Member handbook and consumer disclosure

Important information about your health benefits

EPO Plus

Managed Plus

Open Access EPO Plus

Open Access Managed Plus

Open Access Network Only Plus

Open Access POS II

Preferred Provider Organization (PPO)

Important disclosure information about Texas Open Access or EPO-based plans:

EPO Plus

Managed Plus

Open Access EPO Plus

Open Access Managed Plus

Open Access Network Only Plus

Open Access POS II

Preferred Provider Organization (PPO)

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EPO Plus, Managed Plus, Open Access EPO Plus, Open Access Managed Plus, Open Access Network Only Plus, Open Access POS II, and PPO

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

EPO Plus, Managed Plus, Open Access EPO Plus, Open Access Managed Plus, Open Access Network Only Plus, Open Access POS II, and PPO

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

2. Our website and toll-free phone number

For more information, including information about participating health care providers, you may visit **TexasHealthAetna.com** or call **1-800-213-3224 (TTY: 711).**

3. Preferred and nonpreferred benefits differ by plan

Network-only plans

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

Plans that cover out-of-network services

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

4. Information about specific benefits

Medically necessary and preventive care covered benefits

As a member, you will be entitled to the medically necessary covered benefits as listed in the Evidence of Coverage and included below. Medically necessary and preventive care covered services include:

- Primary care physician and specialist physician (upon referral) outpatient and inpatient visits
- Inpatient services that include room and board and private duty nursing

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- Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF)
- Routine physical examinations for adults age 18 or more, including immunizations and routine vision and hearing screenings
  - Covered immunizations or immunological agents include:
    - › Hepatitis A
    - › Hepatitis B
    - › Herpes zoster
    - › Human papillomavirus
    - › Influenza
    - › Measles, mumps, rubella
    - › Meningococcal
    - › Pneumococcal
    - › Tetanus, diphtheria, pertussis varicella
- Routine physical examinations for children from birth to age 18
  - Immunizations for:
    - › Diphtheria, tetanus, pertussis
    - › Haemophilus influenza type b
    - › Hepatitis A
    - › Hepatitis B
    - › Human papillomavirus
    - › Inactivated poliovirus
    - › Influenza
    - › Measles, mumps, rubella
    - › Meningococcal
    - › Pneumococcal
    - › Rotavirus
    - › Varicella
    - › Any other immunization that is required for children by law
  - Hearing and vision screening for all children to determine the need for hearing and vision correction
  - Hearing screening for all newborns
    - › Newborn hearing screening coverage includes necessary follow-up care
- Pediatric vision care services and supplies as listed in the policy
- Certain tests for the early detection of cardiovascular disease
- Outpatient cognitive rehabilitation, physical, occupational and speech therapy
- Routine cancer screenings that include:
  - Screening mammograms
    - › A low-dose mammography includes a digital mammography and a breast tomosynthesis (3D mammography)
  - Prostate-specific antigen (PSA) tests
  - Digital rectal exams (DREs)
  - Fecal occult blood tests (FOBTs)
  - Sigmoidoscopies
  - Double-contrast barium enemas (DCBEs)
  - Colonoscopies
- Routine physical exams for women, including:
  - Routine gynecological exams: For women over 18 years of age, this includes an annual diagnostic exam for the early detection of ovarian and cervical cancer and human papillomavirus, including a routine Pap Smear, the CA 125 blood test or liquid-based cytology method
  - Osteoporosis: Medically accepted bone mass measurement to detect low bone mass and to determine the person's risk of osteoporosis and fractures associated with osteoporosis
- Injections, including allergy desensitization injections
- Diagnostic, laboratory, X-ray services
- Hearing aids
  - This includes medically necessary hearing aids or cochlear implant and related services and supplies for covered individuals 18 years or younger
  - Coverage includes:
    - › Fitting and dispensing services
    - › Treatment for habilitation and rehabilitation

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› For cochlear implant, an external speech processor and controller with necessary component and replacement every three years

- Cancer chemotherapy, oral cancer drugs and cancer hormone treatments and services that have been approved by the United States Food and Drug Administration (FDA) for general use in treatment of cancer
- Diagnosis and treatment of gynecological or infertility problems by participating gynecologists or participating infertility specialists. Benefits for infertility treatment are limited, and you should call **1-800-575-5999** for more information about coverage under your specific health plan.
- Outpatient and inpatient prenatal and postpartum care and obstetrical services, including minimum inpatient stays for maternity and childbirth
- Complications of pregnancy:
  - Conditions, requiring hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of complete severity, but shall not include false labor, occasional spotting, physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and
  - Nonelective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy, occurring during a period of gestation in which a viable birth is not possible
- Contraceptive drugs and devices
- Progesterone when it is deemed medically necessary (certain exclusions apply — see the "Exclusions and limitations" section)
- Voluntary sterilizations
- Inpatient hospital and skilled nursing facility benefits, including inpatient physician care. If you are admitted to an inpatient facility (such as a hospital or skilled nursing facility), a physician other than your primary care physician may direct and oversee your care. Except in an emergency, all services are subject to pre-authorization by us. Coverage for skilled nursing facility benefits is subject to the maximum number of days, if any, listed in your specific health plan.
- Transplants that are nonexperimental or noninvestigational. Covered transplants must be approved by a our medical director before the surgery. The transplant must be performed at a hospital specifically approved and designated by us to perform these procedures. If we deny coverage of a transplant based on lack of medical necessity, the member may request a review by an independent review organization (IRO). More information can be found in the "Complaints, Appeals and Independent Review" section of the plan documents.
- Outpatient surgical services and supplies in connection with a covered surgical procedure
- Nonemergency services and supplies are subject to pre-authorization by us
- Chemical dependency/substance abuse benefits
- Outpatient and inpatient care benefits are covered for detoxification
- Outpatient rehabilitation visits are covered to a participating behavioral health provider 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 for chemical dependency
- Mental health benefits: a member is covered for services for the treatment of mental or behavioral conditions provided through participating behavioral health providers
- Short-term, outpatient evaluative and crisis intervention or home health mental health services

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- Serious mental illness: diagnosis and medical treatment of a serious mental illness. Serious mental illness means the following psychiatric illnesses, as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM) III-R: schizophrenia; paranoid and other psychotic disorders; bipolar disorders (hypomanic; mixed, manic and depressive); major depressive disorders (single episode or recurrent); schizoaffective disorders (bipolar or depressive); obsessive-compulsive disorders and depression in childhood and adolescence.
- Autism spectrum disorders: a neurological disorder that includes autism, Asperger's syndrome, or Pervasive Development Disorder
  - Benefits include coverage for autism screening for children ages 18 to 24 months
- Services by a physician to diagnose Alzheimer's disease
- Emergency medical services, including screening/evaluation to determine whether an emergency medical condition exists, and for emergency medical transportation. See the "Emergency and urgent care and care after office hours" section for more information.
- Urgent, nonemergent care services obtained from a licensed physician or facility outside the service area if (i) the service is a covered benefit; (ii) the service is medically necessary and immediately required because of unforeseen illness, injury, or condition; and (iii) it was not reasonable, given the circumstances, for the member to return to the service area for treatment
- Inpatient and outpatient physical, occupational and speech rehabilitation services when they are medically necessary and meet or exceed the treatment goals established for the patient
- Cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing or treatment, neurofeedback therapy, remediation, postacute transition services, or community reintegration services, including outpatient day treatment services or other postacute care treatment services necessary as a result of, or related to, an acquired brain injury
- Cardiac rehabilitation benefits following an inpatient hospital stay. A limited course of outpatient cardiac rehabilitation is covered following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction.
- Home health benefits rendered by a participating home health care agency. Pre-authorization must be obtained from the member's attending participating physician. Home health benefits are not covered if we determine that the treatment setting is not appropriate or if there is a more cost-effective setting in which to provide appropriate care. Additional benefits and coverage may be included if your policy includes the home health mandated offer of benefit as referenced in this handbook.
- Hospice care medical benefits when pre-authorized
- Eligible health services, including the initial provision for and subsequent replacement of a prosthetic device that your physician orders and administers. Covered prosthetic appliances generally include those items not excluded under your specific health plan.
- Certain injectable medications when an oral alternative drug is not available and when pre-authorized, unless excluded under your specific health plan
- Mastectomy-related services including reconstructive breast surgery, prostheses and lymphedema, as described in your specific health plan
- Minimum inpatient stays for mastectomy or lymph node dissection

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- Administration of whole blood and blood plasma, processing of blood, processing fees, and fees related to autologous blood donations only, whole blood and blood including the cost of blood, blood plasma, and blood plasma expanders
- Diagnostic and surgical treatment of the temporomandibular joint that is medically necessary as a result of an accident, a trauma, a congenital defect, a developmental defect or a pathology
- Coverage for diabetes including, but not limited to, diabetic outpatient self-management training and education (including medical nutrition therapy for the treatment of diabetes), and equipment and supplies (including blood glucose monitors and monitor-related supplies including test strips and lancets; injection aids; syringes and needles; insulin pumps or tubing or other ancillary equipment and supplies for insulin pumps; insulin infusion devices; glucagon emergency kits; and insulin and other pharmacological agents for controlling blood sugar).
- Coverage 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
- Coverage for amino-acid-based elemental formulas necessary for the diagnosis, treatment or administration of the following to the same extent as for drugs available only on the orders of a physician:
  - Immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins
  - Severe food protein-induced enterocolitis syndrome
  - Eosinophilic disorders, as evidenced by the results of a biopsy
  - Impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length and motility of the gastrointestinal tract
- Orthotic and prosthetic devices
- Clinical trial therapies: Eligible health services include routine patient costs incurred to you by a provider in connection with participation in a phase I, phase II, phase III or phase IV approved clinical trial as a qualified individual for the prevention, detection or treatment of cancer or other life-threatening disease or condition, as those terms are defined in the federal Public Health Service Act, Section 2709. Approved clinical trials can be found in your Explanation of Coverage (EOC) document.
- Reconstructive surgery for craniofacial abnormalities for a child who is younger than 18 years of age
- Coverage for telehealth and telemedicine services
- Diagnostic or surgical treatment of conditions affecting the temporomandibular joint (including the jaw and the craniomandibular joint) if the treatment is medically necessary as a result of an accident; a trauma; a congenital defect; a developmental defect; or a pathology

Notice of additional mandatory benefits — Texas

This notice is to advise you of certain coverage and/or benefits provided by your contract with us.

Coverage for tests for detection of colorectal cancer

Benefits are provided, for each person enrolled in the plan who is 45 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. Colorectal screening benefits include:

- examinations
- preventive services
- laboratory tests (assigned a grade of “A” or “B” by the United State Preventive Services Task Force for average-risk individuals)
- initial colonoscopy or other medical test or procedures
- follow-up colonoscopy if initial results are abnormal

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You may have to pay part of the cost, if you go outside the plan's network for these services. If any person covered by this plan has questions concerning the above, they can call Member Services at **1-800-213-3224 (TTY: 711)**.

Coverage of tests for detection of human papillomavirus, ovarian cancer 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 ovarian and cervical cancer. Coverage required under this section includes a CA 125 blood test and, at a minimum, a conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the FDA, alone or in combination with a test approved by the FDA for the detection of the human papillomavirus.

Coverage and/or benefits for reconstructive surgery after mastectomy

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 determined 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.

Examinations for detection of prostate cancer

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

(1) A physical examination for the detection of prostate cancer

(2) A prostate-specific antigen test for each covered male who is

a. At least 50 years of age; or

b. At least 40 years of age with a family history of prostate cancer or other prostate cancer risk factor.

If any person covered by this plan has questions concerning the above, please call Member Services at **1-800-213-3224 (TTY: 711)**.

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, and

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

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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 breastfeeding 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.

Since 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 (e) penalize a physician for recommending inpatient care for the mother and/or the newborn child.

If any person covered by this plan has questions concerning the above, please call Member Services at **1-800-213-3224 (TTY: 711)**.

Coverage for newborn children

We will provide initial coverage of a newborn child born to a covered member from the moment of birth through the 31st day of life. This includes coverage for congenital defects and for the cost and administration of the required newborn screening tests. Continuation of coverage beyond this initial period of time will require the child to be enrolled in the plan.

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 covered person 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.

If any person covered by this plan has questions concerning the above, they can call Member Services at **1-800-213-3224 (TTY: 711)**.

Mental health parity

Mental health/substance abuse disorder services are covered in parity with medical and surgical benefits.

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Notice of coverage for acquired brain injury

Your health benefit plan coverage for an acquired brain injury includes the following services when they are medically necessary:

- Cognitive rehabilitation therapy
- Cognitive communication therapy
- Neurocognitive therapy and rehabilitation
- Neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing and treatment
- Neurofeedback therapy and remediation
- Postacute transition services and community reintegration services, including outpatient day treatment services or other post-acute-care treatment services
- Reasonable expenses related to periodic reevaluation of the care of an individual covered under the plan who has incurred an acquired brain injury, has been unresponsive to treatment, and becomes responsive to treatment at a later date, at which time the cognitive rehabilitation services would be a covered benefit.

The fact that an acquired brain injury does not result in hospitalization or acute-care treatment does not affect the right of the insured or the enrollee to receive the preceding treatments or services that commensurate with their condition.

Post-acute-care treatment or services may be obtained in any facility where those services may legally be provided, including acute or post-acute rehabilitation hospitals and assisted living facilities regulated under the Health and Safety Code.

You may obtain additional information from the Texas Department of Insurance regarding your rights by contacting them. Their website is **TDI.Texas.gov**. Their toll-free telephone number is **1-800-252-3439**.

Their address is Texas Department of Insurance 1601 Congress Avenue, Austin, TX 78701 or P.O. Box 12030, Austin, TX 78711

Pediatric hearing aids and cochlear implants and related services

Eligible health services include hearing aids or cochlear implants and the following related services and supplies:

- Fitting and dispensing services and ear molds necessary to maintain optimal fit of hearing aids
- Treatment related to hearing aids and cochlear implants, including: habilitation and rehabilitation necessary for educational gain
- For cochlear implants, an external speech processor and controller
- Internal replacement of cochlear implants

Notice of optional benefits your employer may decide to include in your benefit package — Texas

Below is a list of optional benefits your employer may decide to include in your benefits package. These benefits are also known as mandated offer benefits because we must offer the benefit to your employer and then your employer will have the option to include or not include the benefit in the actual policy. If included, some of these optional benefits will add additional coverage onto your other benefits. Be sure to check your plan documents for exact details.

Additional coverage benefits your employer has the option to include:

- Developmental delays
- Home health
- In-vitro fertilization
- Serious mental illness, crisis stabilization unit, residential treatment center for children and adolescents, and psychiatric day treatment facilities
- Speech and hearing impairment additional coverage

Other benefits and programs

Mental health and addiction benefits

Mental health and substance use disorder services coverage is provided on the same terms and conditions as medical and surgical benefits for any other physical illness. This includes inpatient and outpatient services, partial hospitalization and other mental health services.

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Our Behavioral Health offers two screening and prevention programs for our members

- Beginning Right® Depression Program: perinatal and postpartum depression education, screening and treatment referral
- Opioid Overdose Risk Screening (OORS) program

Women's Health and Cancer Rights Act of 1998 (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under WHCRA. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of the mastectomy, including lymphedema

Benefits will be provided to a person who has already undergone a mastectomy as a result of breast cancer while covered under a different health plan. Coverage is provided according to your plan design and is subject to plan limitations, copays, deductibles, coinsurance and referral requirements, if any, as outlined in your plan documents.

Please contact Member Services for more information. Or follow these links to learn more.
Fact sheet from the U.S. Department of Health and Human Services: **https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/whcra_ factsheet.html**
Pamphlet from the U.S. Department of Labor: **https://www.dol.gov/sites/default/files/ebsa/ about-ebsa/our-activities/resource-center/ publications/your-rights-after-a-mastectomy.pdf**

Transplants and other complex conditions

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

Additional notice on prescription drug benefits

Check your plan documents to see if your plan includes prescription drug benefits. If covered, go to **TexasHealthAetna.com/en/members/find-a-pharmacy.html** and review the prescription drug list (formulary). You can call the toll-free number on your ID card to ask for a printed copy. We frequently add new drugs to the guide. Look online or call Member Services for the latest updates. In addition, you may contact Pharmacy Member Services toll-free at **1-888-792-3862** to determine whether a specific drug is included in your plan's formulary.

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.

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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 Pharmacy Drug Guide (formulary). This guide shows which prescription drugs are covered on a preferred basis. It also explains how we choose which medications go into the guide.

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

Coverage of off-label drugs for certain conditions

Some plans will cover off-label drugs for certain chronic, disabling, or life-threatening illnesses.

Advanced metastatic cancer drug coverage

If your plan covers treatment of stage four advanced metastatic cancer, your plan will provide coverage for an FDA-approved prescription drug without first making you try and fail to respond successfully to other drugs first as long as certain other conditions are met.

5. Emergency and urgent care and care after office hours

Emergency care, including ambulance services, 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.

An emergency medical condition means your symptoms are sudden and severe. If you don't get help right away, an average person with average medical knowledge will expect you could die or risk your health. For a pregnant woman, that includes her unborn child, where one will expect that failure to get immediate medical care could result in serious jeopardy to the health of the fetus.

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

Sometimes you don't have a choice about where you go for care, like if you go to the emergency room for chest pain after a car accident. When you need care right away, go to any doctor, walk-in clinic, urgent care center or emergency room. This includes any emergency care services you may receive at any hospital. When you have no choice, we will pay the bill as if you got care in network. You pay your plan's copayments, coinsurance and deductibles for your in-network level of benefits.

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

6. Out-of-area services and benefits

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

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7. Your financial responsibility

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

Copay — A fixed amount (for example, $25) you pay for a covered health care service. You usually pay this when you receive the service. The amount can vary by the type of service. For example, the copay for your primary care doctor office visit may differ from the one you pay for a specialist.

Coinsurance — Your share of the costs of a covered service. Coinsurance is calculated as a percentage — such as 20 percent — of the allowed amount for the service. For example, if the health plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20 percent would be $20. The health plan pays the rest of the allowed amount.

Deductible — Some plans include a deductible. This is the amount you owe for health care services before your health plan begins to pay. For example, if your deductible is $1,000, your plan won't pay anything until you have paid $1,000 for any covered health care services that are subject to the deductible. The deductible may not apply to all services.

Inpatient hospital deductible — This deductible applies when you are a patient in a hospital.

Emergency room deductible — This is the amount you pay when you go to the emergency room. If you are admitted to the hospital within 24 hours, you won't have to pay it.

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

What you pay

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

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

Prescription drug costs

As an enrollee in a prescription drug plan, you are not required to make a payment for a prescription drug that is more than the lesser of:

- The applicable copayment
- The allowable claim amount
- The amount the individual would pay if purchasing without health benefits or discounts

Maintenance drugs

If there are drugs you take regularly for conditions like high blood pressure or diabetes, your prescription refills can be synchronized (so they can be refilled at the same time) at prorated cost-sharing amounts. This means you won't pay an extra cost for the convenience of having them synchronized.

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

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

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

EPO plans: Services and supplies obtained from out-of-network providers are not covered under the Open Access Elect Choice plan. Exceptions include: (1) care received from an out-of-network provider when a network provider is not reasonably available, (2) when services are provided by an out-of-network provider at an in-network facility, (3) when services are provided by an out-of-network diagnostic imaging provider in connection with medical care or health care services received by a preferred provider, (4) when services provided by an out-of-network laboratory are performed in connection with medical care or health care services received by a preferred provider, and (5) emergency care for an emergency medical condition.

In these cases, we generally will reimburse the out-of-network provider at our usual and customary rate or at the rate agreed to by the issuer and the provider.

When we help facilitate your out-of-network provider selection in these circumstances and you select an out-of-network provider that is not on the list provided by us, the reimbursement will typically be at the usual and customary charge. Please contact Member Services if you receive a bill from the out-of-network provider. We will work to resolve the outstanding balance so that all you pay is the appropriate network deductible, coinsurance or copayments under your plan.

PPO plans: Out-of-network services and care will generally be reimbursed at the usual and customary rate or an agreed upon rate in the following circumstances: (1) when care is received by an out-of-network provider when a network provider is not reasonably available, (2) when services are provided by an out-of-network provider at an in-network facility, (3) when services are provided by an out-of-network diagnostic imaging provider in connection with medical care or health care services received by a preferred provider, (4) when services provided by an out-of-network laboratory are performed in connection with medical care or health care services received by a preferred provider, and (5) emergency care for an emergency medical condition.

When we help facilitate your out-of-network provider selection in these circumstances and you select an out-of-network provider that is not on the list provided by us, the reimbursement will typically be at the usual and customary charge. Please contact Member Services if you receive a bill from the out-of-network provider. We will work to resolve the outstanding balance so that all you pay is the appropriate network deductible, coinsurance or copayments under your plan.

What you pay when you go outside the network

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

Out of network (nonpreferred benefits) means we do not have a contract for discounted rates with that doctor. We don't know exactly what an out-of-network doctor will charge you. If you voluntarily choose a doctor who is out of network, your health plan may pay some of that doctor's bill.

Most of the time, you will pay more money out of your own pocket if you voluntarily choose to use an out-of-network doctor. If you have an emergency or it is another special circumstance like mentioned above in "EPO plans" or "PPO plans," your claim will be considered in-network and paid accordingly.

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

When you voluntarily choose to see an out-of-network doctor, we pay for your health care depending on the plan you or your employer chooses. Some of our plans pay for out-of-network services by looking at what Medicare would pay and adjusting that amount up or down. Our plans range from paying 90% of Medicare (that is, 10% less than Medicare would pay) to 300% of Medicare (the Medicare rate multiplied by three). Some plans pay for out-of-network services based on what is called the usual and customary charge or reasonable amount rate. These plans use information from FAIR Health, Inc., a not-for-profit company, that reports how much providers charge for services in any ZIP code.

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

- **Reasonable amount rate:** The reasonable amount rate is generally based on the 80th percentile value reported in a database prepared by FAIR Health, a nonprofit company. FAIR Health changes these rates periodically.
- **Medicare rates:** The Centers for Medicare & Medicaid Services (CMS) develops rates for specific services based on the time, effort and expertise needed to perform that service and other relevant factors. More specifically, CMS rates take into account three factors: (1) the time or effort to provide the service; (2) provider administrative costs in the relevant geographic area; and (3) malpractice insurance costs by specialty in the relevant geographic area. CMS reflects these factors in Relative Value Units (RVUs) for each service. CMS assigns the RVU values based on recommendations of a committee composed of physicians. Providers widely accept Medicare patients and are reimbursed at the Medicare rates.
- **Our facility fee schedule:** Our facility fee schedule is based upon all of the plan's out-of-network claims experience.

Our way of paying out-of-network doctors and hospitals, described above, applies when you voluntarily choose to get care out of network.
In addition, we must pay for out-of-network services at in-network rates if you reasonably relied (within 30 days of the service date) on a statement that a doctor or other health care provider was a preferred provider as specified in:

- Our provider listing
- Provider information on our website

8. Exclusions and limitations

The following is a summary of services that are not covered. You are responsible for all costs. Limitations to medical care products and services as well as prescription drugs may also apply to covered services but vary by plan. Refer to your plan documents for details. Expenses for these health care services and supplies are not covered:

- Acupuncture, acupressure and acupuncture therapy, except where described in the "Eligible health services" section under your policy
- Ambulance services

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- Ambulance services for routine transportation to receive outpatient or inpatient services
- Fixed wing air ambulance transportation from an out-of-network provider

• Artificial organs

• Any device that would perform the function of a body organ

• Early intensive behavioral intervention

• Early intensive behavioral interventions (including LEAP, TEACCH, Rutgers, floor time, Lovaas and similar programs) and other intensive educational interventions

• Blood, blood plasma, synthetic blood, blood derivatives or substitutes (except as provided in the "Medically necessary and preventive care covered benefits" section)

- Examples of these are:
  - › The provision of blood to the hospital, other than blood derived clotting factors
  - › Any related services including processing, storage or replacement expenses
  - › The services of blood donors, apheresis or plasmapheresis for autologous blood donations; only administration and processing expenses are covered

• Clinical trial therapies (experimental or investigational) — your policy does not cover clinical trial therapies (experimental or investigational), except where described in the "Eligible health services — Clinical trial therapies (experimental or investigational)" section under your policy

- Clinical trial therapies (routine patient costs)
- Services and supplies related to data collection and record keeping that is solely needed due to the clinical trial (i.e., protocol-induced costs)
- Services and supplies provided by the trial sponsor without charge to you
- The experimental intervention itself (except medically necessary Category B investigational devices and promising experimental and investigational interventions for terminal illnesses in certain clinical trials in accordance with our claim policies)

• See "clinical trial therapies" that are covered in the "Medically necessary and preventive covered benefits" section above

• Cosmetic services and plastic surgery

- This exclusion does not include breast reconstruction following a mastectomy, reconstructive surgery for craniofacial abnormalities, or congenital defects — they are covered the same as any other illness or injury

• Any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body, whether or not for psychological or emotional reasons. This cosmetic services exclusion does not apply to surgery after an accidental injury when performed as soon as medically feasible. Injuries that occur during medical treatments are not considered accidental injuries, even if unplanned or unexpected.

• Counseling

• Marriage, religious, family, career, social adjustment, pastoral, or financial counseling

• Court-ordered services and supplies includes those court-ordered services and supplies, or those required as a condition of parole, probation, release or because of any legal proceeding

• Custodial care examples are:

- Routine patient care such as changing dressings, periodic turning and positioning in bed
- Administering oral medications
- Care of a stable tracheostomy (including intermittent suctioning)
- Care of a stable colostomy/ileostomy
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings

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- Care of a bladder catheter (including emptying/changing containers and clamping tubing)
- Watching or protecting you
- Respite care, adult (or child) day care, or convalescent care
- Institutional care: includes room and board for rest cures, adult day care and convalescent care
- Help with walking, grooming, bathing, dressing, getting in or out of bed, going to the bathroom, eating or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform
- Any service performed by a person without any medical or paramedical training

• Durable medical equipment (DME)
- Examples of these items are:
  › Whirlpools
  › Portable whirlpool pumps
  › Massage table
  › Sauna baths
  › Message devices (personal voice recorder)
  › Over bed tables
  › Elevators
  › Communication aids
  › Vision aids
  › Telephone alert systems

• Educational services (coverage for generally recognized educational services for autism spectrum disorder is not excluded)
- Examples of those services are:
  › Any service or supply for education, training or retraining services or testing. This includes special education, remedial education, wilderness treatment programs, job training and job hardening programs.
  › Services provided by a school district
  › Emergency services and urgent care
  › Nonemergency care in a hospital emergency room facility, freestanding emergency medical care facility or comparable emergency facility
  › Nonurgent care in an urgent care facility or at a nonhospital freestanding facility

• Elective abortions

• Examinations.

• Any health or dental examinations needed:
- Because a third party requires the exam. Examples include examinations to get or keep a job, or examinations required under a labor agreement or other contract
- Because a court order requires it
- To buy insurance or to get or keep a license
- To travel
- To go to a school, camp, or sporting event, or to join in a sport or other recreational activity

• Experimental or investigational

• Experimental or investigational drugs, devices, treatments or procedures unless otherwise covered under clinical trial therapies (experimental or investigational) or covered under clinical trials (routine patient costs)

• Facility charges for care, services or supplies provided in:
- Rest homes
- Assisted living facilities, except if you have an acquired brain injury. See the “Specific therapies and tests” section of the policy.
- Similar institutions serving as a person’s main residence or providing mainly custodial or rest care
- Health resorts
- Spas or sanitariums
- Infirmaries at schools, colleges, or camps

• Family planning services and supplies
- Examples of services and supplies that are not covered under the preventive care and wellness benefit include:

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› Any contraceptive methods that are only reviewed by the FDA and not approved by the FDA

› Contraception services during a stay in a hospital or other facility for medical care

› The reversal of voluntary sterilization procedures, including any related follow-up care

› Family planning services — other

› Reversal of voluntary sterilization procedures including related follow-up care

› Services and supplies provided for an abortion (voluntary termination of pregnancy) unless they're provided due to a medical emergency

› Charges incurred for family planning services while confined as an inpatient in a hospital or other facility

• Foot care

- Services and supplies for:

› The treatment of calluses, bunions, toenails, hammertoes, fallen arches

› The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes

› Supplies (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams and ointments, and other equipment, devices and supplies, except for complications of diabetes. See the "Specific conditions" section of the policy

• Growth/Height care

- A treatment, device, drug, service or supply to increase or decrease height or alter the rate of growth
- Surgical procedures, devices and growth hormones to stimulate growth

• Hearing aids and exams (exceptions to these exclusions include: (1) hearing aids and cochlear implants for children age 18 or younger and (2) when the policy includes the speech and hearing mandated offer benefit as referred to on page 8 of this handbook)

- The following services or supplies:

› A replacement of:

1. A hearing aid that is lost, stolen or broken
2. A hearing aid installed within the prior 36-month period

- Replacement parts or repairs for a hearing aid
- Batteries or cords
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss
- Any ear or hearing exam performed by a physician who is not certified as an otolaryngologist or otologist
- Any hearing aid furnished or ordered because of a hearing exam that was done before the date you became covered under this policy
- Hearing exams given during a stay in a hospital or other facility, except those provided to newborns as part of the overall hospital stay
- Any tests, appliances and devices to:

1. Improve your hearing includes hearing aid batteries and auxiliary equipment
2. Enhance other forms of communication to make up for hearing loss or devices that simulate speech

• Home health care (unless the policy includes mandated offer benefit as referenced on page 8 of this handbook)

- Services for infusion therapy (see the "Eligible health services — Outpatient infusion therapy" section under the policy for more information)
- Services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities)
- Transportation
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present
- Services are not for applied behavior analysis

• Hospice care

- Funeral arrangements
- Pastoral counseling

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- Financial or legal counseling: includes estate planning and the drafting of a will
- Homemaker or caretaker services, which are not solely related to your care, such as:
  - › Sitter or companion services for either you or other family members
  - › Maintenance of the house

• Maintenance care
- Care made up of services and supplies that maintain, rather than improve, a level of physical or mental function except for habilitation therapy services

• Medical supplies — outpatient disposable.
- Any outpatient disposable supply or device. Examples of these include:
  - › Sheaths
  - › Bags
  - › Elastic garments
  - › Support hose
  - › Bandages (does not apply to adhesive supplies associated with treatment of diabetes)
  - › Bedpans
  - › Syringes, except for treatment of diabetes
  - › Blood or urine testing supplies, except for treatment of diabetes
  - › Other home test kits
  - › Splints
  - › Neck braces
  - › Compresses
  - › Other devices not intended for reuse by another patient

• Mental health treatment.
- Mental health services for the following categories (or equivalent terms as listed in the most recent version of the International Classification of Diseases [ICD]):
  - › Dementias and amnesias without behavioral disturbances
  - › Sexual deviations and disorders except for gender identity disorders
  - › Tobacco use disorders
  - › Specific disorders of sleep
  - › Antisocial or dissocial personality disorder
  - › Pathological gambling, kleptomania, pyromania
  - › Specific delays in development (learning disorders, academic underachievement)
  - › Intellectual disability
  - › Wilderness treatment programs or any such related or similar programs
  - › School and/or education service
- Services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities)
- Transportation
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present
- Services are not for applied behavior analysis

• Nutritional supplements: Any food item, including infant formulas, nutritional supplements, vitamins, plus prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition, except as covered in the “Eligible health services under your policy — Other services” section

• Obesity (bariatric) surgery:
- Weight management treatment or drug intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity, except as covered in the “Eligible health services — Other services” section and the “Preventive care and wellness — Preventive screening and counseling services” section under your policy for obesity screening and weight management interventions. This is regardless of the existence of other medical conditions. Examples of these are:
  - › Liposuction, banding, gastric stapling, gastric bypass and other forms of bariatric surgery

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  - › Surgical procedures, medical treatments, weight control/loss programs primarily intended to treat, or are related to the treatment of, obesity, including morbid obesity
  - › Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications
  - › Hypnosis, or other forms of therapy
  - › Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement
- Orthotic devices
  - Services covered under any other benefit
  - Repair and replacement due to loss, misuse, abuse or theft
- Outpatient infusion therapy
  - Specialty prescription drugs and medicines provided by your employer or through a third-party vendor contract with your employer
  - Drugs that are included on the list of specialty prescription drugs as covered under your outpatient prescription drug plan
  - Enteral nutrition
  - Blood transfusions and blood products
  - Dialysis
- Outpatient prescription drugs
  - Abortion drugs
  - Allergy serum and extracts
  - Any services related to the dispensing, injection or application of a drug
  - Biological liquids and fluids
  - Brand-name prescription drugs and devices when a generic prescription drug equivalent, biosimilar prescription drug or generic prescription drug alternative is available, unless otherwise covered by formulary exception
- Cosmetic drugs
  - Cosmetic drugs, medications or preparations used for cosmetic purposes
  - Compound prescriptions containing bulk chemicals that have not been approved by the U.S. Food and Drug Administration (FDA)
  - Devices, products and appliances that do not have a National Drug Code (NDC)
  - Dietary supplements including medical foods
  - Drugs or medications:
    - › Administered or entirely consumed at the time and place it is prescribed or dispensed
    - › Which do not, by federal or state law, require a prescription order (i.e., over-the-counter [OTC] drugs), even if a prescription is written, except where stated in the "Eligible health services — Outpatient prescription drugs" section under your policy
    - › That include the same active ingredient or a modified version of an active ingredient
    - › That are therapeutically equivalent or a therapeutic alternative to a covered prescription drug unless a formulary exception request is approved
    - › That are therapeutically equivalent or a therapeutic alternative to an over-the-counter (OTC) product unless a formulary exception request is approved
    - › Provided by, or while the person is an inpatient in, any health care facility, or for any drugs provided on an outpatient basis in any such institution to the extent benefits are payable for it
    - › Recently approved by the U.S. Food and Drug Administration (FDA) but which have not yet been reviewed by our Pharmacy and Therapeutics Committee
    - › That include vitamins and minerals
    - › For which the cost is recoverable under any federal, state, or government agency or any medication for which there is no charge made to the recipient

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  - › That are used for the treatment of sexual dysfunction, to enhance sexual performance or increase sexual desire, including drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ
  - › That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature unless there is evidence that the member meets one or more clinical criteria detailed in our pre-authorization and clinical policies
  - › Not approved by the FDA or not proven to be safe and effective
- Duplicative drug therapy (e.g. two antihistamine drugs)
- Genetic care
- Any treatment, device, drug, service or supply to alter the body's genes, genetic makeup, or the expression of the body's genes except for the correction of congenital birth defects
- Immunizations related to travel or work
- Immunization or immunological agents. See the "Preventive care immunizations" section of the policy for covered immunizations.
- Implantable drugs and associated devices except where stated in the "Eligible health services" section under your policy
- Preventive care and wellness and outpatient prescription drugs sections
- Infertility
- Injectable prescription drugs used primarily for the treatment of infertility
- Injectables:
  - › Any charges for the administration or injection of prescription drugs or injectable insulin and other injectable drugs covered by us. See the "Eligible health services — Diabetic equipment, supplies and education for covered equipment and supplies" section of the policy.
  - › For EPO plans, injectable drugs dispensed by out-of-network pharmacies (this exclusion does not apply to PPO-based plans)
  - › Needles and syringes, including but not limited to diabetic needles and syringes, except where stated in the "Eligible health services — Diabetic equipment, supplies and education" section of the policy.
  - › For EPO plans, injectable drugs that are not dispensed through the network specialty pharmacy (this exclusion does not apply to PPO-based plans)
  - › For EPO plans, any refill of a designated specialty prescription drug not dispensed by or obtained through the network specialty pharmacy (this exclusion does not apply to PPO-based plans). An updated copy of the list of specialty prescription drugs designated by the policy to be refilled by or obtained through the network specialty pharmacy is available upon request or may be accessed by logging in to your member website.
- Prescription drugs:
  - › For EPO plans, prescription drugs dispensed by a pharmacy that is not a network retail, home delivery, or specialty pharmacy (this exclusion does not apply to PPO-based plans)
  - › For EPO plans, prescription drugs dispensed by an out-of-network home delivery pharmacy, except in a medical emergency or urgent care situation (this exclusion does not apply to PPO-based plans)
  - › For which there is an over-the-counter (OTC) product which has the same active ingredient and strength even if a prescription is written (exceptions to this exclusion are drugs associated with the treatment of diabetes)
  - › Filled prior to the effective date or after the end date of coverage under the policy

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› Dispensed by a home delivery pharmacy that includes prescription drugs that cannot be shipped by mail due to state or federal laws or regulations, or when the policy considers shipment through the mail to be unsafe. Examples of these types of drugs include, but are not limited to, narcotics, amphetamines, DEA-controlled substances and anticoagulants

› That include an active metabolite, stereoisomer, prodrug (precursor) or altered formulation of another drug and is not clinically superior to that drug as determined by the policy

› That are ordered by a dentist or prescribed by an oral surgeon in relation to the removal of teeth, or prescription drugs for the treatment of a dental condition unless dental benefits are provided under the policy

› That are considered oral dental preparations and fluoride rinses, except pediatric fluoride tablets or drops as specified in the pharmacy drug guide

› That are nonpreferred drugs, unless nonpreferred drugs are specifically covered as described in your schedule of benefits. However, a nonpreferred drug will be covered if in the judgment of the prescriber there is no equivalent prescription drug in the pharmacy drug guide or the product in the pharmacy drug guide is ineffective in treating your disease or condition or has caused or is likely to cause an adverse reaction or harm you.

› That are not covered or related to a noncovered service

› That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, the use of or intended use of which would be illegal, unethical, imprudent, abusive, not medically necessary, or otherwise improper, and drugs obtained for use by anyone other than the member identified on the ID card

We reserve the right to include only one manufacturer's product in the pharmacy drug guide when the same or similar drug (that is, a drug with the same active ingredient), supply or equipment is made by two or more different manufacturers.

We reserve the right to include only one dosage or form of a drug in the pharmacy drug guide when the same drug (that is, a drug with the same active ingredient) is available in different dosages or forms from the same or different manufacturers. The product in the dosage or form that is listed in our pharmacy drug guide will be covered at the applicable copayment.

- Progesterone is excluded for the treatment of premenstrual syndrome (PMS) and compounded natural hormone therapy replacement
- Prophylactic drugs for travel
- Refills:
  - Refills dispensed more than one year from the date the latest prescription order was written, or as otherwise permitted by applicable law of the area in which the drug is dispensed
  - For prescription eye drops to treat a chronic eye disease or condition, the refill for a 30/60/90-day supply may not be denied for a refill received at 21/43/63 days after the date a prescription supply of eye drops is dispensed
- Replacement of lost or stolen prescriptions
- Tobacco use
  - Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including medications, nicotine patches and gum unless recommended by the United States Preventive Services Task Force (USPSTF). See the "Eligible health services — Outpatient prescription drugs" section of the policy.
  - Test agents except diabetic test agents
- Outpatient surgery
  - The services of any other physician who helps the operating physician

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- A stay in a hospital. (A hospital stay is an inpatient hospital benefit. See the "Eligible health services — Hospital and other facility care" section under the policy.)
- A separate facility charge for surgery performed in a physician's office
- Services of another physician for the administration of a local anesthetic

• Dental care for adults
- Dental services for adults including services related to:
  › The care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth, except for treatment of accidental injury to sound natural teeth
  › Dental services related to the gums
  › Apicoectomy (dental root resection)
  › Orthodontics
  › Root canal treatment
  › Soft tissue impactions
  › Alveolectomy
  › Augmentation and vestibuloplasty treatment of periodontal disease
  › False teeth
  › Prosthetic restoration of dental implants
  › Dental implants

This exclusion does not include removal of bony impacted teeth, bone fractures, removal of tumors, and odontogenic cysts.

• Personal care, comfort or convenience items:
- Any service or supply primarily for your convenience and personal comfort or that of a third party

• Physician surgical services:
- The services of any other physician who helps the operating physician
- A stay in a hospital (see the "Eligible health services — Hospital and other facility care" section under the Evidence of Coverage/policy)
- A separate facility charge for surgery performed in a physician's office
- Services of another physician for the administration of a local anesthetic

• Prosthetic devices
- Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes, or if the orthopedic shoe is an integral part of a covered leg brace
- Trusses, corsets and other support items
- Repair and replacement due to loss, misuse, abuse or theft

• Services provided by a family member: services provided by a spouse, domestic partner, parent, child, stepchild, brother, sister, in-law or any household member

• Services, supplies and drugs received outside of the United States: Nonemergency medical services, outpatient prescription drugs or supplies are not covered when received outside the United States, even if they are covered in the United States under the policy.

• Sexual dysfunction and enhancement
- Any treatment, prescription drug, service, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
  › Surgery, prescription drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ
  › Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services

• Short-term rehabilitation services
- Any service unless provided in accordance with a specific treatment plan
- Services you get from a home health care agency, unless policy includes the home health services mandated offer benefit, as referenced on page 8 of this handbook.

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- Services provided by a physician, or treatment covered as part of the spinal manipulation benefit. This applies whether or not benefits are paid under the spinal manipulation section
- Services not given by a physician (or under the direct supervision of a physician), physical, occupational or speech therapist
- Services for the treatment of delays in development, including speech development, unless as a result of a gross anatomical defect at birth or where the policy includes the developmental delay mandated offer benefit as referenced on page 8 of this handbook.

• Specialty prescription drugs
- Drugs that are included on the list of specialty prescription drugs as covered under your outpatient prescription drug plan

• Strength and performance: Services, devices and supplies such as drugs or preparations designed primarily to enhance your strength, physical condition, endurance or physical performance

• Telemedicine or telehealth
- Any services given by providers that are not contracted with Aetna as telemedicine or telehealth providers
  › Any services that are not provided during an internet-based consult or via telephone

• Therapies and tests
- Full body CT scans
- Hair analysis
- Hypnosis and hypnotherapy
- Massage therapy, except when used as a physical therapy modality
- Sensory or auditory integration therapy

• Tobacco cessation
- Except where described in the policy, any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including, medications, nicotine patches and gum unless recommended by the United States Preventive Services Task Force (USPSTF). This also includes:
  › Counseling, except where stated in the "Eligible health services — Preventive care and wellness" section of the policy
  › Hypnosis and other therapies
  › Medications, except where stated in the "Eligible health services — Outpatient prescription drugs" section of the policy
  › Nicotine patches
  › Gum

• Transplant services
- Services and supplies furnished to a donor when the recipient is not a covered person
- Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing illness
- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence
- Home infusion therapy
- Harvesting and/or storage of bone marrow, or hematopoietic stem cells without intending to use them for transplantation within 12 months from harvesting, for an existing illness

• Treatment in a federal, state, or governmental entity — Any care in a hospital or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws

• Treatment of infertility

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- All charges associated with the treatment of infertility, except as described under the "Eligible health services — Treatment of infertility — Basic infertility" section under the policy. This includes all charges associated with:
  - › Surrogacy for you or the surrogate. A surrogate is a female carrying her own genetically related child where the child is conceived with the intention of turning the child over to be raised by others, including the biological father
  - › Cryopreservation of eggs, embryos or sperm
  - › Storage of eggs, embryos or sperm
  - › Thawing of cryopreserved eggs, embryos or sperm
  - › The care of the donor in a donor egg cycle. This includes, but is not limited to, any payments to the donor, donor screening fees, fees for lab tests, and any charges associated with care of the donor required for donor egg retrievals or transfers
  - › The use of a gestational carrier for the female acting as the gestational carrier. A gestational carrier is a female carrying an embryo to which she is not genetically related
- Home ovulation prediction kits or home pregnancy tests
- Injectable infertility medication, including but not limited to menotropins, hCG, and GnRH agonists
- The purchase of donor embryos, donor oocytes, or donor sperm
- Reversal of voluntary sterilizations, including follow-up care
- Any charges associated with obtaining sperm for ART services
- Ovulation induction with menotropins, intrauterine insemination and any related services, products or procedures
- In vitro fertilization (IVF) (unless policy includes in vitro fertilization mandated offer benefit as referenced on page 8 of this handbook), zygote intrafallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers and any related services, products or procedures (such as intracytoplasmic sperm injection [ICSI] or ovum microsurgery)

• Vision care

- Pediatric vision care
  - › Eyeglass frames, prescription lenses and prescription contact lenses that are not identified as preferred by a vision provider
  - › Eyeglass frames, nonprescription lenses and nonprescription contact lenses that are for cosmetic purposes
- Adult vision care
- Routine vision exam provided by an ophthalmologist or optometrist including refraction and glaucoma testing and vision care services and supplies
- Vision care services and supplies

Your policy does not cover vision care services and supplies, except as described in the "Eligible health services — Other services" section under the policy.

- Special supplies such as nonprescription sunglasses
- Eyeglass frames, nonprescription lenses and nonprescription contact lenses that are for cosmetic purposes
- Special vision procedures, such as orthoptics or vision therapy
- Eye exams during your stay in a hospital or other facility for health care
- Eye exams for contact lenses or their fitting
- Eyeglasses or duplicate or spare eyeglasses or lenses or frames
- Replacement of lenses or frames that are lost or stolen or broken
- Acuity tests
- Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures

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- Services to treat errors of refraction

• Wilderness treatment programs

- Wilderness treatment programs (whether or not the program is part of a residential treatment facility or otherwise licensed institution)
- Educational services, schooling or any such related or similar program, including therapeutic programs within a school setting

• Work-related illness or injuries

- Coverage available to you under workers' compensation or under a similar program under local, state or federal law for any illness or injury related to employment or self-employment.
- A source of coverage or reimbursement is considered available to you even if you waived your right to payment from that source. You may also be covered under a workers' compensation law or similar law.
- If you submit proof that you are not covered for a particular illness or injury under such law, then that illness or injury will be considered nonoccupational regardless of cause.

Drug formulary additional limitations:

Step therapy — you may have to try one drug before you can try another

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

Step-therapy protocol, including denials of step-therapy exception requests, are subject to adverse determination appeal rights, as well as an independent review by an independent review organization (IRO).

You may request an exception for some drugs that are not covered

Your plan documents might list specific drugs that are not covered. Your plan also may not cover drugs that we haven't reviewed yet. You, someone helping you, or your doctor may have to get our approval by making a formulary exception request to use one of these drugs.

No coverage based on U.S. sanctions

If U.S. trade sanctions consider you a blocked person, the plan cannot provide benefits or coverage to you. If you travel to a country sanctioned by the United States, the plan in most cases cannot provide benefits or coverage to you. Also, if your health care provider is a blocked person or is in a sanctioned country, we cannot pay for services from that provider.

9. Pre-authorization: getting approvals for services

Sometimes we will pay for care only if we have given an approval before you get it. We call that pre-authorization. Pre-authorization is usually limited to more serious care like surgery or being admitted to a hospital or skilled nursing facility. Your plan documents list all the services that require you to get pre-authorization. If you don't, you will have to pay for all or a larger share of the cost of the service. For example, you may pay a higher share (such as 50%) or a specific penalty (such as $400). These costs will not apply to your deductible or out-of-pocket limits.

Notice: You must personally bear all costs if you use health care not authorized by this plan or purchase drugs that are not authorized by this plan.

How to request pre-authorization

When you get care from a doctor in the network, your doctor or hospital staff will request pre-authorization for you. But if you get your care outside our network, you must call us for pre-authorization when it's required.

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

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Time frames for pre-authorization requests

Pre-authorization time frames for responses to requests:

- Within three calendar days for nonhospitalized requests
- 24 hours for inpatient and concurrent requests
- One hour or less for post-stabilization or life-threatening requests

When to request pre-authorization

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

What we look for when reviewing a pre-authorization request

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

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

Pre-authorization, when used in this document, means a determination that health care services proposed to be provided to a patient are medically necessary and appropriate.

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

A pre-authorization may not be required if your provider meets the requirements of prior pre-authorization approvals. Please contact your physician or us for additional information.

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

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

Our review process after pre-authorization (utilization review/patient management)
We have developed a patient management program to help you access appropriate health care and maximize coverage for those health care services. In certain situations, we review your case to be sure the service or supply meets established guidelines and is a covered benefit under your plan. We call this a utilization review.

It is possible that a previously preauthorized service can be denied as a result of a utilization review.

Pre-authorization renewal process

We have a pre-authorization renewal process in place that allows for the renewal of an existing prior authorization prior to its expiration. To renew an existing pre-authorization, your physician or health care provider will just need to request the renewal from us at least 60 days before the previous pre-authorization would be expiring. We will then, if practicable, review the request and issue a determination indicating whether the pre-authorization service request is renewed prior to the previous one expiring.

10. What happens if your doctor leaves the health plan

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

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

To be eligible, your doctor cannot have left the network for any of these reasons:
- Imminent harm to your health
- Action against the doctor's professional license

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- Provider fraud
- Failure to satisfy credentialing criteria

11. What to do if you disagree

Complaints, appeals and external review

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

To file a verbal complaint or ask for the address to mail a complaint, contact Member Services by any of the ways below.

- Phone: call the phone number on your ID card
- Email: find the address on **TexasHealthAetna.com**

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

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

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

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

For more information about your right to an appeal, contact the Texas Department of Insurance. You may write the Texas Department of Insurance at:

1601 Congress Avenue, Austin, TX 78701

or

P.O. Box 12030, Austin, TX 78711

Fax: **512-490-1007**

Web: **www.tdi.texas.gov**

Email: **www.tdi.texas.gov/consumer/get-help-with-an-insurance-complaint.html**

Toll-free phone: **1-800-252-3439**

Prescription drugs and infusions

Investigation and resolution of appeals relating to prescription drugs and intravenous infusions for which the patient is receiving benefits will be resolved in one business day.

We will notify you no later than 30 days prior to the discontinuance of a concurrent prescription drug or intravenous infusions.

You'll have coverage for an immediate appeal to an independent review organization (IRO) for denial of prescription drugs or intravenous infusions.

A rush review may be possible

If your doctor thinks you cannot wait 30 days, ask for an expedited review. Examples include denials for emergency care and for continued hospital stays. We will respond as soon as is practicable, but not later than within one working day.

We will give your provider a notice of denial of coverage for post-stabilization care after emergency treatment no later than one hour after the time your physician requests the care. We will also notify you of a denial for continued hospital stay within 24 hours of your request.

Get a review from someone outside Texas Health | Aetna

You may be able to get an outside review if you're not satisfied with your appeal. You have the right to appeal any (eligibility, services not covered) decision to an independent medical review. The right to independent medical review is not restricted to denials based on medical necessity or experimental and investigative products or services.

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

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

To request an IRO review, follow the instructions on our response to your appeal (final determination letter). Call Member Services to ask for an external review form. Or, go to **TexasHealthAetna.com** and in the search bar put **external review**.

You, your doctor or hospital representative must submit a request for an external review within 180 calendar days from the date you receive your final determination letter.

An independent review organization (IRO) will assign the case to a physician reviewer with appropriate expertise in the area in question. Once we receive all necessary information, the IRO will generally make a decision within 30 calendar days of the request. Expedited reviews are available when your health care provider certifies that a delay in service would jeopardize your health.

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

12. Doctors, hospitals and other health care providers

Search our network

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

Existing members: Visit **TexasHealthAetna.com** and log in. From your member website home page, in the top menu bar to start your search, select **Find Care**.

Considering enrollment: Visit **TexasHealthAetna.com** and under **Quick Links**, select **Find a doctor**, and then **Guests**. Next, follow the steps to search for providers.

Get a free printed directory

To get a free printed list of doctors and hospitals, call the toll-free number on your ID card. If you're not yet a member, call **1-800-213-3224 (TTY: 711)**.

Additional information specific to Texas

Go to **MyPlanPortal.com/dsepublicContent/assets/html/content.html?resource=texashealthaetna/index-imp-info-tx** for additional Texas plan information about provider directories.

Special note for female members of EPOs

Note, for EPO plans, female insureds have direct access to an OB/GYN for female services.

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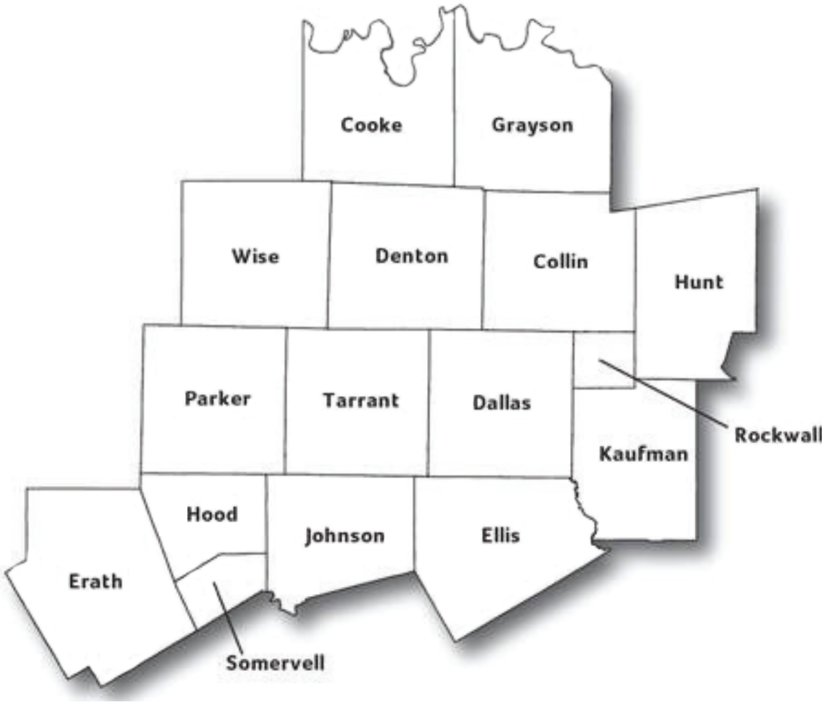
13. Texas Health | Aetna service areas

This plan generally covers benefits in the counties listed below. See “Emergency and urgent care and care after office hours” and “Your costs when you go outside the network” for more information.

Counties: Collin, Cooke, Dallas, Denton, Ellis, Erath, Grayson, Hood, Hunt, Johnson, Kaufman, Parker, Rockwall, Somervell, Tarrant and Wise



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14. Network demographics

To learn more about the number of insureds, providers and hospitals in each service area, please call the toll-free number on your ID card.

15. Network adequacy waivers or local market access plans

Visit **MyPlanPortal.com/dsepublic/#/contentPage?page=providerSearchLanding&site_id=texashealthaetna** to view a listing of counties in Aetna service areas and whether or not they meet state network adequacy rules.

Visit **TDI.texas.gov/hmo/mcqa/networkadqacspln.html** to view where the Texas Department of Insurance posts information relevant to the grant of waivers and access plans.

16. Texas Department of Insurance disclosures

Open Choice® PPO and Open Access® Managed Choice® POS disclosure

Texas Department of Insurance notice

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

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

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

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

You may obtain a current directory of preferred providers at **MyPlanPortal.com/dsepublic/#/contentPage?page=providerSearchLanding&site_id=texashealthaetna** or by calling the number on your ID card. If you're not yet enrolled, call **1-888-982-3862 (TTY: 711)** for assistance in finding available preferred providers. If the directory is materially inaccurate, you may be entitled to have an out-of-network claim paid at the in-network level of benefits.

Exclusive Provider Organization disclosure

Texas Department of Insurance notice

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

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

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

You may obtain a current directory of preferred providers at **MyPlanPortal.com/dsepublic/#/contentPage?page=providerSearchLanding&site_id=texashealthaetna** or by calling **1-800-213-3224 (TTY: 711)** for assistance in finding available preferred providers.

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

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17. Important other information about our plans

We offer quality health plans

By following health plan accreditation standards of the National Committee for Quality Assurance (NCQA), we offer you quality health plans. Visit **Aetna.com/document-library/individuals-families-health-insurance/document-library/documents/2019Disclosures/NCQA-MED-Disclosures-FI-SI.pdf** to learn more about how we meet the NCQA accreditation and standards. You can also call us at the number on your member ID card to ask for a printed copy.

This document details how to:

Understand your health plan

- Benefits and services included in, and excluded from, your coverage
- Prescription drug benefit
- Mental health and addiction benefits
- Care after office hours, urgent care, and emergency care

Get plan information online and by phone

- How you can reach us
- Help for those who speak another language and for the hearing impaired
- Get information about how to file a claim
- Search our network for doctors, hospitals and other health care providers
- Accountable care organizations (ACOs)
- Our quality management programs, including goals and outcomes

Know the costs and rules for using your plan

- What you'll pay
- Your costs when you go outside the network
- Precertification: getting approvals for services
- We study the latest medical technology
- How we make coverage decisions
- Complaints, appeals and external reviews

Understand your rights and responsibilities

- Member rights and responsibilities
- Notice of Privacy Practices

Member rights and responsibilities

Not yet a member?

For help understanding how a certain medical plan works, review the plan's Summary of Benefits and Coverage document.

We don't consider race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age or national origin when giving you access to care. Federal law requires network providers to do the same.

Nondiscrimination policy for genetic testing

We don't use the results of genetic testing to discriminate, in any way, against applicants or enrollees. Also, you choose if you want to tell us your race or ethnicity and preferred language. We'll keep that information private. We use it to help us improve your access to health care and to serve you better.

Your rights under the Employee Retirement Income Security Act of 1974 (ERISA)

If you're a participant in an employer-funded group health plan, you're entitled to certain rights and protections under ERISA. Some of those rights are listed below. Your rights are outlined in more detail in your plan documents.

Below are some of your rights.

- Receive, free of charge, information about your plan and benefits.
- Upon written request to your plan administrator, examine copies of documents governing the operation of the plan, contracts, collective bargaining agreements, annual reports and more. The administrator may charge you a reasonable copy fee.
- Receive a copy of procedures used to determine a qualified domestic relation or medical child support order.
- Continue group health coverage for you, your spouse or dependents if there is a loss of coverage as the result of a qualifying event.

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- Know why a claim was denied.
- Exercise your rights and take steps to enforce your rights, without discrimination or retribution.
- Get answers to your questions about the plan. Contact your plan administrator with questions about your plan. If they don't provide the information you asked for, you can get help from the nearest office of the Employee Benefits Security Administration, which is part of the U.S. Department of Labor. Look them up online or in your local telephone directory.

Your right to enroll later

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? If you chose not to enroll during the normal open enrollment period, you may enroll within 31 days after a life event. Examples of life events are marriage, divorce, birth, adoption, and placement for adoption. Talk to your benefits administrator for more information or to request special enrollment.

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Texas Health | Aetna complies with applicable federal civil rights laws and does not unlawfully discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call **1-800-213-3224 (TTY: 711)**.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,

P.O. Box 14462, Lexington, KY 40512,

1-800-648-7817, TTY: 711,

Fax: **859-425-3379**

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,** or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at **1-800-368-1019**, **800-537-7697 (TDD)**.

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TTY: 711

To access language services at no cost to you, call 1-888-982-3862 .

Para acceder a los servicios de idiomas sin costo, llame al 1-888-982-3862. (Spanish)

如欲使用免費語言服務，請致電 1-888-982-3862 。(Chinese)

Afin d'accéder aux services langagiers sans frais, composez le 1-888-982-3862 . (French)

Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-888-982-3862 . (Tagalog)

Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-888-982-3862 an. (German)

للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1-888-982-3862 . (Arabic)

Pou jwenn sèvis lang gratis, rele 1-888-982-3862 . (French Creole-Haitian)

Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-888-982-3862. (Italian)

言語サービスを無料でご利用いただくには、1-888-982-3862 までお電話ください。(Japanese)

무료 언어 서비스를 이용하려면 1-888-982-3862 번으로 전화해 주십시오. (Korean)

برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-888-982-3862 تماس بگیرید. (Persian-Farsi)

Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-888-982-3862 . (Polish)

Para acessar os serviços de idiomas sem custo para você, ligue para 1-888-982-3862. (Portuguese)

Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-888-982-3862 . (Russian)

Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-888-982-3862 . (Vietnamese)

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