANTAGE PLAN OPTIONS

MEMBER BENEFITS	In-Network	Out-of-Network+
Deductible Individual Family	 $10,000 $20,000	 $10,000 $20,000
Coinsurance (Member's responsibility)	20% / 40% after deductible up to out-of-pocket max.	50% after deductible up to out-of-pocket max.
	$0 once out-of-pocket max. is satisfied	
Coinsurance Maximum Individual Family	 $2,500 $5,000	 $2,500 $5,000
Out-of-Pocket Maximum Individual Family	 $12,500 $25,000	 $12,500 $25,000
	Includes deductible	
Non-Specialist Office Visit General Physician, Family Practitioner, Pediatrician or Internist	Visits 1-5: $40 copay, deductible waived; Visit 6+: No Coverage Non Specialist and Specialist share visit max.	50% after deductible
Specialist Visit	Visits 1-5: $50 copay, deductible waived; Visit 6+: No Coverage Non Specialist and Specialist share visit max.	50% after deductible
Hospital Admission	40% after deductible	50% after deductible
Outpatient Surgery	40% after deductible	50% after deductible
Urgent Care Facility	$100 copay deductible waived	50% after deductible
Emergency Room	$250 copay** (waived if admitted) after deductible	
Annual Routine Gyn Exam *No waiting period* Annual Pap/Mammogram	$0 copay deductible waived	50% after deductible
Maternity	Not covered *Except for pregnancy complications*	
Preventive Health — Routine Physical *No waiting period*	$0 copay deductible waived	50% after deductible
	Includes lab work and X-rays	
Lab/X-Ray (Non-Preventive)	20% after deductible	50% after deductible
Complex Imaging	40% after deductible	50% after deductible
Skilled Nursing — instead of hospital *30 days per calendar year**	40% after deductible	50% after deductible
Physical/Occupational Therapy *24 visits per calendar year**	20% after deductible	50% after deductible
Home Health Care — instead of hospital *30 visits per calendar year**	20% after deductible	50% after deductible
Durable Medical Equipment *Aetna will pay up to $2,000 per calendar year**	40% after deductible	50% after deductible

PHARMACY	In-Network	Out-of-Network+
Pharmacy Deductible per individual	Not Applicable	Not Applicable
Generic	$20 copay deductible waived	$20 copay plus 50% deductible waived
Preferred Brand	Not covered	Not covered
Non-Preferred Brand	Not covered	Not covered
Self-Injectables	Not covered	Not covered

* Maximum applies to combined in and out-of-network benefits.

** Copay is billed separately and not due at time of service. Copay does not count towards coinsurance or out-of-pocket maximum.

\+ For important information on your costs and how Aetna pays for out-of-network care, read "What you need to know about your out-of-network costs."

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63.06.300.1-FL E (1/13)

Aetna®

YOUR PREVENTIVE AND HOSPITAL CARE **PLAN OPTION(S)**

AFFORDABILITY IS ONE OF YOUR TOP PRIORITIES
AND YOU USE ONLY BASIC HEALTH CARE SERVICES ...
AND WANT TO KEEP YOUR MONTHLY PREMIUMS LOWER

FEATURING:

- Coverage for preventive care and major health care services with a lower monthly premium

PREVENTIVE AND HOSPITAL CARE 3000
(HSA COMPATIBLE)
FLORIDA
AETNA ADVANTAGE PLAN OPTIONS

MEMBER BENEFITS	In-Network	Out-of-Network+
Deductible Individual Family	 $3,000 $6,000	 $6,000 $12,000
Coinsurance (Member's responsibility)	20% after deductible up to out-of-pocket max.	50% after deductible up to out-of-pocket max.
Coinsurance Maximum Individual Family	 $2,000 $4,000	 $4,000 $8,000
Out-of-Pocket Maximum Individual Family	 $5,000 $10,000	 $10,000 $20,000
	Includes deductible	
Non-Specialist Office Visit General Physician, Family Practitioner, Pediatrician or Internist	Not covered	Not covered
Specialist Visit	Not covered	Not covered
Hospital Admission	20% after deductible	50% after deductible
Outpatient Surgery	20% after deductible	50% after deductible
Urgent Care Facility	Not covered	Not covered
Emergency Room	$150 copay** (waived if admitted) after deductible	
Annual Routine Gyn Exam *No waiting period* Annual Pap/Mammogram	$0 copay deductible waived	50% after deductible
Maternity	Not covered *Except for pregnancy complications*	
Preventive Health — Routine Physical *No waiting period*	$0 copay deductible waived	50% after deductible
	Includes lab work and X-rays	
Lab/X-Ray (Non-preventive)	Not covered	Not covered
Complex Imaging	Not covered	Not covered
Skilled Nursing — in lieu of hospital *30 days per calendar year**	20% after deductible	50% after deductible
Physical/Occupational Therapy	Not covered	Not covered
Home Health Care — in lieu of hospital *30 visits per calendar year**	20% after deductible	50% after deductible
Durable Medical Equipment	Not covered	Not covered

PHARMACY	In-Network	Out-of-Network+
Pharmacy Deductible per individual	Not Applicable	Not Applicable
Generic	Not covered	Not covered
Preferred Brand	Not covered	Not covered
Non-Preferred Brand	Not covered	Not covered
Self-Injectables	Not covered	Not covered

* Maximum applies to combined in and out-of-network benefits.

** Copay is billed separately and not due at time of service. Copay does not count towards coinsurance or out-of-pocket maximum.

\+ For important information on your costs and how Aetna pays for out-of-network care, read "What you need to know about your out-of-network costs."

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63.06.300.1-FL E (1/13)

Aetna®

YOUR AETNA HEALTH NETWORK OPTION℠ SAVINGS PLUS **PLAN OPTION(S)**

SAVINGS — THE SAME TYPES OF COVERAGE AS OTHER AETNA MEDICAL PLANS, BUT AT A LOWER PREMIUM COST

FEATURING:

- Highest benefit level and the lowest out-of-pocket costs when you access care through the Savings Plus network

AETNA HEALTH NETWORK OPTION℠ SAVINGS PLUS 3500

FLORIDA

AETNA ADVANTAGE PLAN OPTIONS

MEMBER BENEFITS	Maximum Savings	Out-of-Network+ (Non-Designated and Out-of-Network Providers)
Deductible Individual Family	$3,500 $7,000	$7,000 $14,000 (Non-designated and Out-of-Network providers)++
Coinsurance (Member's responsibility)	20%/40% after deductible up to out-of-pocket max.	50% after deductible up to out-of-pocket max.
	$0 once out-of-pocket max. is satisfied	
Coinsurance Maximum Individual Family	$6,500 $13,000	$5,500 $11,000 (Non-designated and Out-of-Network providers)++
Out-of-Pocket Maximum Individual Family	$10,000 $20,000	$12,500 $25,000 (Non-designated and Out-of-Network providers)++
	Includes deductible	
Non-Specialist Office Visit General Physician, Family Practitioner, Pediatrician or Internist	Visits 1-3: $35 copay, deductible waived; Visits 4+ No Coverage	50% after deductible
Specialist Visit	20% after deductible	50% after deductible (Non-designated and Out-of-Network providers)++
Hospital Admission	40% after deductible, plus $150 copay per day (three day maximum per admission)	50% after deductible (Non-designated and Out-of-Network providers)++
Outpatient Surgery	40% after deductible, plus $150 copay per surgery	50% after deductible (Non-designated and Out-of-Network providers)++
Urgent Care Facility	$100 copay deductible waived	50% after deductible
Emergency Room	$250 copay** after deductible (waived if admitted)	
Annual Routine Gyn Exam *No waiting period* Annual Pap/Mammogram	$0 copay deductible waived	50% after deductible
Maternity	Not covered *Except for pregnancy complications*	
Preventive Health — Routine Physical *No waiting period*	$0 copay deductible waived	50% after deductible
	Includes lab work and X-rays	
Lab/X-Ray (Non-Preventive)	20% after deductible	50% after deductible
Complex Imaging	40% after deductible	50% after deductible
Skilled Nursing — instead of hospital *30 days per calendar year**	40% after deductible	50% after deductible
Physical/Occupational Therapy *24 visits per calendar year**	20% after deductible	50% after deductible
Home Health Care — instead of hospital *30 visits per calendar year**	20% after deductible	50% after deductible
Durable Medical Equipment *Aetna will pay up to $2,000 per calendar year**	40% after deductible	50% after deductible

PHARMACY	In-Network	Out-of-Network+
Pharmacy Deductible per individual	Not Applicable	Not Applicable
Generic	$20 copay deductible waived	$20 copay plus 50% deductible waived
Preferred Brand	Not covered	Not covered
Non-Preferred Brand	Not covered	Not covered
Self-Injectables	Not covered	Not covered

* Maximum applies to combined in and out-of-network benefits.

** Copay is billed separately and not due at time of service. Copay does not count towards coinsurance or out-of-pocket maximum.

\+ For important information on your costs and how Aetna pays for out-of-network care, read "What you need to know about your out-of-network costs."

++ For important information on what you will pay for Non-Designated and Out-of-Network Providers, read "How do the Savings Plus plans work"?

This plan provides preferred benefit coverage and access to covered services and supplies through a designated network of health care providers and facilities that are unique to your plan.

This Plan includes different benefit levels based upon the type of network provider that you use (designated or non-designated) or if you choose to see a non-preferred care provider. It is designed to lower your out-of-pocket costs when you use these designated network providers for covered expenses. These designated network providers are identifi ed in the printed directory and the on-line version of the directory. Aetna also contracts with other network providers that are available to you under the plan (referred to as non-designated network providers), but your cost sharing will be at a much higher level when you use these providers.

This material is for information only. A summary of exclusions is listed in the Aetna Advantage Plan brochure. For a full list of benefit coverage and exclusions refer to the plan documents. Plans may be subject to medical underwriting or other restrictions. Rates and benefits vary by location. Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Health insurance plans contain exclusions and limitations. Information is believed to be accurate as of the production date: however, it is subject to change.

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63.06.300.1-FL E (1/13)

Aetna®

AETNA HEALTH NETWORK OPTION℠ SAVINGS PLUS 6500

FLORIDA

AETNA ADVANTAGE PLAN OPTIONS

MEMBER BENEFITS	Maximum Savings	Out-of-Network+ (Non-Designated and Out-of-Network Providers)
Deductible Individual Family	$6,500 $13,000	$10,000 $20,000 (Non-designated and Out-of-Network providers)++
Coinsurance (Member's responsibility)	20%/40% after deductible up to out-of-pocket max.	50% after deductible up to out-of-pocket max.
	$0 once out-of-pocket max. is satisfied	
Coinsurance Maximum Individual Family	$3,500 $7,000	$2,500 $5,000 (Non-designated and Out-of-Network providers)++
Out-of-Pocket Maximum Individual Family	$10,000 $20,000	$12,500 $25,000 (Non-designated and Out-of-Network providers)++
	Includes deductible	
Non-Specialist Office Visit General Physician, Family Practitioner, Pediatrician or Internist	Visits 1-3: $40 copay, deductible waived; Visits 4+ No Coverage	50% after deductible
Specialist Visit	20% after deductible	50% after deductible (Non-designated and Out-of-Network providers)++
Hospital Admission	40% after deductible, plus $150 copay per day (three day maximum per admission)	50% after deductible (Non-designated and Out-of-Network providers)++
Outpatient Surgery	40% after deductible, plus $150 copay per surgery	50% after deductible (Non-designated and Out-of-Network providers)++
Urgent Care Facility	$100 copay deductible waived	50% after deductible
Emergency Room	$250 copay** after deductible (waived if admitted)	
Annual Routine Gyn Exam *No waiting period* Annual Pap/Mammogram	$0 copay deductible waived	50% after deductible
Maternity	Not covered *Except for pregnancy complications*	
Preventive Health — Routine Physical *No waiting period*	$0 copay deductible waived	50% after deductible
	Includes lab work and X-rays	
Lab/X-Ray (Non-Preventive)	20% after deductible	50% after deductible
Complex Imaging	40% after deductible	50% after deductible
Skilled Nursing — instead of hospital *30 days per calendar year**	40% after deductible	50% after deductible
Physical/Occupational Therapy *24 visits per calendar year**	20% after deductible	50% after deductible
Home Health Care — instead of hospital *30 visits per calendar year**	20% after deductible	50% after deductible
Durable Medical Equipment *Aetna will pay up to $2,000 per calendar year**	40% after deductible	50% after deductible

PHARMACY	In-Network	Out-of-Network+
Pharmacy Deductible per individual	Not Applicable	Not Applicable
Generic	$20 copay deductible waived	$20 copay plus 50% deductible waived
Preferred Brand	Not covered	Not covered
Non-Preferred Brand	Not covered	Not covered
Self-Injectables	Not covered	Not covered

* Maximum applies to combined in and out-of-network benefits.

** Copay is billed separately and not due at time of service. Copay does not count towards coinsurance or out-of-pocket maximum.

\+ For important information on your costs and how Aetna pays for out-of-network care, read "What you need to know about your out-of-network costs."

++ For important information on what you will pay for Non-Designated and Out-of-Network Providers, read "How do the Savings Plus plans work"?

This plan provides preferred benefit coverage and access to covered services and supplies through a designated network of health care providers and facilities that are unique to your plan.

This Plan includes different benefit levels based upon the type of network provider that you use (designated or non-designated) or if you choose to see a non-preferred care provider. It is designed to lower your out-of-pocket costs when you use these designated network providers for covered expenses. These designated network providers are identifi ed in the printed directory and the on-line version of the directory. Aetna also contracts with other network providers that are available to you under the plan (referred to as non-designated network providers), but your cost sharing will be at a much higher level when you use these providers.

This material is for information only. A summary of exclusions is listed in the Aetna Advantage Plan brochure. For a full list of benefit coverage and exclusions refer to the plan documents. Plans may be subject to medical underwriting or other restrictions. Rates and benefits vary by location. Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Health insurance plans contain exclusions and limitations. Information is believed to be accurate as of the production date: however, it is subject to change.

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63.06.300.1-FL E (1/13)

Aetna®

INDIVIDUAL DENTAL PPO MAX PLAN **PLAN OPTION**

INDIVIDUAL DENTAL PPO MAX PLAN

FLORIDA

AETNA ADVANTAGE PLAN OPTIONS

MEMBER BENEFITS	Preferred	Non-Preferred
Annual Deductible per Member (Does not apply to Diagnostic and Preventive Services)	$25; $75 family maximum	$25; $75 family maximum
Annual Maximum Benefit	Unlimited	Unlimited
DIAGNOSTIC SERVICES		
Oral exams		
Periodic oral exam	100% deductible waived	50% deductible waived
Comprehensive oral exam	100% deductible waived	50% deductible waived
Problem-focused oral exam	100% deductible waived	50% deductible waived
X-rays		
Bitewing — single film	100% deductible waived	50% deductible waived
Complete series	100% deductible waived	50% deductible waived
PREVENTIVE SERVICES		
Adult cleaning	100% deductible waived	50% deductible waived
Child cleaning	100% deductible waived	50% deductible waived
Sealants — per tooth	Not covered*	Not covered
Fluoride application — with cleaning	100% deductible waived	50% deductible waived
Space maintainers	Not covered*	Not covered
BASIC SERVICES		
Amalgam fillings — 2 surfaces	100% after deductible	50% after deductible
Resin fillings — 2 surfaces	Not covered*	Not covered
Oral Surgery		
Extraction — exposed root or erupted tooth	Not covered*	Not covered
Extraction of impacted tooth — soft tissue	Not covered*	Not covered
MAJOR SERVICES		
Complete upper denture	Not covered*	Not covered
Partial upper denture (resin based)	Not covered*	Not covered
Crown — Porcelain with noble metal	Not covered*	Not covered
Pontic — Porcelain with noble metal	Not covered*	Not covered
Inlay — Metallic (3 or more surfaces)	Not covered*	Not covered
Oral Surgery		
Removal of impacted tooth — partially bony	Not covered*	Not covered
Endodontic Services		
Bicuspid root canal therapy	Not covered*	Not covered
Molar root canal therapy	Not covered*	Not covered
Periodontic Services		
Scaling & root planing — per quadrant	Not covered*	Not covered
Osseous surgery — per quadrant	Not covered*	Not covered
ORTHODONTIC SERVICES	Not covered*	Not covered

Participating dentists may offer discounted rates on additional services such as tooth whitening. Discounts for non-covered services may not be available in all states.

Nonpreferred (Out-of-Network) Coverage is limited to a maximum of the Plan's payment, which is based on the contracted maximum fee for participating providers in the particular geographic area.

This list of covered services is representative. A summary of exclusions is listed in the Aetna Advantage Plan brochure. For a full list of benefit coverage and exclusions refer to the plan documents.

All products not available in all counties.

This material is for information only. Dental insurance plans contain exclusions and limitations. Not all dental services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. Information is believed to be accurate as of the production date; however, it is subject to change.

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* Discounts for non-covered services may not be available in all states.

63.06.300.1-FL E (1/13)

WHAT YOU NEED TO KNOW ABOUT **YOUR OUT-OF-NETWORK COSTS**

We cover the cost of care differently based on whether health care providers, such as doctors and hospitals, are "in network" or "out of network." We want to help you understand how much Aetna pays for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this out-of-network care.

As an example, you may choose a doctor in our network. You may choose to visit an out-of-network doctor. 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 a lot more money out of your own pocket if you choose to use an out-of-network doctor or hospital.

When you choose out-of-network care, Aetna limits the amount it will pay. This limit is called the "recognized" or "allowed" amount. For medical plans, Aetna recognizes an amount based on what Medicare pays for these services. The government sets the Medicare rate.

Your out-of-network doctor 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 Aetna doesn't recognize. You must also pay any copayments, coinsurance and deductibles under your plan.

No dollar amount above the recognized charge counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit **www.Aetna.com**. Type "how Aetna pays" in the search box.

You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to **www.Aetna.com** and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Aetna Navigator member site.

This way of paying out-of-network doctors and hospitals applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident), 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. Contact Aetna if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your copayments, coinsurance and deductibles.

For dental plans, your share of costs for care is determined in a similar way as your medical plan, which is outlined in detail above. If you choose an out-of-network dentist, you will pay a lot more money out of your own pocket most of the time.

But the amount Aetna recognizes for out-of-network dentists is based on different rates than the medical plan. Aetna bases payments to out-of-network dentists on rates we use to begin contract negotiations with dentists in our network.

HOW CAN I GET PERSONALIZED **HEALTH INFORMATION — IN ONE SEARCH?**

Aetna SmartSource℠ delivers health information that's specific to each member, based on where you live, your Aetna health plan, and other information. Whether researching a condition, symptom, procedure or other health topic, Aetna SmartSource scans Aetna's vast resources to bring you, in a single search:

- Specialists in your local area
- Related medications, treatment options and estimated health costs
- Aetna programs that may help you manage a condition
- Easy-to-understand health articles and tips

You can access Aetna SmartSource through Aetna Navigator®, or your Personal Health Record, if these tools are available to you.

HOW DO THE SAVINGS PLUS PLANS WORK?

THE AETNA SAVINGS PLUS PLANS† OFFER YOU ACCESS TO HEALTH SERVICES THAT FIT YOUR NEEDS AND BUDGET. THEY GIVE YOU ACCESS TO AN AFFORDABLE NETWORK OF HEALTH PROVIDERS IN YOUR OWN COMMUNITY.

The Aetna Savings Plus insurance plans provide you with the same types of coverage as other Aetna medical plans, but at a lower premium cost. Savings are generated by using the Savings Plus network, a network of local health care providers.

The plans also:

- cover doctor's visits, hospital stays and preventive care.
- include prescription drugs.
- provide access to a secure member self-service website.

Each Savings Plus plan has three levels of benefits:

- **Level 1:** when you use the Savings Plus network, you realize **maximum savings**.
- **Level 2:** when you use the non-designated network providers, you realize **standard savings.**
- **Level 3:** when you use out-of-network providers, you will pay the **highest member cost.**

You have the freedom to receive care from any hospital or specialist. However, you realize the highest benefit level and the lowest out-of-pocket costs when you access care through the Savings Plus network.

All Savings Plus plans include coverage for doctor visits, hospital stays, preventive care, pharmacy and more.

Premiums and out-of-pocket expense levels vary. So select the plan that's right for you and your family.

EXAMPLE

The following is an example* of what you might typically pay for each of the levels based on which network you choose.

	Maximum savings	Non-designated provider	Out-of-network provider
Cost of service	$1,750	$1,750	$1,750
Aetna's negotiated rate/ recognized amount	$1,000	$1,000	N/A
Amount covered by your plan (Aetna pays)	$800	$500	$500
Coinsurance (you pay)	$200	$500	$500
Amount that can be balance billed to you	$0	$0	$750
TOTAL COST YOU ARE RESPONSIBLE TO PAY	**$200**	**$500**	**$1,250**

* This is an example of how the Savings Plus plans work after a member meets their deductible.

†This plan provides preferred benefit coverage and access to covered services and supplies through a designated network of health care providers and facilities that are unique to your plan.

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THINGS YOU **NEED TO KNOW**

To qualify for an Aetna Advantage Plan, you must be:

- At least age 19 and under age 64 3/4 (If applying as a couple, both you and your spouse must be at least age 19 and under 64 3/4)
- Legal residents in a state with products offered by the Aetna Advantage Plans
- Legal U.S. residents for at least six continuous months

If you qualify for an Aetna Advantage Plan, we offer dependent coverage under your policy for dependent children up to age 26 (except in Florida, where dependent coverage is up to age 30; and in Ohio, where dependent coverage is up to age 28).

MEDICAL UNDERWRITING REQUIREMENTS

The Aetna Advantage Plans are not guaranteed issue plans and require medical underwriting. Some individuals may qualify as eligible under the Health Insurance Portability Accountability Act (HIPAA) for guaranteed issue plans.

All applicants, enrolling spouses and dependents are subject to medical underwriting to determine eligibility and appropriate premium rate level.

We offer various premium rate levels based on the medical underwriting of each applicant.

63.44.316.1 A (10/12)

10-DAY RIGHT TO REVIEW

Do not cancel your current insurance until you are notified that you have been accepted for coverage. We'll review your enrollment form or application to determine if you meet underwriting requirements. If your application or enrollment form is denied, you'll be notified by mail. If your application or enrollment form is approved, you'll be notified by mail and sent an Aetna Advantage Plan contract and ID card.

If, after reviewing the contract, you find that you're not satisfied for any reason, simply return the contract to us within 10 days. We will refund any premium you've paid (including any contract fees or other charges) less the cost of any medical or dental services paid on behalf of you or any covered dependent.

YOUR COVERAGE REMAINS IN EFFECT AS LONG AS YOU PAY THE REQUIRED PREMIUM CHARGES ON TIME, AND AS LONG AS YOU MAINTAIN ELIGIBILITY IN THE PLAN.

CONVENIENT PREMIUM PAYMENTS

You can make simple automatic payments via Electronic Funds Transfer (EFT) or by Visa, MasterCard or American Express credit cards.

Registration: Complete the payment section of the Aetna Advantage Plans enrollment form or application. Select the appropriate payment method (EFT or credit card) to approve the automatic withdrawal of your initial premium and all subsequent premium payments. (Please note: The initial premium payment is debited UPON APPROVAL of your application).

Invoices: You will not receive a paper invoice when you are enrolled in EFT. Payments will appear on your bank statement as "Aetna Autodebit Coverage."

Terminating: To terminate EFT or the automatic credit card payment option, Aetna requires 10 days written notice before the date your next scheduled payment is due to be processed. Without this written notice, your bank account or credit card may be debited for the next month's premium payment. You would then need to contact us to have a refund processed to your bank account or credit card.

Refunds: To process an EFT refund (placing money back in member's checking account), we need at least five days after the withdrawal was made to ensure valid payment. Credit card refunds will be returned to the credit card charged within 3-5 business days from the date it is processed.

Rejected transactions: If the EFT (checking account) or credit card payment rejects for any reason, we will send you a letter requesting corrected information. If we receive corrected information, you will have the full amount due debited on the next billing cycle. If you fail to send corrected information, we will continue to attempt to debit your bank account or charge your credit card for the full amount due. Failure to supply correct account information may result in your policy being terminated for non-payment.

Timing: Please note the following dates when automatic payments are processed:

- Payments for Cycle 1 accounts (1st of the month effective date):
  - EFT (checking accounts) will be debited between the 3rd and 10th of each month the premium is due.
  - Credit Cards will be debited between the 5th and 12th of each month the premium is due.
- Payments for Cycle 2 accounts (15th of the month effective date):
  - EFT (checking accounts) will be debited between the 18th and 23rd of each month the premium is due.
  - Credit Cards will be debited between the 20th and 25th of each month the premium is due.

YOUR COVERAGE

Your coverage remains in effect as long as you pay the required premium charges on time, and as long as you maintain eligibility in the plan. Coverage will be terminated if you become ineligible due to any of the following circumstances:

- Non-payment of premiums
- Becoming a resident of a state or location in which Aetna Advantage Plans are not available
- Obtaining duplicate coverage
- For other reasons permissible by law

Levels of coverage and enrollment

These plans are subject to medical underwriting. To the extent that you are subject to medical underwriting, the following may occur once we have evaluated your application or enrollment form:

- You may be enrolled in your selected plan at the lowest rate available (known as the standard premium charge)
- You may be enrolled in your selected plan at a higher premium
- You may be declined coverage (except for dependents under age 19)

Duplicate coverage

If you are currently covered by another carrier, you must agree to discontinue the other coverage before or on the effective date of the Aetna Advantage Plan. However, do not cancel your current insurance until you are notified that you have been accepted for coverage and are certain that you are keeping your Aetna Advantage Plan coverage.

LIMITATIONS & EXCLUSIONS

Medical

These medical plans do not cover all health care expenses and include exclusions and limitations. You should refer to your plan documents to determine which health care services are covered and to what extent.

The following is a partial list of services and supplies that are generally not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s). Services and supplies that are generally not covered include, but are not limited to:

- All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents, including costs of services before coverage begins and after coverage terminates
- Cosmetic surgery
- Custodial care
- Donor egg retrieval
- Infertility services and other related reproductive services unless specifically listed as covered in your plan documents
- Over-the-counter medications and supplies
- Weight control services including surgical procedures for the treatment of obesity, medical treatment, and weight control/loss programs
- Experimental and investigational procedures, (except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial)
- Charges in connection with pregnancy care other than for pregnancy complications (unless otherwise mandated by your state)
- Immunizations for travel or work
- Implantable drugs and certain injectable drugs including injectable infertility drugs
- Orthotics
- Radial keratotomy or related procedures
- Reversal of sterilization
- Services, supplies or counseling related to the treatment of sexual dysfunction
- Special or private duty nursing
- Therapy or rehabilitation other than those listed as covered in the plan documents
- Mental health and substance abuse coverage (unless otherwise mandated by your state)

Dental

Listed below are some of the charges and services for which our dental plans do not provide coverage.
For a complete list of exclusions and limitations, refer to plan documents.

- Dental services or supplies that are primarily used to alter, improve or enhance appearance (negotiated rates for cosmetic procedures may be available when a participating dentist is accessed)
- Experimental services, supplies or procedures
- Treatment of any jaw joint disorder, such as temporomandibular joint disorder
- Replacement of lost or stolen appliances and certain damaged appliances
- Services that Aetna defines as not necessary for the diagnosis, care or treatment of a condition involved
- All other limitations and exclusions in your plan documents

PRE-EXISTING CONDITIONS

For Applicants 19 and older: During the first 12 months* following your effective date of coverage, no coverage will be provided for the treatment of a pre-existing condition unless you have prior creditable coverage.

A pre-existing condition is an illness, disease, physical condition, or injury for which medical advice, or treatment was recommended or received and/or the use of prescription drugs of any kind within six months preceding the effective date of coverage. Services or supplies for the treatment of a pre-existing condition are not covered for the first 12 months after the member's effective date. If the member had continuous prior creditable coverage within the 63 days** immediately preceding the signature on the application and meets certain other requirements, then the pre-existing condition exclusion of 12 months* may not apply.

* Six months in California
** 90 days in Alaska; 120 days in Connecticut

WANT TO MAKE THE MOST OF YOUR MONEY? **THE MORE YOU KNOW, THE BETTER IT GETS.**

Compare and save with the Member Payment Estimator

Before thinking about health care services, you should know what they will cost. With this tool, you can find out what you'll be paying, what you're getting and what you can expect when you have office visits or tests. By planning ahead, you can get the most from your money.

No matter where you are or what time of day, we've designed helpful and practical tools to make your life a little easier. It's what we call people care.

- Review costs for tests and procedures by type and locations
- See cost details based on your health insurance plan, including copays and deductibles
- Access the comparison feature so you can shop around
- Get ready for your upcoming procedure with helpful advice

Explore a smarter health plan.
Visit us at **www.aetna.com**.

IMPORTANT
INFORMATION ABOUT YOUR HEALTH BENEFITS AND HEALTH INSURANCE

FOR OPEN CHOICE PPO PLANS AND THESE AETNA OPEN ACCESS® PLANS: OPEN ACCESS MANAGED CHOICE, AND HEALTH NETWORK OPTION.

UNDERSTANDING YOUR PLAN OF BENEFITS

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

TO OHIO MEMBERS

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

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

After you enroll, most of the information in this booklet applies to all plans. But some does not. For example, not all plans have deductibles or prescription drug benefits. Information about those topics will only apply if your plan includes those provisions.

State-specific information throughout this booklet does not apply to all plans. To be sure, review your plan documents, or call Aetna Member Services.

WHERE TO FIND INFORMATION ABOUT YOUR SPECIFIC PLAN

Your plan documents list all the details for your plan, such as what's covered, what's not covered and the specific amounts you will pay for services. Plan document names vary. They may include a Certificate of Coverage or Policy and/or any inserts, riders and updates. If you can't find your plan documents, call Member Services to ask for a copy. Use the toll-free number on your Aetna ID card.

GETTING HELP

CONTACT US

After you enroll, Member Services can help with your questions. To contact Member Services, call the toll-free number on your ID card. You can also send Member Services an e-mail. Just go to your secure Aetna Navigator® member website at **www.aetna.com**. Click on "Contact Us" after you log on.

Member Services can help you:

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

IN THIS DOCUMENT

* Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies. Health benefits and health insurance plans are provided, underwritten or administered by Aetna Health Inc. and/or Aetna Life Insurance Company.

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HELP FOR THOSE WHO SPEAK ANOTHER LANGUAGE AND FOR THE HEARING IMPAIRED

Do you need help in another language? Member Services representatives can connect you to a special line where you can talk to someone in your own language. You can also get interpretation assistance for registering a complaint or appeal.

Language hotline – **1-888-982-3862** *(140 languages are available. You must ask for an interpreter.)*
TDD **1-800-628-3323** *(hearing impaired only)*

Ayuda para las personas que hablan otro idioma y para personas con impedimentos auditivos
¿Necesita ayuda en otro idioma? Los representantes de Servicios al Miembro le pueden conectar a una línea especial donde puede hablar con alguien en su propio idioma. También puede obtener asistencia de un intérprete para presentar una queja o apelación.

Línea directa: **1-888-982-3862** *(Tenemos 140 idiomas disponibles. Debe pedir un intérprete.)*

TDD **1-800-628-3323** *(sólo para personas con impedimentos auditivos)*

SEARCH OUR NETWORK FOR DOCTORS, HOSPITALS AND OTHER HEALTH CARE PROVIDERS

It's important to know who is in our network. Some plans only let you go in network. Some plans let you go out of network. But, most of the time you pay less when you visit doctors, hospitals, labs and other health care providers who are in our network.

Here's how you can find out if your health care provider is in our network.

- Log on to your secure Aetna Navigator member website at **www.aetna.com**. Follow the path to find a doctor and enter your doctor's name in the search field.
- Call us at the toll-free number on your Aetna ID card. If you don't have your card you can call us at **1-888-87-AETNA (1-888-872-3862).**

For up-to-date information about how to find inpatient and outpatient services, partial hospitalization and other behavioral health care services, please follow the instructions above. If you do not have Internet access and would like a printed list of providers, please contact Member Services at the toll-free number on your Aetna ID card to ask for a copy.

Our online directory is more than just a list of doctor's names and addresses. It also includes information about where the physician attended medical school, board certification status, language spoken, gender and more. You can even get driving directions to the office. If you don't have Internet access, you can call Member Services to ask about this information.

Not every health care provider who participates in the Aetna network will be accepting new patients. Although we have identified those providers who were not accepting patients as known to us at the time the listing was created, the status of the physician's practice may have changed. For the most current information about the status of any physician's practice, please contact either the selected physician or call Member Services at the toll-free number listed on your ID card.

If you live in **Georgia**, you can call toll-free at **1-800-223-6857** to confirm that the preferred provider in question is in the network and/or accepting new patients.

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

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

For more information on your health plan, call Member Services at **1-800-208-8755** or refer to your plan documents.

COSTS AND RULES FOR USING YOUR PLAN

WHAT YOU PAY

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

- Copay – A fixed amount (for example, $15) you pay for a covered health care service. 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 percent (for example, 20%) of the allowed amount for the service. For example, if the health plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health plan pays the rest of the allowed amount.
- Deductible – 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 some preventive services, such as an annual physical or mammogram. Other deductibles may apply at the same time:
    - 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.

YOUR COSTS WHEN YOU GO OUTSIDE THE NETWORK

Network-only plans
Open Access HMO and Health Network Only plans are network-only plans. That means the plan covers health care services only when provided by a doctor who participates in the Aetna network. If you receive services from an out-of-network doctor or other health care provider, you will have to pay all of the costs for the services.

Plans that cover out-of-network services
With Open Choice, Health Network Option, Open Access Managed Choice and Aetna Choice POS plan, you may choose a doctor in our network. You may choose to visit an out-of-network doctor.

We cover the cost of care based on if the provider (such as a doctor or hospital), is "in network" or "out of network." We want to help you understand how much Aetna pays for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this care. We will use examples for a doctor.

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 a lot more money out of your own pocket if you choose to use an out-of-network doctor.

"In network" – This means we have a contract with that doctor. He agrees to how much he will charge you for covered services. That amount is often less than what he would charge you if he was not in our network. Most of the time it costs you less to use doctors in our network.

Most plans pay a higher percentage of the bill if you stay in network. The doctor agrees he won't bill you for any amount over his contract rate. All you have to pay is your coinsurance or copayments, along with any deductible. Your network doctor will handle any precertification required by your plan.

"Out of network" means that 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 a lot more money out of your own pocket if you choose to use an out-of-network doctor.

Your out-of-network doctor or hospital sets the rate to charge you. It may be higher — sometimes much higher — than what your Aetna plan "recognizes" or "allows." Your doctor may bill you for the dollar amount that Aetna doesn't "recognize." You must also pay any 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 Aetna allows for a service or procedure.

How we pay doctors who are not in our network

When you choose to see an out-of-network doctor, hospital or other health care provider, Aetna pays for your health care using "prevailing or reasonable" charge obtained from an industry database; a rate based on what Medicare would pay for that service; or a local market fee set by Aetna. Your plan will state which method is used.

This way of paying out-of-network doctors and hospitals applies when you choose to get care out of network. See "Emergency and urgent care and care after office hours" for more.

Going in network just makes sense

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

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

PRECERTIFICATION: GETTING APPROVALS FOR SERVICES

Sometimes we will pay for care only if we have given an approval before you get it. We call that "precertification." Precertification is usually limited to more serious care like surgery or being admitted to a hospital or skilled nursing facility. When you get care from a doctor in the Aetna network, your doctor takes care of precertification. But if you get your care outside our network, you must call us for precertification when that's required. Your plan documents list all the services that require you to get the precertification. If you don't, you will have to pay for all or a larger share of the cost of the service. Even with precertification, if you receive services from an out-of-network provider, you will usually pay more.

Call the number shown on your Aetna ID card to begin the process. You must get the approval before you receive the care.

Precertification is not required for emergency services.

What we look for when reviewing a precertification 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. 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.

Precertification does not, however, verify if you have reached any plan dollar limits or visit maximums for the service requested. That means precertification is not a guarantee that the service will be covered.

YOU NEVER NEED REFERRALS WITH OPEN ACCESS PLANS

As an Aetna Open Access plan member, you never need a referral from your regular doctor to see a specialist. You also do not need to select a primary care provider (PCP), but we encourage you to do so to help you navigate the health care system. Regardless, some states require us to tell you about certain open access benefits. Be assured that all of your benefits are "open access," including the following:

Direct Access Chiropractor and Podiatrist

In **Florida**, you have direct access to a participating primary care chiropractic and podiatric provider of your choice and do not need a referral from your PCP to access these benefits covered under your health benefits plan.

Direct Access Dermatologist

In **Florida**, you have direct access to a participating primary care dermatologist provider of your choice and do not need a referral from your PCP to access these benefits covered under your health benefits plan.

Routine Vision Care

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

Other benefits for members in Georgia

Female members have direct access to the participating primary Ob/Gyn provider of their choice and do not need a referral from their PCP for a routine well-woman exam, including a Pap smear when appropriate and an unlimited number of visits for gynecologic problems and follow-up care.

You have direct access to the participating dermatologist provider of your choice and do not need a referral from your primary care physician(s) to access dermatologic benefits covered under your health plan.

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

FILING CLAIMS IN OKLAHOMA

Aetna participating doctors and other health care providers in the Aetna network will file claims for you. Out-of-network doctors generally do not. If you need to file a claim, you can download and print a claim form at **www.aetna.com/individuals-families-healthinsurance/document-library/find-documentform. html**. You can also call Member Services at the number on your ID card to ask for a form. The claim form includes complete instructions including what documentation to send with it.

Aetna determines how and whether a claim is paid based on the terms and conditions of the health coverage plan and our internal coverage policies. See section "Knowing what is covered" to learn more about coverage policies.

INFORMATION ABOUT SPECIFIC BENEFITS

EMERGENCY AND URGENT CARE AND CARE AFTER OFFICE HOURS

An emergency medical condition means your symptoms are sudden and severe. This means that a person with average medical knowledge could expect that if you don't get medical treatment right away, you could risk your health or die. 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 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 precertification.

How we cover out-of-network emergency care

You are covered for emergency and urgently needed care. You have this coverage while you are traveling or if you are near your home. That includes students who are away at school. When you need care right away, go to any doctor, walk-in clinic, urgent care center or emergency room.

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.

Your plan pays out-of-network benefits when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident), 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. Under federal health care reform (Affordable Care Act), the government will allow some plans an exception to this rule.

Contact Aetna if your provider asks you to pay more. We will help you determine if you need to pay that bill.

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.

PRESCRIPTION DRUG BENEFIT

Some plans encourage generic drugs over brand-name drugs

A generic drug is the same as a brand-name drug in dose, use and form. They are FDA approved and safe to use.

Generic drugs usually sell for less; so many plans give you incentives to use generics. That doesn't mean you can't use a brand-name drug, but you'll pay more for them. You'll not only pay your normal share of the cost, 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 list shows which prescription drugs are covered on a preferred basis. It also explains how we choose medications to be on the list.

When you get a drug that is not on the preferred drug list, you usually will pay more. Check your plan documents to see how much you will pay. If your plan has an "open formulary," that means you can use those drugs, but you'll pay the highest copay under the plan. If your plan has a "closed formulary," those drugs are not covered.

Drug Manufacturer Rebates

Drug manufacturers may give us rebates when our members buy certain drugs. While those rebates for the most part apply to drugs on the Preferred Drug List, they may also apply to drugs not on the Preferred Drug List. But, in any case, in plans where you pay a percent of the cost, your share of the cost is based on the price of the drug before any rebate is received by Aetna.

In plans where you pay a percent of the cost instead of a flat dollar amount, you may pay more for a drug on the Preferred Drug List than for a drug not on the list.

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

Aetna Rx Home Delivery and Aetna Specialty Pharmacy are pharmacies that Aetna owns. These pharmacies are for-profit entities.

You might not have to stick to the list

If it is medically necessary for you to use a drug that's not on your plan's preferred drug list, you or your doctor (or pharmacist in the case of antibiotics and pain medicines) can ask us to make an exception. Check your plan documents for details.

You may have to try one drug before you can try another

Step therapy means you have to try one or more "prerequisite" drugs before a "step-therapy" drug will be covered. The preferred drug list includes step-therapy drugs. Your doctor might want you to skip one of these drugs for medical reasons. If so, you or your doctor (or pharmacist in the case of antibiotics and pain medicines) can ask for a medical exception.

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 or your doctor may have to get our approval to use one of these new drugs.

Get a copy of the preferred drug list

The Aetna Preferred Drug Guide is posted to our website at **www.aetna.com/formulary/**. If you don't use the Internet, you can ask for a printed copy. Just call Member Services at the toll-free number on your Aetna ID card. We are constantly adding new drugs to the list. Look online or call Member Services for the latest updates.

Have questions? Get answers

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

BEHAVIORAL HEALTH AND SUBSTANCE ABUSE BENEFITS

With Open Access HMO and Health Network Only plans, you must use behavioral health professionals who are in the Aetna network. With all other plans, you can use any licensed behavior health provider, in or out of the Aetna network.

Here's how to get behavioral health services

- Emergency services – call 911.
- Call the toll-free Behavioral Health number on your Aetna ID card.
- If no other number is listed, call Member Services.
- If you're using your employer's or school's EAP program, the EAP professional can help you find a behavioral health specialist.

If you access a behavioral health professional who is not in the Aetna network, you are responsible for getting any required precertification. You can access most outpatient therapy services without precertification. However, you should first consult Member Services to confirm that any such outpatient therapy services do not require precertification.

Read about behavioral health provider safety

We want you to feel good about using the Aetna network for behavioral health services. Visit **www.aetna.com/docfind** and click the "Get info on Patient Safety and Quality" link. No Internet? Call Member Services instead. Use the toll-free number on your Aetna ID card to ask for a printed copy.

Behavioral health programs to help prevent depression

Aetna Behavioral Health offers two prevention programs for our members:

- **Beginning Right® Depression Program:** Perinatal Depression Education, Screening and Treatment Referral and
- **SASDA:** Identification and Referral of Substance Abuse Screening for Adolescents with Depression and/or Anxiety Prevention

For more information on either of these prevention programs and how to enroll in the programs, ask Member Services for the phone number of your local Care Management Center.

BREAST RECONSTRUCTION BENEFITS

Notice Regarding Women's Health and Cancer Rights Act

Under this health plan, as required by the Women's Health and Cancer Rights Act of 1998, coverage will be provided to a person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy for:

(1) all stages of reconstruction of the breast on which a mastectomy has been performed;

(2) surgery and reconstruction of the other breast to produce a symmetrical appearance;

(3) prostheses; and

(4) treatment of physical complications of all stages of mastectomy, including lymph edemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be provided in accordance with the plan design, limitations, copays, deductibles, and referral requirements, if any, as outlined in your plan documents.

If you have any questions about our coverage of mastectomies and reconstructive surgery, please contact the Member Services number on your ID card.

For more information, you can visit this U.S. Department of Health and Human Services website, **www.cms.hhs.gov/HealthInsReformforConsume/06_TheWomen'sHealthandCancerRightsAct.asp** and the U.S. Department of Labor at: **www.dol.gov/ebsa/consumer_info_health.html.**

Oklahoma Breast Cancer Patient Protection Act

The Oklahoma Breast Cancer Patient Protection Act requires Aetna health plans to provide the following benefits:

- A member receiving benefits for a medically necessary mastectomy will be provided coverage for not less than 48 hours of inpatient care following the mastectomy, unless the attending physician in consultation with the member determines that a shorter period of hospital stay is appropriate.
- A member receiving benefits for a lymph node dissection for the treatment of breast cancer will be provided coverage for not less than 24 hours of inpatient care following the lymph node dissection, unless the attending physician in consultation with the member determines that a shorter hospital stay is appropriate.
- A member receiving benefits for a medically necessary partial or total mastectomy will be provided coverage for reconstructive breast surgery performed as a result of the mastectomy, except as prohibited by federal laws or regulations pertaining to Medicaid. When such reconstructive surgery is performed on a diseased breast, coverage will be provided for all stages of reconstructive surgery performed on a nondiseased breast to establish symmetry with the diseased breast, provided that the reconstructive surgery and any adjustments made to the nondiseased breast must occur within 24 months of reconstruction of the diseased breast.

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.

KNOWING 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. 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. It also has to 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 deny coverage if the reason is medical necessity. We do not give financial incentives or otherwise to Aetna employees for denying coverage.

Sometimes the review of medical necessity is handled by a physicians' group. 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 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.

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 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 Health Care Research and Quality.
- Ask experts.
- Check how often and how successfully it has been used.

We publish our decisions in our Clinical Policy Bulletins.

WE POST OUR FINDINGS ON WWW.AETNA.COM

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

CPBs tell if we view a product or service as medically necessary. They also help us decide whether to approve a coverage request. But your plan may not cover everything that 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** 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 particular product or service.

WE CAN HELP WHEN MORE SERIOUS CARE IS SUITABLE

In certain cases, we review a request for coverage to be sure the service or supply is consistent with established guidelines. Then we follow up. We call this "utilization management review."

It's a three step process:

First, we begin this process if your hospital stay lasts longer than what was approved. We verify that it is necessary for you to still be in the hospital. We look at the level and quality of care you are getting.

Second, we begin planning your discharge. This process can begin at any time. We look to see if you may benefit from any of our programs. We might have a nurse case manager follow your progress. Or we might recommend that you try a wellness program after you get back home.

Third, after you are home, we may review your case. We may look over your medical records and claims from your doctors and the hospital. We look to see that you got appropriate care. We also look for waste or unnecessary costs.

We follow specific rules to help us make your health a top concern:

- Aetna employees are not compensated based on denials of coverage.
- We do not encourage denials of coverage. In fact, our utilization review staff is trained to focus on the risks of members not adequately using certain services.

Where such use is appropriate, our Utilization Review/Patient Management staff uses nationally recognized guidelines and resources, such as The Milliman Care Guidelines® to guide these processes. When provider groups, such as independent practice associations, are responsible for these steps, they may use other criteria that they deem appropriate.

WHAT TO DO IF YOU DISAGREE WITH US

COMPLAINTS, APPEALS AND EXTERNAL REVIEW

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

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

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

If you don't agree with a denied claim, you can file an appeal. To file an appeal, follow the directions in the letter or explanation of benefits statement that explains that your claim was denied. The letter also tells you what we need from you and how soon we will respond.

Get a review from someone outside Aetna
In some cases, you can ask for an outside review if you're not satisfied after going through our internal appeals process. Follow the instructions on our response to your appeal. Call Member Services to ask for an External Review Form or log on to **www.aetna.com/individualsfamilies-health-insurance/member-guidelines/ ext_review.html.**

Most claims are allowed to go to external review. An exception would be if you are denied because you're no longer eligible for the plan.

If your case qualifies, an Independent Review Organization (IRO) will assign it to an outside expert. The expert will be a doctor or other professional who specializes in that area or type of dispute. You should have a decision within 45 calendar days of the request.

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

A "rush" review may be possible

If your doctor thinks you cannot wait 45 days, ask for an "expedited review." That means we will make our decision more quickly.

MEMBER RIGHTS & RESPONSIBILITIES

KNOW YOUR RIGHTS AS A MEMBER

You have many legal rights as a member of a health plan. You also have many responsibilities. You have the right to suggest changes in our policies and procedures, 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-healthinsurance/ member-guidelines/member-rights.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 "advanced directive" tells your family and doctors what to do when you can't tell them yourself. You don't need an advanced directive to receive care. But you have the right to create one. Hospitals may ask if you have an advanced directive when you are admitted.

There are three types of advanced 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 advanced directive in several ways:

- Ask your doctor for an advanced directive form.
- 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 advanced directive.
- Create an advanced directive using computer software designed for this purpose.

*Source: American Academy of Family Physicians. Advanced Directives and Do Not Resuscitate Orders. September 2010. Available at **http://familydoctor.org/online/famdocen/home/pat-advocacy/endoflife/003 html**. Accessed December 6, 2010.*

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/individuals-familieshealth- insurance/member-guidelines/health-carequality.html**. You can also call Member Services to ask for a printed copy.

WE PROTECT YOUR PRIVACY

We consider your personal information to be private. Our policies help us protect your privacy. By "personal information," we mean information about your physical condition, the health care you receive and what your health care costs. Personal information does not include what is available to the public. For example, anyone can find out what your health plan covers or how it works. It also does not include summarized reports that do not identify you.

Below is a summary of our privacy policy. For a copy of our actual policy, go to **www.aetna.com**. You'll find the "Privacy Notices" link at the bottom of the page. You can also write to:

Aetna Legal Support Services Department
151 Farmington Avenue, W121
Hartford, CT 06156

Summary of the Aetna privacy policy

We have policies and procedures in place to protect your personal information from unlawful use and disclosure. We may share your information to help with your care or treatment and administer our health plans and programs. We use your information internally, share it with our affiliates, and we may disclose it to:

- Your doctors, dentists, pharmacies, hospitals and other caregivers
- Those who pay for your health care services. That can include health care provider organizations and employers who fund their own health plans or who share the costs.
- Other insurers
- Third-party administrators
- Vendors
- Consultants
- Government authorities and their respective agents

These parties must also keep your information private. Doctors in the Aetna network must allow you to see your medical records within a reasonable time after you ask for them.

Some of the ways we use your personal information include:

- Paying claims
- Making decisions about what to cover
- Coordinating payments with other insurers
- Preventive health, early detection, and disease and case management

We consider these activities key for the operation of our health plans. We usually will not ask if it's okay to share your information unless the law requires us to. We will ask your permission to disclose personal information if it is for marketing purposes. Our policies include how to handle requests for your information if you are unable to give consent.

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
- All other laws that protect your rights to receive health care

HOW WE USE INFORMATION ABOUT YOUR RACE, ETHNICITY AND THE LANGUAGE YOU SPEAK

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

YOUR RIGHTS TO ENROLL LATER IF YOU DECIDE NOT TO ENROLL NOW

When you lose your other coverage

You might choose not to enroll now because you already have health insurance. You may be able to enroll later if you lose that other coverage. This includes enrolling your spouse or children and other dependents. If that happens, you must apply within 31 days after your coverage ends.

When you have a new dependent

Getting married? Having a baby? A new dependent changes everything. And you can change your mind. 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.

Getting proof that you had previous coverage

Sometimes when you apply for health coverage, the insurer may ask for proof that you were covered before. This helps determine if you are eligible for their plan. Ask us for a Certificate of Prior Health Coverage anytime you want to check the status of your coverage. If you lost your coverage, you have 24 months to make this request. Just call Member Services at the toll-free number on your ID card.

CONSUMER CHOICE OPTION FOR GEORGIA MEMBERS

The Consumer Choice Option is available for Georgia residents enrolled in certain Aetna managed care plans. Under this benefits option, with certain restrictions required by law and an additional monthly premium cost, members of certain Aetna managed care plans may nominate an out-of-network provider to provide covered services for themselves and their covered family members. Your benefits and any applicable copayments will be the same as for in-network providers. The out-of-network provider must agree to accept the Aetna compensation, to adhere to the plan's quality assurance requirements, and to meet all other reasonable criteria required by the plan of its in-network participating providers. It is possible the provider you nominate will not agree to participate.

NONDISCRIMINATION FOR GENETIC TESTING

Aetna will not in any way use the results of genetic testing to discriminate against applicants or enrollees.

OTHER RIGHTS BY STATE

Illinois

Illinois law requires health plans to provide the following information each year to enrollees and to prospective enrollees upon request:

- A complete list of participating health care providers in the health care plan's service area
- A description of the following terms of coverage:

1. The service area
2. The covered benefits and services with all exclusions, exceptions and limitations
3. The precertification and other utilization review procedures and requirements
4. A description of the process for the selection of a PCP, any limitation on access to specialists, and the plan's standing referral policy
5. The emergency coverage and benefits, including any restrictions on emergency care services
6. The out-of-area coverage and benefits, if any
7. The enrollee's financial responsibility for copayments, deductibles, premiums, and any other out-of-pocket expenses
8. The provisions for continuity of treatment in the event a health care provider's participation terminates during the course of an enrollee's treatment by the provider
9. The appeals process, forms, and time frames for health care services appeals, complaints, and external independent reviews, administrative complaints, and utilization review complaints, including a phone number to call to receive more information from the health care plan concerning the appeals process
10. A statement of all basic health care services and all specific benefits and services to be provided to enrollees by a state law or administrative rule

- A description of the financial relationship between the health plan and any health care provider, including, if requested, the percentage of copayments, deductibles, and total premiums spent on health care related expenses and the percentage of copayments, deductibles and total premiums spent on other expenses, including administrative expenses.

Kansas

Kansas law permits you to have the following information upon request:

1. A complete description of the health care services, items and other benefits to which the insured is entitled in the particular health plan that is covering or being offered to such person
2. A description of any limitations, exceptions or exclusions to coverage in the health benefits plan, including prior authorization policies, restricted drug formularies or other provisions that restrict access to covered services or items by the insured
3. A listing of the plan's participating providers, their business addresses and telephone numbers, their availability, and any limitation on an insured's choice of provider
4. Notification in advance of any changes in the health benefit plan that either reduces the coverage or benefits or increases the cost to such person
5. A description of the grievance and appeal procedures available under the health benefits plan and an insured's rights regarding termination, disenrollment, nonrenewal or cancellation of coverage

If you are a member, contact Member Services by calling the toll-free number on your ID card to request additional information.

North Carolina

Procedures and medically based criteria for determining whether a specified procedure, test or treatment is experimental, are available upon request.

SCALP HAIR PROSTHESIS

(applies only to the states listed below)

In AK, AZ, DC, DE, IL, IN, MO, OH, PA, TN, AND VA , Aetna will provide coverage for expenses for a scalp hair prosthesis worn for hair loss suffered as a result of alopecia areata, resulting from an autoimmune disease. The same limitations and guidelines that apply to other prosthesis as outlined in your Benefit Plan will apply to scalp hair prosthesis as a result of alopecia areata.

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 listing of health plans and their NCQA status can be found on the NCQA website located at reportcard.ncqa.org.

To refine your search, we suggest you search these areas: **Managed Behavioral Healthcare Organizations** – for behavioral health accreditation; **Credentials Verification Organizations** – for credentialing certification; **Health Insurance Plans** – for HMO and PPO health plans; **Physician and Physician Practices** – for physicians recognized by NCQA in the areas of heart/stroke care, diabetes care, back pain and medical home. Providers who have been duly recognized by the NCQA Recognition Programs are annotated in the provider listings section of this directory.

Providers, in all settings, achieve recognition by submitting data that demonstrates 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. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice.

Aetna does not provide care or guarantee access to health services. For up-to-date information, please visit our DocFind® directory at **www.aetna.com** or, if applicable, visit the NCQA's new top-level recognition listing at **recognition.ncqa.org**.

I ALWAYS NEED SOME INCENTIVE TO GET IN SHAPE. WHAT CAN YOU OFFER ME?

A fit body is a healthier body. Aetna can help you stay in shape. Access the Aetna Fitness℠ discount program and you'll receive preferred rates on gym memberships as well as discounts on at-home weight loss programs, home fitness options, and one-on-one health coaching services through GlobalFit™.

So get ready to start exercising — and feeling good.

With these savings, it's a great time to join the Fitness Program from Aetna.

Explore a smarter health plan. Visit us at **www.aetna.com**.

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Aetna has been in business for more than 150 years.

In 2010, for the third year in a row, Aetna was named the most admired health care insurance company by *Fortune* magazine.*

* *Fortune* magazine, March 22, 2010, March 16, 2009, and March 17, 2008

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