Consumer Disclosure Information - Small Group Texas

HMO
Quality Point-of-Service® (HMO portion only)

Type of Coverage

Aetna Health Inc. is licensed by the Texas Department of Insurance to operate as a Health Maintenance Organization (HMO) within an approved service area.

Additional Information

You may call 1-888-982-3862 or write to Aetna, P.O. Box 569441, Dallas, TX 75356-9441 if you wish to obtain additional information, including provider information.

Dependent Eligibility (if your employer provides coverage for dependent children)

Your unmarried children are eligible for coverage if they are less than 25 years old. Student status is not required for initial enrollment or to continue coverage.

Your unmarried grandchildren are eligible for coverage if they are (i) less than 25 years old; and (ii) your dependents for federal income tax purposes at the time of application for coverage. Student status is not required for initial enrollment or to continue coverage.

For further information concerning dependent eligibility, please contact your employer's benefits manager or call us toll-free at 1-888-982-3862.

Medically Necessary Covered Benefits

A member shall be entitled to the medically necessary covered benefits as specified in accordance with the terms and conditions of the Certificate of Coverage which you will receive after enrollment in the Aetna HMO plan. This plan does not provide coverage for all health care expenses and includes exclusions and limitations. These exclusions and limitations will be clearly and unambiguously disclosed in your Certificate of Coverage. Read your Certificate of Coverage carefully to determine which health care services are covered benefits and to what extent. Services and supplies that are generally not covered benefits are itemized in the "Exclusions and Limitations" section of this document (depending on the specific benefits offered by your employer).

You will receive your Certificate of Coverage after enrollment, and you should consult that document to determine the terms and conditions of your plan. To find out before you enroll whether your Certificate of Coverage contains exclusions and limitations different from those listed in this document, contact your employer's benefits manager. You may also request a sample copy of the Aetna Certificate of Coverage by calling us toll-free at 1-888-982-3862.

In order for benefits to be covered, they must be medically necessary and, in many cases, must also be pre-authorized by Aetna.

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

Determinations by the Aetna of whether care is medically necessary under this definition shall also include determinations of whether the services and supplies are cost-effective, timely, and sufficient in quality, quantity, and frequency, consistent with the applicable standard of care. For purposes of this definition, "cost-effective" means the least expensive medically necessary treatment selected from two or more treatments that are equally effective, meaning the care can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects, in achieving a desired health outcome for that particular member. Medical necessity, when used in relation to services, shall have the same meaning as medically necessary services. This definition applies only to the determination by Aetna of

whether health care services are medically necessary covered benefits under your Certificate of Coverage.

The determination of medically necessary care is an analytical process applied on a case-by-case basis by qualified professionals who have the appropriate training, education, and experience and who possess the clinical judgment and case-specific information necessary to make these decisions. The determination of whether proposed care is a covered benefit is independent of, and should not be confused with, the determination of whether proposed care is medically necessary.

Aetna will not use any decision-making process that operates to deny medically necessary care that is a covered benefit under your Certificate. Since Aetna has authority to determine medical necessity for purposes of the Certificate, a determination under the Certificate that a proposed course of treatment, health care service or supply is not medically necessary may be made by Texas-licensed physicians other than the member's provider. This means that, even if the member's provider determines in his or her clinical judgment that a treatment, service or supply is medically necessary for the Member, Aetna's Texas-licensed physician may determine that it is not medically necessary under this Certificate. If Aetna determines that a service or supply is not medically necessary for the member, the member (or their authorized representative) may appeal to the Texas independent review organization, as described below in the section entitled "Complaints, Appeals and Independent Review."

For the purpose of coverage, except for certain specialist benefits (referred to as "direct access" benefits) or in a medical emergency or an urgent care situation outside the service area, the following benefits must be accessed through the primary care physician (PCP) or elsewhere upon prior referral issued by the member's PCP. Although listed as covered below, benefits are subject to the exclusions and limitations following this section and set out in further detail in the Certificate of Coverage. Please review the exclusions and limitations section in this document. To find out before you enroll whether your Certificate of Coverage contains exclusions and limitations different from those listed in this document, contact your employer's benefits manager, or call us toll-free at 1-888-982-3862. Members are responsible for copayments in the amount specified in their benefit plan for each service or visit.

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

- Primary care physician and specialist physician (upon referral) outpatient and inpatient visits.
- Routine physical examinations; routine gynecological examinations for women, including pap smear; and well-child care from birth including immunizations and booster doses according to the standards of the Advisory Committee on Immunization Practices of the Centers for Disease Control, U.S. or as required by law.
- Colorectal cancer screening for members age 50 and older. This includes (i) a fecal occult blood test every year; and (ii) a flexible sigmoidoscopy every 5 years or a colonoscopy every 10 years.
- Prostate cancer screening for men (i) age 50 and older and (ii) ages 40-49 who have an increased risk of developing prostate cancer.
- Routine vision, speech and hearing screenings (including newborns).
- Injections, including allergy desensitization injections.
- Diagnostic, laboratory, x-ray services; mammograms; prostate cancer screening; and osteoporosis screening.
- Cancer chemotherapy and cancer hormone treatments and services which have been approved by the United States Food and Drug Administration for general use in treatment of cancer.
- Diagnosis and treatment of gynecological or infertility problems by participating gynecologists or participating infertility specialists. Benefits for infertility treatment are limited and you should call 1-800-575-5999 for more information regarding coverage under your specific health plan.
- Outpatient and inpatient pre-natal and postpartum care and obstetrical services.
- Inpatient hospital & skilled nursing facility benefits. Except in an emergency, all services are subject to preauthorization by Aetna. Coverage for skilled nursing facility benefits is subject to the maximum number of days, if any, listed in your specific health plan.
- Transplants which are non-experimental or noninvestigational. Covered transplants must be approved by Aetna's medical director in advance of the surgery. The transplant must be performed at a hospital specifically approved and designated by Aetna to perform these procedures. If Aetna denies coverage of a transplant based on lack of medical necessity, the member may request a review by an independent review organization (IRO). More information can be found below in the "Complaints, Appeals and Independent Review" section.
- Outpatient surgical services and supplies in connection with a covered surgical procedure. Non-emergency services and supplies are subject to preauthorization by Aetna.

- Chemical Dependency/Substance Abuse Benefits. There is a lifetime maximum of 3 treatment episodes for inpatient hospital, inpatient treatment facility, partial hospitalization and outpatient treatment combined.
- Outpatient and inpatient care benefits are covered for detoxification.
- Outpatient rehabilitation visits are covered to a participating behavioral health provider upon referral by the PCP for diagnostic, medical or therapeutic rehabilitation services for chemical dependency.
- Inpatient rehabilitation benefits are covered for medical, nursing, counseling or therapeutic rehabilitation services in an appropriately licensed participating facility upon referral by the member's participating behavioral health provider for chemical dependency.
- Mental Health Benefits. A member is covered for services for the treatment of mental or behavioral conditions provided through participating behavioral health providers.
- Up to 20 outpatient visits are covered for short-term, outpatient evaluative and crisis intervention or home health mental health services.
- Up to 14 inpatient days are covered for medical, nursing, counseling or therapeutic services in an appropriately licensed, participating, inpatient, hospital or non-hospital residential facility including a mental health treatment facility, crisis stabilization unit, or residential treatment center. Benefits are in conjunction with your individual treatment plan. Inpatient benefit exchanges are also covered, as described in the "Covered Benefits" section of your Certificate of Coverage.
- Emergency medical services, including screening/evaluation to determine whether an emergency medical condition exists, and emergency medical transportation. See the "Emergency Care" section, below. As a reminder, a referral from your PCP is not required for this service.
- Urgent, non-emergent care services obtained from a licensed physician or facility outside of the service area if (i) the service is a covered benefit; (ii) the service is medically necessary and immediately required because of unforeseen illness, injury, or condition; and (iii) it was not reasonable, given the circumstances, for the member to return to the Aetna HMO service area for treatment. As a reminder, a referral from your PCP is not required for this service.
- Inpatient and outpatient physical, occupational and speech rehabilitation services when they are medically necessary and meet or exceed the treatment goals established for the patient.
- Aetna will not exclude coverage for cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological,
- neuropsychological, and psychophysiological testing or treatment, neurofeedback therapy, remediation, postacute transition services, or community reintegration services necessary as a result of and related to an acquired brain injury.[HB1676]
- Cardiac rehabilitation benefits following an inpatient hospital stay. A limited course of outpatient cardiac rehabilitation is covered following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction.
- Home health benefits rendered by a participating home health care agency. Preauthorization must be obtained from the member's attending participating physician. Home health benefits are not covered if Aetna determines the treatment setting is not appropriate or if there is a more cost effective setting in which to provide appropriate care.
- Hospice care medical benefits when preauthorized by Aetna.
- Initial provision of prosthetic appliances. Covered prosthetic appliances generally include those items covered by Medicare unless otherwise excluded under your specific health plan.
- Certain injectable medications when an oral alternative drug is not available and when preauthorized by Aetna, unless excluded under your specific health plan.
- Mastectomy-related services including reconstructive breast surgery, prostheses and lymphedema, as described in your specific health plan.
- Voluntary sterilizations.
- Administration, processing of blood, processing fees, and fees related to autologous blood donations only.
- Diagnostic and surgical treatment of the temporomandibular joint that is medically necessary as a result of an accident, a trauma, a congenital defect, a developmental defect or a pathology.
- Diabetic outpatient self-management training and education (including medical nutrition therapy for the treatment of diabetes), equipment and supplies (including blood glucose monitors and monitor-related supplies including test strips and lancets; injection aids; syringes and needles; insulin infusion devices; and insulin and other pharmacological agents for controlling blood sugar).

- Certain infertility services. Refer to the "Covered Benefits" section of the Certificate of Coverage for detailed information. Benefits for infertility treatment are limited and you should call 1-800-575-5999 for more information regarding coverage under your specific health plan.
- Coverage is provided for formulas necessary for the treatment of phenylketonuria or other heritable diseases to the same extent as for drugs available only on the orders of a physician.

Prescription Drugs

If your plan covers outpatient prescription drugs, your plan may include a preferred drug list (also known as a "drug formulary"). The preferred drug list includes a list of prescription drugs that, depending on your prescription drug benefits plan, are covered on a preferred basis. Many drugs, including many of those listed on the preferred drug list, are subject to rebate arrangements between Aetna and the manufacturer of the drugs. Such rebates are not reflected in and do not reduce the amount you pay to your pharmacy for a prescription drug. In addition, in circumstances where your prescription plan utilizes copayments or coinsurance calculated on a percentage basis or a deductible, your costs may be higher for a preferred drug than they would be for a nonpreferred drug. For information regarding how medications are reviewed and selected for the preferred drug list, please refer to Aetna's website at **www.aetna.com** or the Aetna Preferred Drug (Formulary) Guide. Printed Preferred Drug Guide information will be provided, upon request or if applicable, annually for current members and upon enrollment for new members. Additional information can be obtained by calling Member Services at the toll-free number listed on your ID card. The medications listed on the preferred drug list are subject to change in accordance with applicable state law.

Your prescription drug benefit is generally not limited to drugs listed on the preferred drug list. Medications that are not listed on the preferred drug list (nonpreferred or nonformulary drugs) may be covered subject to the limits and exclusions set forth in your plan documents. Covered nonformulary prescription drugs may be subject to higher copayments or coinsurance under some benefit plans. Some prescription drug benefit plans may exclude from coverage certain nonformulary drugs that are not listed on the preferred drug list. If it is medically necessary for you to use such drugs, your physician (or pharmacist in the case of antibiotics and analgesics) may contact Aetna to request coverage as a medical exception. Check your plan documents for details.

In addition, certain drugs may require precertification or step-therapy before they will be covered under some prescription drug benefit plans. Step-therapy is a different form of precertification which requires a trial of one or more "prerequisite therapy" medications before a "step therapy" medication will be covered. If it is medically necessary for you to use a medication subject to these requirements, your physician can request coverage of such drug as a medical exception. In addition, some benefit plans include a mandatory generic drug cost-sharing requirement. In these plans, you may be required to pay the difference in cost between a covered brand name drug and its generic equivalent in addition to your copayment if you obtain the brand-name drug. Nonprescription drugs and drugs in the Limitations and Exclusions section of the plan documents (received and/or available upon enrollment) are not covered, and medical exceptions are not available for them.

Depending on the plan selected, new prescription drugs not yet reviewed for possible addition to the preferred drug list are either available at the highest copay under plans with an "open" formulary, or excluded from coverage unless a medical exception is obtained under plans that use a "closed" formulary. These new drugs may also be subject to precertification or step-therapy.

You should consult with your treating physician(s) regarding questions about specific medications. Refer to your plan documents or contact Member Services for information regarding terms, conditions and limitations of coverage. If you use the mail order prescription program of Aetna Rx Home Delivery, LLC, or the Aetna Specialty PharmacySM specialty drug program, you will be acquiring these prescriptions through an affiliate of Aetna. Aetna's negotiated charge with Aetna Rx Home Delivery® and Aetna Specailty Pharmacy may be higher than their cost of purchasing drugs and providing pharmacy services. For these purposes, Aetna Rx Home Delivery's and Aetna Specialty Pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

Updates to the Drug Formulary

You can obtain formulary information from the Internet at **www.aetna.com/formulary/**, or by calling your Member Services toll-free number.

Behavioral Health Provider Safety Data Available:

For information regarding our Behavioral Health provider network safety data, please go to **www.aetna.com** and review the quality and patient safety links posted: **http://www.aetna.com/docfind/quality.html#jcaho**. You may select the quality checks link for details regarding our providers' safety reports.

Behavioral Health Prevention Programs

Aetna Behavioral Health offers two prevention programs for our members: Perinatal Depression Education, Screening and Treatment Referral Program also known as "Mom's to Babies Depression Program" and Identification and Referral of Adolescent Members Diagnosed With Depression Who Also Have Co-morbid Substance Abuse Needs. For more information on either of these prevention programs and how to use the programs, ask Member Services for the phone number of your local Care Management Center.

Emergency Care

If you need emergency care, you are covered 24 hours a day, 7 days a week, anywhere in the world. An emergency medical condition means health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in: (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part; (4) serious disfigurement; or (5) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

In determining whether services provided to you will be covered as emergency services, we have the right to review the services and the circumstances in which you received them.

- If your condition is an emergency, we will cover the medical screening examination, evaluation, stabilization and treatment.
- If your condition is not an emergency, we will cover only the medical screening examination and evaluation. You will be responsible for the other charges.

Whether you are within or outside of your Aetna HMO service area, we simply ask that you follow the guidelines below when you believe you need emergency care.

1. Call the local emergency hotline (ex. 911) or go to the nearest emergency facility. If a delay would not be detrimental to your health, call a participating physician. Notify a participating physician as soon as possible after receiving treatment.
2. After assessing and stabilizing your condition, the emergency facility should contact a participating physician so they can assist the treating physician by supplying information about your medical history.
3. If you are admitted to an inpatient facility, you a family member or friend acting on your behalf should notify a participating physician or Aetna as soon as possible.

Follow-up Care after Emergencies

All follow-up care should be coordinated by a participating physician. Follow-up care with nonparticipating providers is only covered with pre-approval from Aetna. Whether you were treated within or outside of your Aetna service area, you must obtain pre-approval before any follow-up care can be covered. Suture removal, cast removal, X-rays and clinic or emergency room revisits are examples of follow-up care.

Accessing Care After Hours

You can call your primary care physician's (PCP's) office 24 hours a day, seven days a week if you have medical questions or concerns. If you need after-hours treatment for a problem such as fever, earache, sore throat, sprained ankle, minor laceration, vomiting or diarrhea, you should consider an urgent care facility.

Urgent Care

When you need urgent care (not emergency care), your PCP may direct you to an urgent care facility, to provide you convenient and timely care. For up-to-date listings of participating urgent care centers, visit our DocFind® online provider directory at **www.aetna.com**. You do not need a referral from your PCP to visit a participating urgent care

What To Do Outside Your Aetna HMO Service Area

If you are traveling outside your Aetna service area or are a student who is away at school, you are covered for emergency services and urgently needed care. Urgent care means covered benefits provided in a non-emergency situation as a result of an acute injury or illness that is severe or painful enough to lead a prudent layperson, possessing an average knowledge of medicine and health,

to believe that his or her condition, illness or injury is of such a nature that failure to obtain treatment within a reasonable period of time would result in serious deterioration of the condition or his or her health. Certain conditions, such as severe vomiting, earaches, sore throats or fever, are considered "urgent care" when they occur outside your Aetna HMO service area. Urgent care may be obtained from a private practice physician, a walk-in clinic, an urgent care center or an emergency facility.

Your Financial Responsibility

You are responsible for all applicable copayments and premiums under your particular plan. Please refer to the plan design overview contained in your pre-enrollment packet for a brief description of these provisions. In addition, you are also financially responsible for all noncovered services and, in some cases, out-of-area expenses. (Out-of-area emergency and urgent care expenses are reimbursed by the health plan.) Should you receive a bill for covered services from your participating physician or provider, please contact Member Services at the number on your ID card or at 1-888-982-3862. Participating physicians and providers have agreed to look exclusively to Aetna for payment of covered services.

Exclusions and Limitations

The following is a summary of services that are not covered unless your employer has included them in your plan or purchased a separate, optional rider. Additional exclusions and limitations may apply for your specific plan, so your Certificate of Coverage should be consulted for more detail. To find out before you enroll whether your Certificate of Coverage contains different exclusions and limitations, contact your employer's benefits manager or call us toll-free at 1-888-982-3862.

Exclusions

- Acupuncture and acupuncture therapy, except when performed by a participating provider as a form of anesthesia in connection with covered surgery.
- Ambulance or medical transportation services for nonemergency transportation.
- Bereavement counseling, funeral arrangements, pastoral counseling, financial or legal counseling, homemaker or caretaker services, respite care, and any service not solely related to the care of the member, including but not limited to, sitter or companion services for the member or other members of the family, transportation, house cleaning, and maintenance of the house.
- Biofeedback.
- Blood and blood plasma, including provision of blood, blood plasma, blood derivatives, synthetic blood or blood products other than blood-derived clotting factors, the collection or storage of blood plasma, the cost of receiving the services of professional blood donors, apheresis (removal of the plasma) or plasmapheresis (cleaning and filtering of the plasma). Only administration, processing of blood, processing fees, and fees related to autologous blood donations are covered.
- Care for conditions that state or local laws require to be treated in a public facility, including but not limited to mental illness commitments.
- Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury. Examples include asbestos removal, air filtration, and special ramps or doorways.
- Cosmetic surgery, or treatment relating to the consequences of, or as a result of, Cosmetic Surgery, including but not limited to surgery to correct gynecomastia, breast augmentation, and otoplasties. This exclusion does not apply to (i) surgery to restore normal bodily functions, including but not limited to, cleft lip and cleft palate or as a continuation of a staged reconstruction procedure, or congenital defects; (ii) breast reconstruction following a mastectomy, including the breast on which mastectomy surgery has been performed and the breast on which mastectomy surgery has not been performed; and (iii) reconstructive surgery performed on a member who is less than 18 years of age to improve the function of or to attempt to create a normal appearance of a craniofacial abnormality.
- Costs for court-ordered services, or those required by court order as a condition of parole or probation.
- Custodial care.
- Dental services, including false teeth. This exclusion does not apply to: the removal of bone fractures, tumors, and orthodontogenic cysts; diagnostic and medical/surgical treatment of the temporomandibular joint disorder; or medical services required when the dental services cannot be safely provided in a dentist's office due to the member's physical, mental or medical condition.

- Durable medical equipment and household equipment, including but not limited to crutches, braces, the purchase or rental of exercise cycles, water purifiers, hypo-allergenic pillows, mattresses or waterbeds, whirlpool or swimming pools, exercise and massage equipment, central or unit air conditioners, air purifiers, humidifiers, dehumidifiers, escalators, elevators, ramps, stair glides, emergency alert equipment, handrails, heat appliances, improvements made to a member's house or place of business and adjustments made to vehicles.
- Educational services and treatment of behavioral disorders and services for remedial education including evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, behavioral training, and cognitive rehabilitation. This includes services, treatment or educational testing and training related to behavioral (conduct) problems, learning disabilities, or developmental delays. Special education, including lessons in sign language to instruct a member, whose ability to speak has been lost or impaired, to function without that ability, are not covered.
- Experimental or investigational procedures or ineffective surgical, medical, psychiatric or dental treatments or procedures, research studies, or other experimental or investigational health care procedures or pharmacological regimes as determined by Aetna, unless pre-authorized by Aetna. This exclusion will not apply with respect to drugs: (i) that have been granted treatment investigational new drug (IND) or Group c/treatment IND status; (ii) that are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; or (iii) Aetna has determined that available scientific evidence demonstrates that the drug is effective or the drug shows promise of being effective for the disease.
- Hair analysis.
- Health services, including those related to pregnancy, rendered before the effective date or after the termination of the member's coverage.
- Hearing aids.
- Home births.
- Home uterine activity monitor.
- Hypnotherapy.
- Infertility services not otherwise covered, including injectable infertility drugs, charges for the freezing and storage of cryopreserved embryos, charges for storage of sperm, and donor costs, including but not limited to, the cost of donor eggs and donor sperm, ovulation predictor kits, and donor egg program or gestational carriers, ZIFT, GIFT or in-vitro fertilization. Call 1-800-575-5999 for more information regarding exclusions.
- Injectable drugs, as follows: experimental drugs or medications, or drugs or medications that have not been proven safe and effective for a specific disease or approved for a mode of treatment by the Food and Drug Administration (FDA) and the National Institutes of Health (NIH); needles, syringes and other injectable aids (except for diabetic supplies.); drugs related to the treatment of non-covered services; and drugs related to contraception (unless covered by a prescription drug rider), the treatment of infertility, and performance enhancing steroids.
- Military service related diseases, disabilities or injuries for which the member is legally entitled to receive treatment at government facilities and which facilities are reasonably available to the member.
- Missed appointment charges.
- Non-diagnostic and non-medical/surgical treatment of temporomandibular joint disorder (TMJ).
- Oral or topical drugs used for sexual dysfunction or performance
- Orthoptic therapy (vision exercises).
- Orthotics.
- Outpatient medical consumable or disposable supplies such as syringes, incontinence pads, elastic stockings, and reagent strips. This exclusion does not apply to diabetic supplies.
- Performance, athletic performance or lifestyle enhancement drugs and supplies.
- Personal comfort or convenience items.
- Prescription or non-prescription drugs and medicines, except as provided on an inpatient basis (unless covered by a prescription drug rider). This exclusion does not apply to diabetes supplies, including but not limited to insulin.
- Private duty or special nursing care (unless medically necessary and pre-authorized by Aetna).
- Recreational, educational, and sleep therapy, including any related diagnostic testing.
- Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling, and sex therapy.
- Reversal of voluntary sterilizations.
- Routine foot/hand care
- Serious mental illness.
- Services for which a member is not legally obligated to pay in the absence of this coverage.
- Services for the treatment of sexual dysfunctions or inadequacies, including therapy, supplies, or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.

- Services or supplies as follows:
    1. services or supplies that do not require the technical skills of a medical, mental health or a dental professional;
    2. services or supplies furnished mainly for the personal comfort or convenience of the member, or any person who cares for the member, or any person who is part of the member's family, or any provider;
    3. services or supplies furnished solely because the member is an inpatient on any day in which the member's disease or injury could safely and effectively be diagnosed or treated while the member is not an inpatient;
    4. services or supplies furnished in a particular setting that could safely and effectively be furnished in a physician's or a dentist's office or other less costly setting consistent with the applicable standard of care.
- Services performed by a relative of a member for which, in the absence of any health benefits coverage, no charge would be made.
- Services rendered for the treatment of delays in speech development, unless resulting from disease, injury, or congenital defects.
- Services required by third parties, including but not limited to, physical examinations, diagnostic services and immunizations in connection with obtaining or continuing employment, insurance, travel, school admissions or attendance, including examinations required to participate in athletics, except when such examinations are considered to be part of an appropriate schedule of wellness services.
- Specific non-standard allergy services and supplies, including but not limited to, skin titration (wrinkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine autoinjections.
- Special medical reports, including those not directly related to treatment of the member (i.e., reports prepared in connection with litigation).
- Spinal manipulation for subluxation.
- Surgical operations, procedures or treatment of obesity.
- Therapy or rehabilitation as follows: primal therapy (intense non-verbal expression of emotion expected to result in improvement or cure of psychological symptoms), chelation therapy (removal of excessive heavy metal ions from the body), rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, vision perception training, carbon dioxide and other therapy or rehabilitation not supported by medical and scientific evidence. This exclusion does not apply to rehabilitative services such as physical, speech and occupational therapy.
- Transsexual surgery, sex change or transformation, including any procedure or treatment or related service designed to alter a Member's physical characteristics from the Member's biologically determined sex to those of another sex, regardless of any diagnosis of gender role or psychosexual orientation problems.
- Treatment in a federal, state, or governmental entity, including care and treatment provided in a nonparticipating hospital owned or operated by any federal, state or other governmental entity, except to the extent required by applicable laws.
- Treatment of mental retardation, defects, and deficiencies.
- Treatment of occupational injuries and occupational diseases.
- Unauthorized services, including any non-emergency service obtained by or on behalf of a member without prior referral by the member's PCP or certification by Aetna.
- Vision care services and supplies, including orthoptics (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision) and radial keratotomy, including related procedures designed to surgically correct refractive errors.
- Weight reduction programs or dietary supplements, except formulas necessary for the treatment of phenylketonuria or other heritable diseases.

Precertification and Other Review Processes

Precertification

Your doctor may be required to obtain prior approval of coverage for certain services. This is called "precertification." It is also referred to as "prospective review". You should ask your participating physician or Aetna whether precertification is necessary for any covered services. Failure to obtain precertification where required may cause you to be financially responsible for those services.

If your plan covers out-of-network benefits and you may self-refer for covered services, it is your responsibility to contact Aetna to precertify those services that require precertification.

Concurrent Review

Aetna also reviews certain services at the time of delivery (concurrent review) to assess the necessity for continued stay, level of care, and quality of care you are receiving for inpatient services. All inpatient services extending beyond the initial certification period require concurrent review. Concurrent review is the responsibility of Aetna and the provider.

Discharge Planning

Discharge planning may be initiated at any stage of the patient management process and begins immediately upon identification of post-discharge needs during precertification or concurrent review. The discharge plan may include initiation of a variety of services/benefits to be utilized by you upon discharge from an inpatient stay.

Retrospective Review

Retrospective review is a review performed for the first time after you have received the treatment in question. Retrospective review does not include subsequent review of services for which prospective or concurrent reviews for medical necessity and appropriateness were previously conducted. The purpose of retrospective review is to determine coverage and payment of such claims under the plan, retrospectively analyze potential quality and utilization issues, initiate appropriate follow-up action based on quality or utilization issues, and review all appeals of decisions for coverage and payment of such healthcare services.

Prescription Drugs

If your plan covers outpatient prescription drugs, certain drugs may require precertification or step therapy. Step therapy is a form of precertification that requires a trial of one or more "prerequisite therapy" medications before a "step therapy" medication will be covered. If it is medically necessary for you to use a step therapy medication initially, your physician can request coverage of such drug as a formulary exception. Refer to your plan documents and formulary guide or contact Member Services for questions on coverage. You may also contact Member Services to determine if a specific prescription drug is included on the formulary, or visit our website at www.aetna.com.

What Happens If A Provider Leaves the Health Plan

If your physician or provider leaves the plan, you may be able to continue to see that physician or provider during a transitional period. For information on continuity of care in these situations, please refer to your Certificate of Coverage or call Member Services at the toll-free number on your ID card.

Complaints, Appeals and Independent Review

This Complaint Appeal and Independent Review process may not apply if your plan is self-funded. Contact your Benefits Administrator if you have any questions.

Complaint Process

Aetna is committed to addressing your coverage issues, complaints and problems. If you have a coverage issue or other problem, call Member Services at the toll free number on your ID card or e-mail us from your secure member website, Aetna Navigator. Click on "Contact Us" after you log in. You can also contact Member Services through the Internet at: www.aetna.com, or write to:

Aetna
P.O. Box 14586
Lexington, KY 40512-1486

A Member Services representative will address your concern. If you are dissatisfied with the outcome of your initial contact, you may file a formal complaint. If you are not satisfied after filing a formal complaint, you may appeal the decision as described below.

Appeals Process

Upon receipt of a written appeal, Aetna will send an acknowledgment letter describing the applicable appeal procedures. Appeals that do not involve medical necessity issues will be addressed by an appeal panel. You may appear in person or by telephone before the appeal panel or address the issues in writing. Appeals of medical necessity denials will be reviewed by a Texas-licensed physician who was not involved in the original decision. If Aetna determines that a service or supply is not medically necessary for you (or your authorized representative) may appeal to the Texas independent review organization (IRO) after exhausting the internal review process. If you have a life-threatening condition (e.g., a disease or condition in which death is probable unless the course of the disease or condition is interrupted), you may appeal a medical necessity denial immediately to an IRO, as described below, without first exhausting this internal appeal process.

Aetna will notify the appealing party of the outcome of an appeal.

You may obtain additional information from the Texas Department of Insurance regarding their rights. The website for the Texas Department of Insurance is **www.tdi.state.tx.us**. Their toll-free telephone number is 1-800-578-4677.

Independent Review of Medical Necessity Appeals

Aetna participates in the Texas independent review organization (IRO) process. You may request IRO review upon receiving a denial based on medical necessity and exhausting the internal appeal process (except in cases of a life-threatening condition, where it is not necessary to exhaust the internal appeals process before requesting IRO review, as discussed in the "Appeals Process" section above). The process for IRO review is defined by Texas law and is described in your plan documents. You will also receive information on the independent review process when you initiate an appeal in Aetna's internal complaint and appeals process. You may also call the Member Services toll-free number on your ID card or the Texas Department of Insurance for further information about the IRO procedures.

Aetna is interested in hearing all comments, questions, complaints or appeals from customers, members, physicians and providers, and does not retaliate against any of those individuals or groups for initiating a complaint or appeal.

Binding Arbitration

Most of our plans contain the following binding arbitration provision: Aetna, Contract Holder and you may agree to binding arbitration to resolve any controversy, dispute or claim between them arising out of or relating to this Certificate, whether stated in tort, contract, statute, claim for benefits, bad faith, professional liability or otherwise ("Claim"). Said binding arbitration shall be administered pursuant to the Texas Arbitration Act before a sole arbitrator ("Arbitrator"). Judgment on the award rendered by the Arbitrator ("Award") may be entered by any court having jurisdiction thereof. If administrator declines to oversee the case and the parties do not agree on an alternative administrator, a sole neutral Arbitrator shall be appointed upon petition to a court having jurisdiction. Should the parties agree to resolve their controversy, dispute or claim through binding arbitration, said arbitration shall be held in lieu of any and all other legal remedies and rights that the parties may have regarding their controversy, dispute or claim, unless otherwise required by law. If the parties do not agree to binding arbitration, nothing herein shall limit any legal right or remedy that the parties may otherwise have. Check your plan documents to determine if your plan contains this provision.

Current List of Physicians and Providers

Please refer to your Physician & Hospital Directory for a list of physicians and other providers who participate in your plan. If you do not have a directory, you may request one from Aetna by calling 1-888-982-3862. You can also refer to our on-line provider directory, DocFind®, at **www.aetna.com** for a current list of participating physicians and providers. Your mental health providers are listed in this directory. You may contact your PCP or call 1-800-424-3803 to find out how to access mental health services.

While the provider directory is believed to be accurate as of the print date, it is subject to change without notice. Consult Aetna's on-line provider directory on our website at **www.aetna.com** for the most current provider listings. The on-line provider directory is updated at least weekly. Participating providers are independent contractors in private practice and are neither employees nor agents of Aetna or its affiliates. The availability of any particular provider cannot be guaranteed for referred or in-network benefits, and provider network composition is subject to change without notice. In addition, not every provider listed in the directory will be accepting new patients. Although Aetna has identified providers who were not accepting patients as known to Aetna at the time the provider directory was created, the status of a provider's practice may have changed. For the most current information, please contact the selected physician or Member Services at the toll-free number on your ID card.

Your PCP may be part of a practice group or association of health professionals (often referred to as a "limited provider network") who work together to provide a full range of health care services. That means when you choose your PCP, in some cases, you are also choosing a limited provider network. In most instances, you will not be allowed to receive services from any physician or provider who is not also part of your PCP's limited provider network. You will not be able to select any physician or provider outside of your PCP's limited provider network, even though that physician or provider appears in the directory. To the extent it is available, your care will be provided or arranged for within your PCP's limited provider network, so make sure your PCP's limited provider network includes the specialists and hospitals you prefer.

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

Female members:

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

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

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

Please also see the "Prior Authorization, Precertification and Other Review Processes" and "Emergency Care" sections for additional information on accessing care.

How Aetna Compensates Your Health Care Provider

All the physicians are independent practicing physicians that are neither employed nor exclusively contracted with Aetna. Individual physicians and other providers are in the network by either directly contracting with Aetna and/or affiliating with a group or organization that contract with us. Participating providers in our network are compensated in various ways:

- Per individual service or case (fee for service at contracted rates).
- Per hospital day (per diem contracted rates).
- Capitation (a prepaid amount per member, per month).
- Through Integrated Delivery Systems (IDS), Independent Practice Associations (IPA), Physician Hospital Organizations (PHO), Physician Medical Groups (PMG), behavioral health organizations and similar provider organizations or groups. Aetna pays these organizations, which in turn may reimburse the physician, provider organization or facility directly or indirectly for covered services. In such arrangements, the group or organization has a financial incentive to control the cost of care.

One of the purposes of managed care is to manage the cost of health care. Incentives in compensation arrangements with physicians and health care providers are one method by which Aetna attempts to achieve this goal. In some regions, the PCP can receive additional compensation based upon performance on a variety of measures intended to evaluate the quality of care and services the PCP provides to you. This additional compensation is typically based on the scores received on one or more of the following measures of the PCP's office:

- member satisfaction,
- percentage of members who visit the office at least annually,
- medical record reviews,
- the burden of illness of the members that have selected the primary care physician,
- management of chronic illnesses like asthma, diabetes and congestive heart failure;
- whether the physician is accepting new patients; and
- participation in Aetna's electronic claims and referral submission program.

Some regions may use some different measures designed to enhance physician performance or improve administrative efficiency. You are encouraged to ask your physicians and other providers how they are compensated for their services.

Claims Payment for Nonparticipating Providers and Use of Claims Software

If your plan includes coverage for out-of-network services, and you obtain coverage under this portion of your plan, you should be aware that Aetna generally determines payment for an out-of-network provider by referring to (i) commercially available data reflecting the customary amount paid to most providers for a given service in that geographic area or (ii) by accessing other contractual arrangements. If such data is not commercially available, our determination may be based upon our own data or other sources.

Aetna may also use computer software (including ClaimCheck®) and other tools to take into account factors such as the complexity, amount of time needed and manner of billing. You may be responsible for any charges Aetna determines are not covered under your plan.

Technology Review

Aetna reviews new medical technologies, behavioral health procedures, pharmaceuticals and devices to determine which one should be covered by our plans. And we even look at new uses for existing technologies to see if they have potential. To review these innovations, we may:

- Study medical research and scientific evidence on the safety and effectiveness of medical technologies.
- Consider position statements and clinical practice guidelines from medical and government groups, including the federal Agency for Health care Research and Quality.
- Seek input from relevant specialists and experts in the technology.
- Determine whether the technologies are experimental or investigational.

You can find out more on new tests and treatments in our Clinical Policy Bulletins. You can find the bulletins at www.aetna.com, under the "Members and Consumers" menu.

Service Area

A service area map is contained on the back cover of the Physician & Hospital directory. If you have questions about our service area, please call Member Services at 1-888-982-3862.

Member Rights & Responsibilities

You have the right to receive a copy of our Member Rights and Responsibilities Statement. This information is available to you online at http://www.aetna.com/about/MemberRights/. You can also obtain a print copy by contacting Member Services at the number on your ID card.

Member Services

To file a compliant or an appeal, for additional information regarding copayments and other charges, information regarding benefits, to obtain copies of plan documents, information regarding how to file a claim or for any other question, you can contact Member Services at the toll-free number on your ID card, or e-mail us from your secure member website, Aetna Navigator at www.aetna.com. Click on "Contact Us" after you log in.

Interpreter/Hearing Impaired

When you require assistance from an Aetna representative, call us during regular business hours at the number on your ID card. Our representatives can:

- Answer benefits questions
- Help you get referrals
- Find care outside your area
- Advise you on how to file complaints and appeals
- Connect you to behavioral health services (if included in your plan)
- Find specific health information
- Provide information on our Quality Management program, which evaluates the ongoing quality of our services

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

Quality Management Programs

Call Aetna to learn about the specific quality efforts we have under way in your local area. Ask Member Services for the phone number of your regional Quality Management office. If you would like information about Aetna Behavioral Health's Quality Management Program, ask Member Services for the phone number of your Care Management Center Quality Management office.

Privacy Notice

Aetna considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By "personal information," we mean information that relates to your physical or mental health or condition, the provision of health care to you, or payment for the provision of health care to you. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify you. When necessary or appropriate for your care or treatment, the operation of our health plans, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), payors (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your plan), other insurers, third party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. Participating network providers are also required to give you access to your medical records within a reasonable amount of time after you make a request.

Some of the ways in which personal information is used include claims payment; utilization review and management; medical necessity reviews; coordination of care and benefits; preventive health, early detection, and disease and case management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; health claims analysis and reporting; health services research; data and information systems management;

compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health plans. To the extent permitted by law, we use and disclose personal information as provided above without your consent. However, we recognize that you may not want to receive unsolicited marketing materials unrelated to your health benefits. We do not disclose personal information for these marketing purposes unless you consent. We also have policies addressing circumstances in which you are unable to give consent.

To obtain a hard copy of our Notice of Privacy Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please write to Aetna's Legal Support Services Department at 151 Farmington Avenue, W121, Hartford, CT 06156. You can also visit our Internet site at **www.aetna.com**. You can link directly to the Notice of Privacy Practices by Plan Type, by selecting the "Privacy Notices" link at the bottom of the page, and selecting the link that corresponds to you specific plan.

NOTICE OF CERTAIN MANDATORY BENEFITS

This notice is to advise you of certain coverage and/or benefits provided by your contract with Aetna. If you have any questions concerning this notice, please call us at the Member Services number on the back of your ID card, or write us at the following address: **Aetna Patient Management P.O. Box 569440 Dallas, Texas 75356-9440**

Coverage of Tests for Detection of Human Papillomavirus and Cervical Cancer

Coverage is provided, for each woman enrolled in the plan who is 18 years of age or older, for expenses incurred for an annual medically recognized diagnostic examination for the early detection of cervical cancer. Coverage required under this section includes at a minimum a conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the United States Food and Drug Administration, alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus.

Form Number LHL391Human Papillomavirus and Cervical Cancer Screen

Coverage for Tests for Detection of Colorectal Cancer

Benefits are provided, for each person enrolled in the plan who is 50 years of age or older and at normal risk for developing colon cancer, for expenses incurred in conducting a medically recognized screening examination for the detection of colorectal cancer. Benefits include the covered person's choice of:

(a) a fecal occult blood test performed annually and a flexible sigmoidoscopy performed every five years, or

(b) a colonoscopy performed every 10 years.

Form Number 1467 Colorectal Cancer Screening

Prostate Cancer Screening

Benefits are provided for each covered male for an annual medically recognized diagnostic examination for the detection of prostate cancer. Benefits include a:

(a) Physical examination for the detection of prostate cancer

(b) Prostate-specific antigen test for each covered male who is at least:

(1) 50 years of age

(2) 40 years of age with a family history of prostate cancer or other prostate cancer risk factor.

Form Number 258 Prostate

Inpatient Stay Following Birth of a Child

For each person covered for maternity/childbirth benefits, we will provide inpatient care for the mother and her newborn child in a health care facility for a minimum of:

(a) 48 hours following an uncomplicated vaginal delivery.

(b) 96 hours following an uncomplicated delivery by cesarean section.

This benefit does not require a covered female who is eligible for maternity/childbirth benefits to (a) give birth in a hospital or other health care facility or (b) remain in a hospital or other health care facility for the minimum number of hours following birth of the child.

If a covered mother or her newborn child is discharged before the 48 or 96 hours has expired, we will provide coverage for postdelivery care. Postdelivery care includes parent education, assistance and training in breast-feeding and bottle-feeding and the performance of any necessary and appropriate clinical tests. Care will be provided by a physician, registered nurse or other appropriate licensed health care provider, and the mother will have the option of receiving the care at her home, the health care provider's office or a health care facility.

Because we provide in-home postdelivery care, we are not required to provide the minimum number of hours outlined above unless (a) the mother's or child's physician determines the inpatient care is medically necessary or (b) the mother requests the inpatient stay.

Prohibitions: We may not (a) modify the terms of this coverage based on any covered person requesting less than the minimum coverage required; (b) offer the mother financial incentives or other compensation for waiver of the minimum number of hours required; (c) refuse to accept a physician's recommendation for a specified period of inpatient care made in consultation with the mother if

the period recommended by the physician does not exceed guidelines for prenatal care developed by nationally recognized professional associations of obstetricians and gynecologists or pediatricians; (d) reduce payments or reimbursements below the usual and customary rate; or (f) penalize a physician for recommending inpatient care for the mother or the newborn child.

Form Number 102 Maternity

Breast Reconstruction

Coverage and/or benefits are provided to each covered person for reconstructive surgery after mastectomy, including:

(a) All stages of the reconstruction of the breast on which mastectomy has been performed.

(b) Surgery and reconstruction of the other breast to achieve a symmetrical appearance.

(c) Prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

The coverage and/or benefits must be provided in a manner to be appropriate in consultation with the covered person and the attending physician.

Prohibitions: We may not (a) offer the covered person a financial incentive to forego breast reconstruction or waive the coverage and/or benefits shown above; (b) condition, limit, or deny any covered person 's eligibility or continued eligibility to enroll in the plan or fail to renew this plan solely to avoid providing the coverage and/or benefits shown above; or (c) reduce or limit the amount paid to the physician or provider, nor otherwise penalize, or provide a financial incentive to induce the physician or provider to provide care to a covered person in a manner inconsistent with the coverage and/or benefits shown above.

Form Number 1764 Reconstructive Surgery After Mastectomy - Enrollment

Mastectomy or Lymph Node Dissection Minimum Inpatient Stay

If due to treatment of breast cancer, any person covered by this plan has either a mastectomy or a lymph node dissection, this plan will provide coverage for inpatient care for a minimum of:

(a) 48 hours following a mastectomy, and

(b) 24 hours following a lymph node dissection.

The minimum number of inpatient hours is not required if the individual receiving the treatment and the attending physician determine that a shorter period of inpatient care is appropriate.

Prohibitions: We may not (a) deny any covered person eligibility or continued eligibility or fail to renew this plan solely to avoid providing the minimum inpatient hours; (b) provide money payments or rebates to encourage any covered person to accept less than the minimum inpatient hours; (c) reduce or limit the amount paid to the attending physician, or otherwise penalize the physician, because the physician required a covered person to receive the minimum inpatient hours; or (d) provide financial or other incentives to the attending physician to encourage the physician to provide care that is less than the minimum hours.

Form Number 349 Mastectomy

Health Insurance Portability and Accountability Act

Note: The following information is provided to inform you of certain provisions contained in the Group Health Plan, and related procedures that may be utilized by you in accordance with Federal law.

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption or placement for adoption. To request special enrollment or obtain more information, contact your benefits administrator.

Request for Certificate of Creditable Coverage

If you are a member of an insured plan sponsor or a member of a self insured plan sponsor who have contracted with us to provide Certificates of Prior Health Coverage, you have the option to request a certificate.

This applies to you if you are a terminated member, or are a member who is currently active but who would like a certificate to verify your status. As a terminated member, you can request a certificate for up to 24 months following the date of your termination. As an active member can request a certificate at any time. To request a Certificate of Prior Health Coverage, please contact Member Services at the telephone number on your ID card.

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