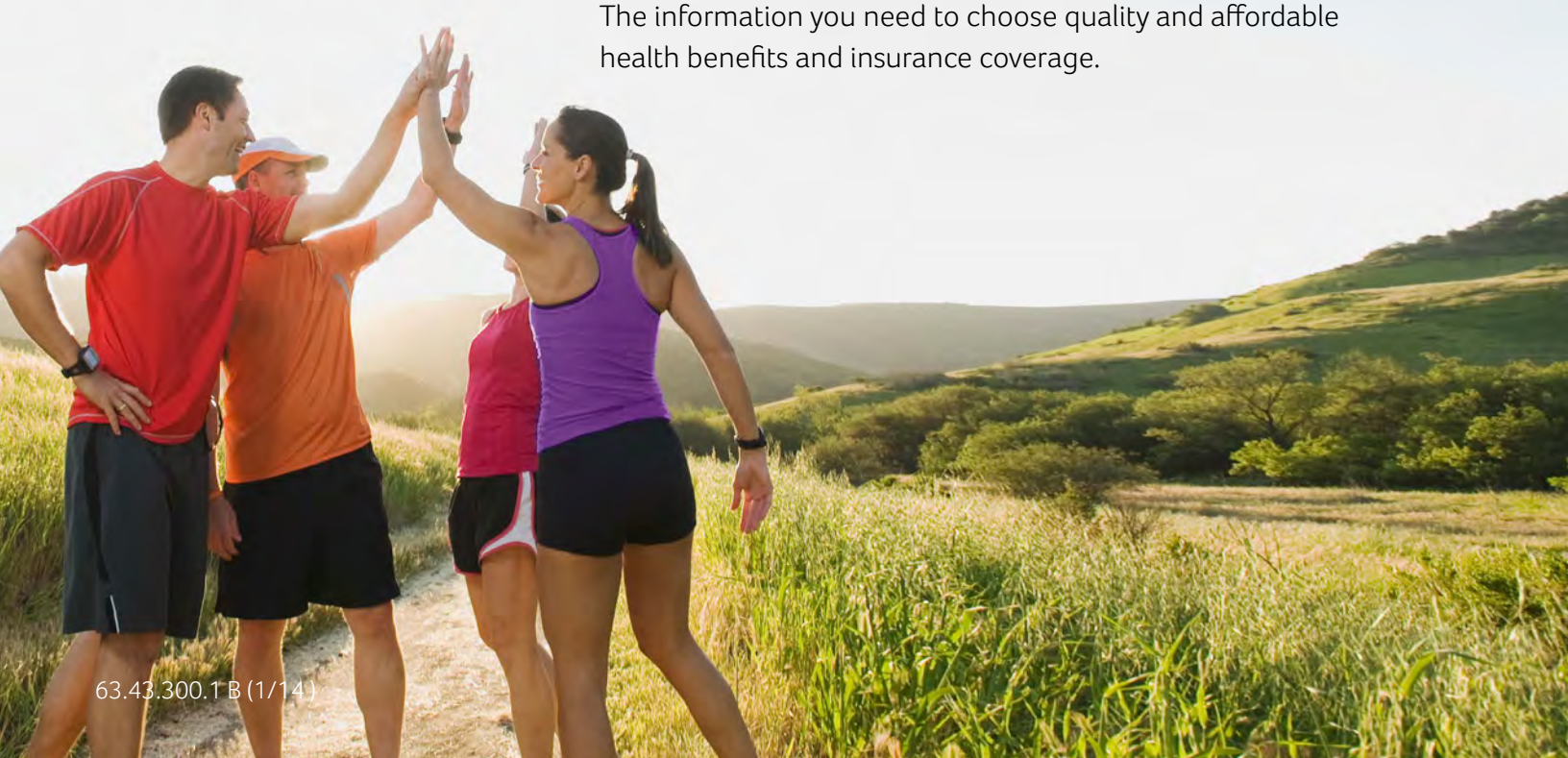
Quality health plans & benefits
Healthier living
Financial well-being
Intelligent solutions

aetna®

Take charge of your health

Choose Aetna, choose affordable coverage

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



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First things first. Is my doctor covered?

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

- Just visit **http://www.aetnaindividualdocfind.com** to find the doctors and hospitals you trust most.

Thank you for your interest in Aetna Health Plans

We know how important it is for you to make the right choice. This packet contains helpful tools and important tips to consider along the way. Or, if you prefer, you can call us.

We're here to help

Call **1-866-336-8253 (TTY: 711).**
We're available 8 a.m. to 10 p.m. local time, Monday through Friday.

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Shouldn't your plan give YOU the advantage?

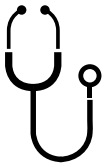
Your care is important to us. We know there are few things more important than making the best choice for your health coverage. That's why every plan we provide begins with a simple question: "What's your healthy?"SM

We want you to have a positive health care experience. So let's get started with what matters most:

150 years

Your confidence

Aetna has been in business for more than 150 years. We strive to direct our business–and our industry–toward more simple and honest services.



Your doctors

Our goal is to provide you with quality health care at an affordable price. And we have tools to help you find your doctor (or a new doctor in your area) who will help you get the most out of your benefits.

Your prescriptions

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

Your way

Good news – your way begins with choice. We have plans to meet your needs and offer you more control over how you manage your health: whether by phone, online, in print or in person.

For 2014 benefits, the open enrollment period is October 1, 2013 through March 31, 2014. If you miss this window, you must wait until the next open enrollment period, unless you qualify for an exception.

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What does that mean?

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

For a full, "A-Z" listing, visit **http://www.planforyourhealth.com**.
Under "Tools & Resources," select "Glossary."*

Coinsurance

The portion of the cost of covered medical services you pay under a health plan, after first meeting any applicable plan deductible.

Copayment

A set dollar amount or portion that you pay for your medical services. Usually, copays start after you first pay any plan deductible. Copays may differ by type of service.

Deductible

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

Exclusions and limitations

Specific conditions or circumstances that aren't covered under a plan.

Out-of-pocket maximum

The limit on the amount an individual is required to pay for health care services that his/her benefits plan covers.

Premiums

The amount a health insurer charges for a health insurance policy. If you have a health plan through your employer, you and your employer may share this cost. If you buy a health plan yourself, you pay the full amount.

Pre-existing condition

A condition, disability or illness (physical or mental) that you had before you signed up for a health plan.

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

We're here to help

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

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 enrollment process.

Online

Go to **http://www.aetna.com/ individuals-families-health- insurance/ buy-insurance/ exchange/index.htm** for easy ways to find the plan that is best for you.

By phone

Call us toll-free at **1-866-336-8253 (TTY: 711).**
We're available from 8 a.m. to 10 p.m. local time, Monday through Friday.

What happens next?

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

Material name	Description	Delivery
What comes next	This will let you know how to pay your first monthly payment to activate your coverage.	
Welcome	This welcome letter will let you know when to expect your member ID card and plan documents. We'll also tell you how to register for Aetna Navigator®, access discount programs and other helpful tips.	
Quick start guide	This will remind you to register for Aetna Navigator®, download our mobile app and let you know how to talk to a registered nurse. It also includes your member ID card and a copy of our privacy notice.	
Doctor visit	See your doctor to take advantage of the annual health care services available to you.	
Plan documents (Certificate of Coverage, etc.)	Think of this as your owner's manual. It includes important information about how to use your plan, what's covered and how benefits are paid. It also tells you who to call if you have questions.	

Questions?

Call us toll-free at **1-866-336-8253 (TTY: 711).**

We're available from 8 a.m. to 10 p.m. local time, Monday through Friday. Or visit us at **http://www.aetna.com/individuals-families-health-insurance/buy-insurance/exchange/index.html.**

Top reasons to choose Aetna

Robust coverage, competitive costs

We offer health insurance plans with valuable features, which include an excellent combination of quality coverage and competitively priced premiums. Most plans also include:

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

Our goal is to provide you with quality health care at an affordable price. And we have tools to help you find your doctor (or a new doctor in your area) that will help you get the most out of your benefits.

Walk-in clinics

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

E-visits

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

Family coverage

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

*Referrals are required for HMO plans in Pennsylvania and all plans in New Jersey.

13.02.365.1 (1/14)

Get more from your plan

◄ **Scan to watch a video about our discount program. It offers you savings on fitness, weight management, books, vision, hearing and so much more.**

You want to look and feel your best for many years to come. So give yourself a healthy advantage and use discounts available to you through our plans. Or visit **http://go.aetna.com/IndvDiscountProgram**

Discount programs are not insurance, and program features are not guaranteed under the plan contract and may be discontinued at any time. The member is responsible for the full cost of the discounted services. Discount programs are in addition to any plan benefits and may require a separate charge to access such programs. Discounts offered hereunder are not insurance.

Health care reform — What you need to know

Since President Obama signed the Affordable Care Act (ACA), we have periodically updated the Aetna Health Plans for Individuals, Families and the Self-Employed to include any necessary changes.

Be assured–your Aetna Health Plan will always meet the federal health care reform legislation requirements.

Gear up for 2014—it's an important year

In 2014, major parts of the law will be put into place, and your own coverage may be affected. The ACA will bring more, required benefits to all new health plans.

Quick facts about health care reform

- Beginning in 2014, most people must have insurance or potentially pay a penalty
- Preventive care (including immunizations) provided without cost share, including enhanced coverage of women's preventive health benefits
- Coverage will include Essential Health Benefits
- Subsidies and tax credits available for some through the Exchanges to help cover monthly payments
- No annual or lifetime limits on Essential Health Benefits
- No pre-existing condition exclusions
- Public exchanges ("online Marketplaces" where you can compare/buy a plan)
- Only four criteria determine rates you pay
- Young adults up to age 26 can stay on parents' plan

Learn more about health care reform

Visit

http://www.aetna.com/health-reform-connection/index.html

Save money — use Aetna's provider network

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

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

How our network helps you save

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

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

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

How much you can save

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

Find doctors and hospitals in the network

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

Visit **http://www.aetna.com/individuals-families-health-insurance/buy-insurance/exchange/index.html,** and select "Find a Doctor," or call **1-866-336-8253 (TTY: 711),** and ask for provider information.

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*** **

View more examples on the following page.

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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*** **

* Doctors, hospitals and other health care providers in the Aetna network accept our payment rate and agree that you owe only your copay, coinsurance and deductible.

** When you go out of network, the plan determines a recognized amount. You may be responsible for the difference between the billed amount and the recognized amount. See your plan documents for details. Your plan may instead call the recognized amount the recognized charge.

*** Most plans cap out-of-pocket costs for covered services. The deductible and coinsurance you owe count toward that cap. But when you go outside the network, the difference between the health care provider's bill and the recognized amount does not count toward that cap.

† You also may be responsible for a portion of fees charged by the facility in which the surgery takes place. The figures in the example do not include those facility fees.

Costs for out-of-network doctors and hospitals

People are paying more of their health care costs these days. It's no wonder there is a lot of interest in keeping these costs down.

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

Why out-of-network costs more

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

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

Cost sharing is more

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

Out-of-network rates are higher

- An out-of-network doctor sets the rate to charge you. It is usually higher than the amount your Aetna plan "recognizes" or "allows."
- An out-of-network doctor can bill you for anything over the amount that Aetna recognizes or allows. This is called "balance billing." A network doctor has agreed not to do that.
- We do not base our payments on what the out-of-network doctor bills you. We do not know in advance what the doctor will charge.

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Deductibles are separate, higher

- What you pay when you are balance billed does not count toward your deductible. And it is not part of any cap your plan has on how much you have to pay for covered services.
- Many plans have a separate out-of-network deductible. This is usually higher than your in-network deductible. (Sometimes, you have no deductible at all for care in the network.) You must meet the out-of-network deductible before your plan pays any out-of-network benefits.

You'll have more work, too

Plus, when you visit an out-of-network doctor, you handle precertification, or preapproval of some health care services, if needed. This means more time and more paperwork for you.

Emergency care is covered

You're covered for emergency care. You have this coverage while you're traveling or at home. This includes students who are away at school. Detailed information can be found in the disclosure section of this packet.

Know your costs before you go

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

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Your Aetna catastrophic plan option

Catastrophic plans generally have lower monthly payments, and recommended preventive services are covered at 100 percent. Catastrophic plans are only available if you qualify, based on the information you provide when you apply for insurance.

Featuring:

- Aetna Basic

The Basic Plan is a catastrophic plan offering. Unlike metal-level coverage, only individuals age 30 and under, or individuals for whom insurance is determined to be unaffordable as evidenced by a hardship exemption, are eligible to enroll in this catastrophic plan.

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Aetna Basic

Aetna Health Plan options in Texas

Catastrophic

Aetna is a Qualified Health Plan issuer in the Texas Health Insurance Exchange.

Member benefits	In network	Out of network+
Deductible individual/ family (applies toward out of pocket maximum, includes pharmacy)	$6,350/$12,700	$12,700/$25,400
Member coinsurance	0%	50%
Out-of-pocket maximum individual/family (maximum you will pay for all covered services)	$6,350/$12,700	$15,000/$30,000
Primary care visit	$20 copay, deductible waived for visits 1-3, thereafter 0% after deductible	50% after deductible
Specialist visit	0% after deductible	50% after deductible
Hospital stay	0% after deductible	50% after deductible
Outpatient surgery	0% after deductible	50% after deductible
Emergency room	0% after deductible	
Urgent care	0% after deductible	50% after deductible
Preventive care/ screening/immunization	$0 copay, deductible waived	50% after deductible, 0% for Immunizations, deductible waived
Annual routine gyn exam (annual pap/mammogram)	$0 copay, deductible waived	50% after deductible
Diagnostic lab	0% after deductible	50% after deductible
Diagnostic X-ray	0% after deductible	50% after deductible
Imaging (CT/PET scans, MRIs)	0% after deductible	50% after deductible
Vision		
Adult and pediatric eye exam (1 visit per year)*	0% after deductible	50% after deductible
Pediatric glasses/contacts (1 pair lenses and frames OR contacts per year)*	0% after deductible	50% after deductible
Pediatric dental		
Dental checkup/ preventive dental care (2 visits per year)*	Not covered	Not covered
Basic dental care	Not covered	Not covered
Major dental care	Not covered	Not covered
Orthodontia (medically necessary only)	Not covered	Not covered

Pharmacy	In network	Out of network+
Pharmacy deductible	Integrated with medical	Integrated with medical
Preferred generic drugs	0% after deductible	50% after deductible
Preferred brand drugs	0% after deductible	50% after deductible
Preferred specialty drugs	0% after deductible	50% after deductible
Nonpreferred drugs (including nonpreferred specialty drugs)	0% after deductible	50% after deductible

*Any applicable benefit maximums are combined in and out of network.

+ For important information on your costs and how Aetna pays for out-of-network care, read "Costs for out-of-network doctors and hospitals."

Aetna Health Plans for Individuals, Families and the Self-Employed are underwritten by Aetna Life Insurance Company (Aetna). In some states, individuals may qualify as a business group of one and may be eligible for guaranteed issue, small group health plans.

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13.06.311.1-TX (1/14)

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Healthier living
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Your Aetna bronze plan options

Bronze-level plans pay for about 60 percent of covered health care costs. They tend to have lower monthly payments, but you will pay more for your deductible, copayments and coinsurance.

Featuring:

- Aetna Advantage 6350
- Aetna Advantage 5750 PD
- Aetna AdvantagePlus 5500 PD

Aetna Advantage 6350

Aetna Health Plan options in Texas

Bronze

Aetna is a Qualified Health Plan issuer in the Texas Health Insurance Exchange.

Member benefits	In network	Out of network+
Deductible individual/ family (applies toward out of pocket maximum, includes pharmacy)	$6,350/$12,700	$12,700/$25,400
Member coinsurance	0%	50%
Out-of-pocket maximum individual/family (maximum you will pay for all covered services)	$6,350/$12,700	$15,000/$30,000
Primary care visit	$20 copay, deductible waived for visits 1-3, thereafter 0% after deductible	50% after deductible
Specialist visit	0% after deductible	50% after deductible
Hospital stay	0% after deductible	50% after deductible
Outpatient surgery	0% after deductible	50% after deductible
Emergency room	0% after deductible	
Urgent care	0% after deductible	50% after deductible
Preventive care/ screening/immunization	$0 copay, deductible waived	50% after deductible, 0% for Immunizations, deductible waived
Annual routine gyn exam (annual pap/mammogram)	$0 copay, deductible waived	50% after deductible
Diagnostic lab	0% after deductible	50% after deductible
Diagnostic X-ray	0% after deductible	50% after deductible
Imaging (CT/PET scans, MRIs)	0% after deductible	50% after deductible
Vision		
Adult and pediatric eye exam (1 visit per year)*	0% after deductible	50% after deductible
Pediatric glasses/contacts (1 pair lenses and frames OR contacts per year)*	Preferred glasses/ contacts - $0 copay, deductible waived; nonpreferred glasses/contacts - 0% after deductible	50% after deductible
Pediatric dental		
Dental checkup/ preventive dental care (2 visits per year)*	Not covered	Not covered
Basic dental care	Not covered	Not covered
Major dental care	Not covered	Not covered
Orthodontia (medically necessary only)	Not covered	Not covered

Pharmacy	In network	Out of network+
Pharmacy deductible	Integrated with medical	Integrated with medical
Preferred generic drugs	0% after deductible	50% after deductible
Preferred brand drugs	0% after deductible	50% after deductible
Preferred specialty drugs	0% after deductible	50% after deductible
Nonpreferred drugs (including nonpreferred specialty drugs)	0% after deductible	50% after deductible

*Any applicable benefit maximums are combined in and out of network.

+ For important information on your costs and how Aetna pays for out-of-network care, read "Costs for out-of-network doctors and hospitals."

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13.06.311.1-TX (1/14)

Aetna Advantage 5750 PD

Aetna Health Plan options in Texas

Bronze

Aetna is a Qualified Health Plan issuer in the Texas Health Insurance Exchange.

Member benefits	In network	Out of network+
Deductible individual/family (applies toward out of pocket maximum, includes pharmacy)	$5,750 / $11,500	$11,500 / $23,500
Member coinsurance	0%	50%
Out-of-pocket maximum individual/family (maximum you will pay for all covered services)	$6,350 / $12,700	$12,700 / $25,400
Primary care visit	$20 copay, deductible waived	50% after deductible
Specialist visit	$40 copay after deductible	50% after deductible
Hospital stay	$100 copay per admit after deductible	50% after deductible
Outpatient surgery	$100 copay after deductible	50% after deductible
Emergency room (copay waived if admitted)	$250 copay after deductible	
Urgent care	$60 copay, deductible waived	50% after deductible
Preventive care/screening/immunization	$0 copay, deductible waived	50% after deductible, 0% for Immunizations, deductible waived
Annual routine gyn exam (annual pap/mammogram)	$0 copay, deductible waived	50% after deductible
Diagnostic lab	0% after deductible	50% after deductible
Diagnostic X-ray	$100 copay after deductible	50% after deductible
Imaging (CT/PET scans, MRIs)	$250 copay after deductible	50% after deductible
Vision		
Adult and pediatric eye exam (1 visit per year)*	$0 copay, deductible waived	50% after deductible
Pediatric glasses/contacts (1 pair lenses and frames OR contacts per year)*	Preferred glasses/contacts - $0 copay, deductible waived; nonpreferred glasses/contacts - 50% after deductible	50% after deductible
Pediatric dental		
Dental checkup/preventive dental care (2 visits per year)*	$0 copay, deductible waived	$0 copay, deductible waived
Basic dental care	30% after deductible	30% after deductible
Major dental care	50% after deductible	50% after deductible
Orthodontia (medically necessary only)	50% after deductible	50% after deductible

Pharmacy	In network	Out of network+
Pharmacy deductible	Integrated with medical	Integrated with medical
Preferred generic drugs	$10 copay, deductible waived	50% after $10 copay, deductible waived
Preferred brand drugs	$75 copay after deductible	50% after $75 copay after deductible
Preferred specialty drugs	$250 copay after deductible	50% after $250 copay after deductible
Nonpreferred drugs (including nonpreferred specialty drugs)	50% after deductible	50% after deductible

*Any applicable benefit maximums are combined in and out of network.

+ For important information on your costs and how Aetna pays for out-of-network care, read "Costs for out-of-network doctors and hospitals."

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13.06.311.1-TX (1/14)

Aetna AdvantagePlus 5500 PD

Aetna Health Plan options in Texas

Bronze

Aetna is a Qualified Health Plan issuer in the Texas Health Insurance Exchange.

Member benefits	In network	Out of network+
Deductible individual/ family (applies toward out of pocket maximum, includes pharmacy)	$5,500/$11,000	$11,000/$22,000
Member coinsurance	10%	50%
Out-of-pocket maximum individual/family (maximum you will pay for all covered services)	$6,350/$12,700	$12,700/$25,400
Primary care visit	10% after deductible	50% after deductible
Specialist visit	10% after deductible	50% after deductible
Hospital stay	10% after deductible	50% after deductible
Outpatient surgery	10% after deductible	50% after deductible
Emergency room	10% after deductible	
Urgent care	10% after deductible	50% after deductible
Preventive care/ screening/immunization	$0 copay, deductible waived	50% after deductible, 0% for Immunizations, deductible waived
Annual routine gyn exam (annual pap/mammogram)	$0 copay, deductible waived	50% after deductible
Diagnostic lab	10% after deductible	50% after deductible
Diagnostic X-ray	10% after deductible	50% after deductible
Imaging (CT/PET scans, MRIs)	10% after deductible	50% after deductible
Vision		
Adult and pediatric eye exam (1 visit per year)*	10% after deductible	50% after deductible
Pediatric glasses/ contacts (1 pair lenses and frames OR contacts per year)*	Preferred glasses/ contacts - 0% after deductible; nonpreferred glasses/ contacts - 50% after deductible	50% after deductible
Pediatric dental		
Dental checkup/ preventive dental care (2 visits per year)*	0% after deductible	0% after deductible
Basic dental care	30% after deductible	30% after deductible
Major dental care	50% after deductible	50% after deductible
Orthodontia (medically necessary only)	50% after deductible	50% after deductible

Pharmacy	In network	Out of network+
Pharmacy deductible	Integrated with medical	Integrated with medical
Preferred generic drugs	10% after deductible	50% after deductible
Preferred brand drugs	50% after deductible	50% after deductible
Preferred specialty drugs	50% after deductible, not to exceed a $500 copay per prescription	50% after deductible, not to exceed a $500 copay per prescription
Nonpreferred drugs (including nonpreferred specialty drugs)	50% after deductible	50% after deductible

*Any applicable benefit maximums are combined in and out of network.

+ For important information on your costs and how Aetna pays for out-of-network care, read "Costs for out-of-network doctors and hospitals."

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13.06.311.1-TX (1/14)

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

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Your Aetna silver plan options

Silver-level plans pay for about 70 percent of covered health care costs. They tend to have higher monthly payments compared to bronze plans, but you will pay less for your deductible, copayments and coinsurance.

Featuring:

- Aetna Classic 5000
- Aetna Classic 3500 PD

Aetna Classic 5000

Aetna Health Plan options in Texas

Silver

Aetna is a Qualified Health Plan issuer in the Texas Health Insurance Exchange.

Member benefits	In network	Out of network+
Deductible individual/family (applies toward out of pocket maximum)	$5,000/$10,000	$10,000/$20,000
Member coinsurance	30%	50%
Out-of-pocket maximum individual/family (maximum you will pay for all covered services)	$6,350/$12,700	$12,700/$25,400
Primary care visit	$30 copay, deductible waived	50% after deductible
Specialist visit	$60 copay, deductible waived	50% after deductible
Hospital stay	30% after deductible	50% after deductible
Outpatient surgery	30% after deductible	50% after deductible
Emergency room (copay waived if admitted)	$400 copay, deductible waived	
Urgent care	$60 copay, deductible waived	50% after deductible
Preventive care/ screening/immunization	$0 copay, deductible waived	50% after deductible, 0% for Immunizations, deductible waived
Annual routine gyn exam (annual pap/mammogram)	$0 copay, deductible waived	50% after deductible
Diagnostic lab	$30 copay, deductible waived	50% after deductible
Diagnostic X-ray	$60 copay, deductible waived	50% after deductible
Imaging (CT/PET scans, MRIs)	30% after deductible	50% after deductible
Vision		
Adult and pediatric eye exam (1 visit per year)*	$0 copay, deductible waived	50% after deductible
Pediatric glasses/contacts (1 pair lenses and frames OR contacts per year)*	Preferred glasses/ contacts - $0 copay, deductible waived; nonpreferred glasses/contacts - 50% after deductible	50% after deductible
Pediatric dental		
Dental checkup/ preventive dental care (2 visits per year)*	Not covered	Not covered
Basic dental care	Not covered	Not covered
Major dental care	Not covered	Not covered
Orthodontia (medically necessary only)	Not covered	Not covered

Pharmacy	In network	Out of network+
Pharmacy deductible individual/family (combined in and out of network)	$500/$1,000	
Preferred generic drugs	$10 copay, deductible waived	50% after $10 copay, deductible waived
Preferred brand drugs	$60 copay after deductible	50% after $60 copay after deductible
Preferred specialty drugs	50% after deductible, not to exceed a $500 copay per prescription	50% after deductible, not to exceed a $500 copay per prescription
Nonpreferred drugs (including nonpreferred specialty drugs)	50% after deductible	50% after deductible

*Any applicable benefit maximums are combined in and out of network.

+ For important information on your costs and how Aetna pays for out-of-network care, read "Costs for out-of-network doctors and hospitals."

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13.06.311.1-TX (1/14)

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Aetna Classic 3500 PD

Aetna Health Plan options in Texas

Silver

Aetna is a Qualified Health Plan issuer in the Texas Health Insurance Exchange.

Member benefits	In network	Out of network+
Deductible individual/family (applies toward out of pocket maximum)	$3,500/$7,000	$7,000/$14,000
Member coinsurance	20%	50%
Out-of-pocket maximum individual/family (maximum you will pay for all covered services)	$6,350/$12,700	$12,700/$25,400
Primary care visit	$30 copay, deductible waived	50% after deductible
Specialist visit	$60 copay, deductible waived	50% after deductible
Hospital stay	20% after deductible	50% after deductible
Outpatient surgery	20% after deductible	50% after deductible
Emergency room (copay waived if admitted)	$400 copay, deductible waived	
Urgent care	$60 copay, deductible waived	50% after deductible
Preventive care/ screening/immunization	$0 copay, deductible waived	50% after deductible, 0% for Immunizations, deductible waived
Annual routine gyn exam (annual pap/mammogram)	$0 copay, deductible waived	50% after deductible
Diagnostic lab	$30 copay, deductible waived	50% after deductible
Diagnostic X-ray	$60 copay, deductible waived	50% after deductible
Imaging (CT/PET scans, MRIs)	20% after deductible	50% after deductible
Vision		
Adult and pediatric eye exam (1 visit per year)*	$0 copay, deductible waived	50% after deductible
Pediatric glasses/contacts (1 pair lenses and frames OR contacts per year)*	Preferred glasses/ contacts - $0 copay, deductible waived; nonpreferred glasses/contacts - 50% after deductible	50% after deductible
Pediatric dental		
Dental checkup/ preventive dental care (2 visits per year)*	$0 copay, deductible waived	$0 copay, deductible waived
Basic dental care	30% after deductible	30% after deductible
Major dental care	50% after deductible	50% after deductible
Orthodontia (medically necessary only)	50% after deductible	50% after deductible

Pharmacy	In network	Out of network+
Pharmacy deductible individual/family (combined in and out of network)	$500/$1,000	
Preferred generic drugs	$10 copay, deductible waived	50% after $10 copay, deductible waived
Preferred brand drugs	$60 copay after deductible	50% after $60 copay after deductible
Preferred specialty drugs	50% after deductible, not to exceed a $500 copay per prescription	50% after deductible, not to exceed a $500 copay per prescription
Nonpreferred drugs (including nonpreferred specialty drugs)	50% after deductible	50% after deductible

*Any applicable benefit maximums are combined in and out of network.

+ For important information on your costs and how Aetna pays for out-of-network care, read "Costs for out-of-network doctors and hospitals."

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13.06.311.1-TX (1/14)

Quality health plans & benefits
Healthier living
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Your Aetna gold plan option

Gold-level plans pay for about 80 percent of covered health care costs. They tend to have higher monthly payments but you will pay less for your deductible, copayments and coinsurance.

Featuring:

- Aetna Premier 2000 PD

Aetna Premier 2000 PD

Aetna Health Plan options in Texas

Gold

Aetna is a Qualified Health Plan issuer in the Texas Health Insurance Exchange.

Member benefits	In network	Out of network+
Deductible individual/family (applies toward out of pocket maximum)	$2,000/$4,000	$4,000/$8,000
Member coinsurance	30%	50%
Out-of-pocket maximum individual/family (maximum you will pay for all covered services)	$4,500/$9,000	$9,000/$18,000
Primary care visit	$10 copay, deductible waived	50% after deductible
Specialist visit	$30 copay, deductible waived	50% after deductible
Hospital stay	30% after deductible	50% after deductible
Outpatient surgery	30% after deductible	50% after deductible
Emergency room (copay waived if admitted)	$250 copay, deductible waived	
Urgent care	$60 copay, deductible waived	50% after deductible
Preventive care/screening/immunization	$0 copay, deductible waived	50% after deductible, 0% for Immunizations, deductible waived
Annual routine gyn exam (annual pap/mammogram)	$0 copay, deductible waived	50% after deductible
Diagnostic lab	$0 copay, deductible waived	50% after deductible
Diagnostic X-ray	$10 copay, deductible waived	50% after deductible
Imaging (CT/PET scans, MRIs)	30% after deductible	50% after deductible
Vision		
Adult and pediatric eye exam (1 visit per year)*	$0 copay, deductible waived	50% after deductible
Pediatric glasses/contacts (1 pair lenses and frames OR contacts per year)*	Preferred glasses/contacts - $0 copay, deductible waived; nonpreferred glasses/contacts - 50% after deductible	50% after deductible
Pediatric dental		
Dental checkup/preventive dental care (2 visits per year)*	$0 copay, deductible waived	$0 copay, deductible waived
Basic dental care	30% after deductible	30% after deductible
Major dental care	50% after deductible	50% after deductible
Orthodontia (medically necessary only)	50% after deductible	50% after deductible

Pharmacy	In network	Out of network+
Pharmacy deductible individual/family (combined in and out of network)	$500 /$1,000	
Preferred generic drugs	$4 copay, deductible waived	50% after $4 copay, deductible waived
Preferred brand drugs	$50 copay after deductible	50% after $50 copay after deductible
Preferred specialty drugs	50% after deductible, not to exceed a $500 copay per prescription	50% after deductible, not to exceed a $500 copay per prescription
Nonpreferred drugs (including nonpreferred specialty drugs)	50% after deductible	50% after deductible

*Any applicable benefit maximums are combined in and out of network.

+ For important information on your costs and how Aetna pays for out-of-network care, read "Costs for out-of-network doctors and hospitals."

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

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Tell us, what's your healthy℠?

◄ Scan to watch a video and see what we're doing to help you live a healthier life.

Learn what's important and get solutions you can count on.

Then continue the conversation at **http://go.aetna.com/WhatsYourHealthy**

Rating areas*

Texas

Due to changes related to health care reform, the federal government redefined rating areas. This list of rating areas shows where Aetna Health Plans are available in your state. Just look for your county in one of the area listings below.

Your rates will depend on the area in which your county is located. For more information, call your broker or **1-866-336-8253.**

Area 3

Bastrop
Caldwell
Hays
Travis
Williamson

Area 4

Hardin
Jefferson
Orange

Area 8

Collin
Dallas
Denton
Ellis
Parker
Rockwall
Tarrant

Area 10

Austin
Brazoria
Chambers
Fort Bend
Galveston
Harris
Liberty
Montgomery
San Jacinto
Waller

Area 11

Bell
Coryell
Lampasas

Area 19

Atascosa
Bandera
Bexar
Comal
Guadalupe
Kendall
Medina
Wilson

Area 24

McLennan

Area 26

Burnet
Colorado
Falls
Fayette
Jasper
Lee
Limestone
Llano
Matagorda
Palo Pinto
Tyler
Wharton

13.02.359.1-TX (1/14)

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

Language access services:

Kung kailangan ninyo ang tulong sa Tagalog tumawag sa **1-866-336-8253**.

Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' **1-866-336-8253**.

如果需要中文的帮助，请拨打这个号码 **1-866-336-8253**.

Para obtener asistencia en Español, llame al **1-866-336-8253**.

We're here to help

To get help in another language, call **1-866-336-8253**.

Eligibility and requirements

Eligibility and requirements: What you need to know

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

- A resident of the state in which you are applying and a state in which we offer coverage
- Legal U.S. resident

We offer dependent coverage up to age 26, with some state exceptions. In Ohio, we offer dependent coverage up to age 28; in Florida, up to age 30; and in New York, up to age 26, with an option to purchase more coverage to age 30.

Convenient monthly payments

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

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

You can also pay your monthly payment with most major credit cards. To learn more, visit **www.aetna.com** and select "Individuals & Families."

Your coverage

Your coverage stays in effect as long as you pay the required monthly payment on time, and as long as you are eligible in the plan. Coverage will end if you become ineligible due to any of the following circumstances:

- Not paying your monthly bill
- Becoming a resident of a state or location in which Aetna Health Plans aren't available
- Getting duplicate coverage
- Other reasons that the law allows

Levels of coverage and enrollment

These plans are subject to the final rating factors applicable in your state.

- 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 monthly payment due to age, where you live and tobacco use, if applicable in your state.

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Limitations and exclusions

Medical

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

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

Pediatric dental*

These medical plans don't cover all pediatric dental care expenses and include limitations and exclusions. Please refer to your plan documents to see which services we cover. The following is a partial list of services and supplies that we generally don't cover. However, your plan documents may have exceptions to this list. We base these documents on state laws, essential health benefits, or the plan design or rider(s) you buy.

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

* Not all plans sold on Exchanges include coverage for pediatric dental care. Please refer to your plan documents to confirm coverage.

Important information about your health benefits

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

Understanding your plan of benefits

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

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

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

Most of the information in this booklet applies to all plans. But some does not. For example, not all plans have deductibles. Also, some plans do not require referrals and you may not need to pick a primary care physician (PCP). Information about those topics will only apply if the plan includes those rules.

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 the plan you choose. This includes what's covered, what's not covered and what you will pay for services. Plan document names vary. They may include a Schedule of Benefits, Certificate of Coverage, Group Agreement, Group Insurance Certificate, Group Insurance Policy and/or any riders and updates that come with them.

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

Getting help

Contact us

Member Services can help with your questions. To contact Member Services, call the toll-free number on your ID card. Or, call **1-800-US-Aetna (1-800-872-3862)** Monday through Friday, 7 a.m. to 7 p.m. ET. 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 in.

Member Services can help you:

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

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

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

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

*Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies. Aetna Health Plans for Individuals, Families and the Self-Employed are underwritten by Aetna Life Insurance Company (Aetna). In some states, individuals may qualify as a business group of one and may be eligible for guaranteed issue, small group health plans. Health Network Option plans are offered, underwritten and/or administered by Aetna Health Inc., Aetna Health Insurance Company and/or Aetna Life Insurance Company.

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Ayuda para personas que hablan otro idioma y 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 de idiomas: **1-888-982-3862** *(Tenemos 140 idiomas disponibles. Debe pedir un intérprete.)* **TDD 1-800-628-3323** *(solo para personas con impedimentos auditivos)*

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

It's important to know which doctors are in our network. That's because some health plans only let you visit doctors, hospitals and other health care providers if they are in our network. Some plans allow you to go outside the network. But, you pay less when you visit doctors in the network.

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

- Log in 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, or call us at **1-888-87-AETNA (1-888-872-3862)**

For up-to-date information about how to find health care services, please follow the instructions above. If you would like a printed list of doctors, contact Member Services at the toll-free number on your Aetna ID card.

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

- Where the physician attended medical school
- Board certification status
- Language spoken
- Gender
- And more

You can even get driving directions to the office. If you don't have Internet access, call Member Services to ask about this information.

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.

Provider networks improve care while lowering costs

Members who receive care from providers from value-based arrangements are participating in a network designed to improve care while lowering costs. These networks may be set up in different ways, but all include primary care doctors and specialists. They also typically include at least one hospital.

Like most plans, we usually pay doctors and hospitals on a fee-for-service basis. This means your doctor or hospital still gets paid for each visit. However, the value-based network's mission is to better coordinate patient care to improve efficiency, quality, and patient satisfaction.

We agree with the featured network on certain goals,* such as:

- Clinical performance goals – completing enough screenings for cancer, diabetes and cholesterol
- Cost-efficiency goals – reducing the number of "avoidable" ER visits, short-term hospital stays, repetitive tests and the overall cost of care

We pay these value-based networks more when they meet certain goals. The amount of these payments depends on how well the network meets their goals. The network may also have to make payments to us if they fail to meet their financial goals.

In most of our arrangements, we will reward the network financially for both efficient care and higher quality of care. This helps encourage savings that are tied to value and better health outcomes for our members.

Doctor and hospitals that are members of a value-based (accountable care) network may have their own financial arrangements through the network itself. Ask your doctor for details.

Choose a doctor the fast and easy way with DocFind®. Simply log on to your secure Aetna Navigator® website at **www.aetna.com** and select "Find a Doctor, Pharmacy or Facility". After entering your search criteria, look for the ACO logo Ⓐ. If you need a printed directory instead, call the Member Services phone number on your member ID card.

*The specific goals will vary from network to network.

Costs and rules for using your plan

What you pay

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

- Copay – a set amount (for example, $15) you pay for covered health care service. You usually pay this when you get the service. The amount can vary by the type of service. For example, you may pay a different amount to see a specialist than you would pay to see your family doctor.

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

- Deductible – the amount you owe for health care services before your health plan begins to pay. For example, if your deductible is $1,000, you have to pay the first $1,000 for covered services before the plan begins to pay. You may not have to pay for some services. 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 don't get a referral or 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 we will pay for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this care. The following are examples for when you see a doctor:

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

"Out of network" means we do not have a contract 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 much higher than what your Aetna plan "recognizes" or "allows." Your doctor may bill you for the dollar amount that your plan doesn't "recognize." You must also pay any copayments, coinsurance and deductibles that apply. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket limits.

This means you are fully responsible for paying everything above the amount we allow 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, we pay for your care using a "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.

See "Emergency and urgent care and care after office hours" for more information.

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.

You never need referrals with open access plans

As an Aetna Open Access or PPO 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:

Florida

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

Georgia

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

North Carolina

Ob/Gyn – Any female member 13 years or older may visit any participating gynecologist 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.

Tennessee

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

Precertification: Getting approvals for services

Sometimes we will pay for care only if we have given an approval before you get it. We call that "precertification." You usually only need precertification for more serious care like surgery or being admitted to a hospital. When you get care from a doctor in the Aetna network, your doctor gets precertification from us. 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 precertification. If you don't, you will have to pay for all or a larger share of the cost for the service. Even with precertification, you will usually pay more when you use out-of-network doctors.

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

You do not have to get precertification for emergency services.

What we look for when reviewing a request

First, we check to see that you are still a member. And we make sure the service is considered medically necessary for your condition. We also make sure the service and place requested to perform the service are cost effective. We may suggest a different treatment or place of service that is just as effective but costs less. We also look to see if you qualify for one of our case management programs. If so, one of our nurses may contact you.

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

Filing claims in Oklahoma

Aetna participating doctors and other health care providers will file claims for you. However, you may need to file a claim for covered out-of-network services. You can download and print a claim form at **www.aetna.com/individuals-families-health-insurance/document-library/find-document-form.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.

We determine how and whether a claim is paid based on the terms and conditions of the health coverage plan and our internal coverage policies. See the "Knowing what is covered" section in this disclosure 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. If you don't get help right away, an average person with average medical knowledge will expect that you could die or risk your health. For a pregnant woman, that includes her unborn child.

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

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

We will review the information when a 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.

You could pay more when getting emergency care outside the network

Sometimes you don't have a choice about where you go for care. Like if you go to the emergency room for a heart attack. When you need emergency care, some of our plans pay the bill as if you got care in network. For those plans, you pay cost sharing and deductibles based on your in-network level of benefits. You do not have to pay anything else. Some of our plans pay differently. When you get emergency services out of our network, your plan typically will pay part of the bill. The plan's payment for emergency services is usually based on the rates Aetna pays health care providers in our network for those services in the area where you get the emergency care. Sometimes, the plan's payment is based on other methods, such as the local rate set by Medicare. You may be responsible for any amounts above what Aetna covers. Those additional amounts could be very large and would be in addition to your plan's cost sharing and deductibles.

To find out how emergency services are covered under your plan, look at your health plan document called "Certificate of Coverage" or "Summary Plan Description." Or contact us at the number on your member card.

Learn which in-network emergency care centers are in your area

You can avoid high out-of-pocket amounts by using hospitals and emergency care centers in our network. For a list in your local area, use our DocFind® search tool at **www.aetna.com**. Scroll down to "Find a Doctor, Dentist or Facility." You can also call Member Services at the toll-free number on your Aetna ID card. It's a good idea to know which local emergency care centers are in the network before you have an emergency.

Follow-up care for plans that require a PCP

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

After-hours care – available 24/7

Call your doctor when you have medical questions or concerns. Your doctor should have an answering service if you call after the office closes. You can also go to an urgent care center, which may have limited hours. To find a center near you, log in to **www.aetna.com** 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

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

Some plans encourage generic drugs over brand-name drugs

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

We may also encourage you to use certain drugs

Some plans encourage you to buy certain prescription drugs over others. The plan may even pay a larger share for those drugs. We list those drugs in the Aetna Preferred Drug Guide (also known as a "drug formulary"). This 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, your share of the cost will usually be more. Check your plan documents to see how much you will pay. You can use those drugs if your plan has an "open formulary," but you'll pay the highest copay under the plan. If your plan has a "closed formulary," those drugs are not covered.

Drug company rebates

Drug companies may give us rebates when our members buy certain drugs. We may share those rebates with your employer. Rebates usually apply to drugs on the preferred drug list. They may also apply to drugs not on the list. In plans where you pay a percent of the cost, your share of the cost is based on the price of the drug before Aetna receives any rebate. Sometimes, in plans where you pay a percent of the cost instead of a flat dollar amount, you may pay more for a drug on the preferred drug list than for a drug not on the list.

Mail-order and specialty-drug services from Aetna-owned pharmacies – Aetna Rx Home Delivery and Aetna Specialty Pharmacy

Mail-order and specialty drug services are from pharmacies that Aetna owns. These are for-profit pharmacies.

You might not have to stick to the list

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

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

Step therapy means you have to try one or more 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, someone helping you or your doctor can ask for a medical exception. Your pharmacist can also ask for an exception for antibiotics and pain medicines.

Some drugs are not covered at all

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

New drugs may not be covered

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

Get a copy of the preferred drug list

You can find the Aetna Preferred Drug Guide on our website at **www.aetna.com/formulary/**. You can also ask for a printed copy by calling 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 the number on your Aetna ID card to ask about how your plan pays for them. Your plan documents also spell out what's covered and what is not.

Mental health and addiction benefits

With Open Access HMO and Health Network Only plans, you must use therapists and other behavioral health professionals who are in the Aetna network. With all other plans, you can use any licensed behavioral health provider, in or out of the Aetna network. Here's how to get mental 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 mental health specialist.

Get information about using network therapists

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.

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.

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

Call Member Services for more information on either of these prevention programs. Ask for the phone number of your local Care Management Center.

Transplants and other complex conditions

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

Breast reconstruction benefits

Notice regarding 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:

- All stages of reconstruction of the breast on which a mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of all stages of mastectomy, including lymph edemas

We will talk to you and your doctor about these rules when we provide the coverage. We will also follow your plan design. For example, the following may apply to your breast reconstruction benefits as outlined in your plan design:

- Limitations
- Copays
- Deductibles
- Referral requirements

If you have any questions about this coverage, please contact the Member Services number on your ID card.

Also, you can visit the following websites for more information:

- U.S. Department of Health and Human Services – **http://cciio.cms.gov/programs/protections/WHCRA/whcra_factsheet.html**
- U.S. Department of Labor – **www.dol.gov/ebsa/consumer_info_health.html**

Oklahoma Breast Cancer Patient Protection Act

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

- For members who receive benefits for a medically necessary mastectomy the plan must also cover at least 48 hours of inpatient care after the mastectomy, unless the member and attending doctor determine that a shorter hospital stay is appropriate.
- For members who receive a lymph node dissection, the plan must cover at least 24 hours of inpatient care after the lymph node dissection, unless the member and attending doctor determine that a shorter hospital stay is appropriate.
- For members who receive benefits for a medically necessary partial or total mastectomy, the plan must cover reconstructive breast surgery performed as a result of the mastectomy, except as prohibited by federal laws or regulations pertaining to Medicaid. When the reconstructive surgery is performed on a diseased breast, the plan will cover all stages of reconstructive surgery performed on a nondiseased breast to establish symmetry with the diseased breast. Adjustments made to the nondiseased breast must occur within 24 months of reconstruction of the diseased breast.

Other state-mandated benefits

In Connecticut, an insurer may issue to a religious employer a policy that excludes coverage for infertility treatment that is contrary to the religious employer's beliefs. Some of these treatments may include:

- Ovulation induction (OI)
- Intrauterine insemination
- In-vitro fertilization (IVF)
- Embryo transfer
- Gamete intra-fallopian transfer (GIFT)
- Zygote intra-fallopian transfer (ZIFT)
- Low tubal ovum transfer
- Uterine embryo lavage

Knowing what is covered

You can avoid unexpected bills with a simple call to Member Services. Call the toll-free number on your ID card to find out what's covered before you receive the care.

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

We check if it's "medically necessary"

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

The product or service:

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

Only medical professionals can decide if a treatment or service is not medically necessary. We do not reward Aetna employees for denying coverage. Sometimes a physician's

group will determine medical necessity. Those groups might use different resources than we do.

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

We study the latest medical technology

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

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

- Read medical journals to see the research. We want to know how safe and effective it is.
- See what other medical and government groups say about it. That includes the federal Agency for Health Care Research and Quality.
- Ask experts.
- Check how often and how successfully it has been used.

We publish our decisions in our Clinical Policy Bulletins.

We post our findings on www.aetna.com

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

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

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

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

We can help when more serious care is recommended

We may review a request for coverage to be sure the service is in line with recognized 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 make sure it is necessary for you to 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're home.

Third, we may review your case after your discharge. 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:

- We do not reward Aetna employees for denying coverage.
- We do not encourage denials of coverage. In fact, we train staff to focus on the risks of members not getting proper care. Where such use is appropriate, our staff uses nationally recognized guidelines and resources, such as MCG (formerly Milliman Care Guidelines) to review claims. Physician's groups, such as independent practice associations, may use other resources 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 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 us to send your issue 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

If the denial is based on a medical judgment, you may be able to get an outside review if you're not satisfied with your appeal. Follow the instructions on our response to your appeal. Call Member Services to ask for an External Review Form. You can also visit **www.aetna.com**. Enter "external review" into the search bar.

You can get an outside review for most claims. If the reason for your denial is that you are no longer eligible for the plan, you may not be able to get an outside review.

Some states have a separate external review process. These state processes can vary from state to state. You may even need to pay a filing fee as part of the state mandated program.

If your state does not have a separate external review process, then you would follow the federal external review process. 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.

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

The outside reviewer's decision is final and binding; we will follow the outside reviewer's decision. 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 as soon as possible.

Member rights & responsibilities

Know your rights as a member

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

Some of your rights are below. We also publish a list of rights and responsibilities on our website. Visit **www.aetna.com**. Click on "Rights & Resources" on the home page 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 – names the person you want to make medical decisions for you
- Living will – spells out the type and extent of care you want to receive
- Do-not-resuscitate order – states that you don't want CPR if your heart stops or a breathing tube if you stop breathing

You can create an 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. January 2012. Available at http://familydoctor.org/familydoctor/en/healthcare-management/end-of-life-issues/advance-directives-and-do-not-resuscitate-orders.html. Accessed April 2, 2013.

Learn about our quality management programs

We make sure your doctor provides quality care for you and your family. To learn more about these programs, go to our website at **www.aetna.com**. Enter "commitment to quality" in the search bar. You can also call Member Services to ask for a printed copy. See the "Contact Us" section of this disclosure.

We protect your privacy

We consider personal information to be private. Our policies protect your personal information from unlawful use. By "personal information," we mean:

- Information about your physical or mental health
- Information about the health care you receive
- Information about what your health care costs

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

Summary of the Aetna Privacy Policy

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

- Your doctors, dentists, pharmacies, hospitals and other caregivers
- 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
- Vendors
- Government authorities
- Third party administrators

These parties are required to keep your information private as required by law.

Some of the ways in which we may use your information include:

- Paying claims
- Making decisions about what the plan covers
- Coordination of payments with other insurers
- Quality assessment
- Activities to improve our plans
- Audits

We consider these activities key for the operation of our health plans. If allowed by law, we usually will not ask if it's okay to use your information. However, we will ask for your permission to use your information for marketing purposes. We have policies in place if you are unable to give us permission to use your information. We are required to give you access to your information. You may also request corrections to your personal information. We must fulfill your requests within a reasonable amount of time.

If you'd like a copy of our privacy policy, call the toll-free number on your ID card or visit us at **www.aetna.com**.

Anyone can get health care

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

We must comply with these laws:

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

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 or if your employer stops contributing to the cost. This includes enrolling your spouse or children and other dependents. If that happens, you must apply within 31 days after your coverage ends (or after the employer stops contributing to the other coverage).

When you have a new dependent

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

- Marriage
- Birth
- Adoption
- Placement for adoption

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

Getting proof that you had previous coverage

We may ask for proof that you had previous coverage when you apply. Other insurers may do the same. This helps determine if you are eligible for the plan. Your plan sponsor may have contracted with us to issue a certificate. 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 – Georgia

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

It is possible the provider you nominate will not agree to participate. If the out-of-network provider you nominate agrees to participate, your benefits and any applicable copayments will be the same as for in-network providers. It will be available for an increased premium in addition to the premium you would otherwise pay. Your increased premium responsibility will vary depending on whether you have a single plan or family coverage, and on the type of insurance, riders, and coverage. Call **1-800-433-6917** for exact pricing and other information. Please have your Aetna member ID card available when you call.

Nondiscrimination for genetic testing

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

More information is available

Georgia

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

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 you are entitled in the particular health plan which is covering or being offered to you; (2) a description of any limitations, exceptions or exclusions to coverage in the health benefit plan, including prior authorization policies, restricted drug formularies or other provisions that restrict your access to covered services or items; (3) a listing of the plans' participating providers, their business addresses and telephone numbers, their availability, and any limitation on your choice of provider; (4) notification in advance of any changes in the health benefit plan that either reduces the coverage or increases the cost to you; and (5) a description of the grievance and appeal procedures available under the health benefit plan and your 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 ask for more information. If you are not yet an Aetna member, contact your plan administrator.

North Carolina

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

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.

Better manage your health and health care

Your secure member website

Your Aetna Navigator® website puts all of your plan information and cost-saving tools in one place. It's where you can go 24/7 to:

- **Find the right doctor** — and save money. Locate in-network doctors who accept your plan.
- **See what you owe**. Look up claims to see how much the plan paid and what you may have to pay.
- **Know your plan.** Check who is covered by your plan and what it covers.
- **Get valuable information.** See which doctors and hospitals have met extra standards for quality and efficiency.
- **Know costs before you go.** See cost estimates before you make an appointment for an office visit, test or procedure.
- **Get healthier.** Take a health assessment to learn about your health and how to lower your risks.
- **Check your health accounts.** Easily look up your health savings account or health fund balances.

Our easy-to-use tools help you make the most of your plan's benefits. Log in today at **http://www.aetna.com**.

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This material is for information only. Plan features and availability may vary by location. Rates and benefits may vary by location. Health benefits and insurance plans and dental insurance plans contain exclusions and limitations. Investment services are independently offered by the HSA administrator. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services. Not all health/dental services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features are subject to change. Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a subsidiary of Aetna Inc., which is a licensed pharmacy providing prescription services by mail. Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional. Information is believed to be accurate as of production date; however, it is subject to change.

Policy forms issued in Oklahoma include: Comprehensive PPO-GR-11741 (5/04), Limited-GR-11741-LME (5/04) and Dental-11826 Ed 9/04.

For more information about Aetna plans, refer to **www.aetna.com.**

You can always visit us online for more information: http://www.aetnaindividual.com

How did we do?

Scan to tell us if we gave you what you need to make your enrollment decision. Thank you. We look forward to serving you.

You can also visit us online to complete the survey. Go to **http://go.aetna.com/IndvFeedback**

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