Member handbook and consumer disclosure

Important information about your health benefits

Health Maintenance Organization (HMO)
Open Access® HMO
Point of Service (POS)

TexasHealthAetna.com

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Important disclosure information

HMO

Open Access HMO

Point of Service (POS)

Texas Health Aetna is the brand name used for products and services provided by Texas Health + Aetna Health Insurance Company and Texas Health + Aetna Health Plan Inc. Health benefits and health insurance plans are offered and/or insured by Texas Health + Aetna Health Plan Inc. and Texas Health + Aetna Health Insurance Company (Texas Health Aetna). Each insurer has sole financial responsibility for its own products. Texas Health Aetna is an affiliate of Texas Health Resources and of Aetna Life Insurance Company and its affiliates (Aetna). Aetna provides certain management services to Texas Health Aetna.

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1. Texas Health | Aetna HMO plan types

Texas Health + Aetna Health Plan Inc. (Texas Health Aetna) is licensed by the Texas Department of Insurance to operate as a health maintenance organization (HMO) within an approved service area.

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. Information about specific 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:

- Imaging services
- Inpatient meals and special diets when medically necessary; use of operating room and related facilities; use of intensive care unit and services; drugs, medications, biologicals, anesthesia, and oxygen services; radiation therapy; inhalation therapy; whole blood including cost of blood, blood plasma, and blood plasma expanders, that are not replaced by or for the enrollee
- Outpatient radiation therapy
- Short-term rehabilitation services
- Primary care physician and specialist physician (upon referral) outpatient and inpatient visits
- Inpatient services that include room and board and private duty nursing
- 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, routine vision screenings 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, including 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

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- Hearing screening for all newborns; includes an initial hospital checkup and the administration of the newborn screening tests as required by applicable Texas law. This includes the cost of a newborn screening test kit in the amount provided by the Department of State Health Services. Newborn hearing screening coverage includes necessary follow-up care
- Pediatric and adult vision care services and supplies as listed in the Evidence of Coverage. 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.
- 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 (DCBE)
- 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 methods
- 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
  - 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 (TTY: 711)** 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 comparable 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

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- Progesterone when it is deemed medically necessary (certain exclusions apply — see the "Exclusions and limitations"
- 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 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 when visiting 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
- Coverage for mental health and substance use services is provided on the same terms and conditions as medical and surgical benefits for any other physical illness.
- Short-term, outpatient evaluative and crisis intervention or home health mental health services
- Serious mental illness: diagnosis and medical treatment of a serious mental illness. Serious mental illness means the following psychiatric illnesses (as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual [DSM] III-R): schizophrenia; paranoid and other psychotic disorders; bipolar disorders (hypomanic; mixed, manic and depressive); major depressive disorders (single episode or recurrent); schizoaffective disorders (bipolar or depressive); 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 18–24 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 network service area for treatment.

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- 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 and related to an acquired brain injury
- Cardiac rehabilitation benefits following an inpatient hospital stay. A limited course of outpatient cardiac rehabilitation is covered following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction.
- Home health benefits rendered by a participating home health care agency. Pre-authorization must be obtained from the member's attending participating physician. Home health benefits are not covered if we determine the treatment setting is not appropriate or if there is a more cost-effective setting in which to provide appropriate care.
- Hospice care medical benefits when pre-authorized
- Eligible health services include the initial provision 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
- 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 includes, but is not limited to: Diabetic outpatient self-management training and education (including medical nutrition therapy for the treatment of diabetes), equipment and supplies (including blood glucose monitors and monitor-related supplies including test strips and lancets; injection aids; syringes and needles; insulin 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 is provided for formulas necessary for the treatment of phenylketonuria or other heritable diseases to the same extent as for drugs available only on the orders of a physician
- If ordered by a physician, coverage is provided for amino-acid elemental formulas and associated medically necessary services, regardless of the formula delivery method, to treat the following:
  - Immunoglobulin E and nonimmunoglobulin E mediated allergies to multiple food proteins
  - Severe 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
- Severe food protein-induced enterocolitis syndrome
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- 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 Evidence of Coverage.
- 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
- See also the "Exclusions" section in this document for information about what's not covered.

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

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.

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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)**.

HMO-specific mandates

Mandated Health Benefit Plan HMOs are required to cover:

- certain basic health care services without limit on time or cost;
- rehabilitation therapies without limit if certain treatment goals are met; and
- cost-sharing amounts up to a certain point. Specifically, copayments are capped a certain point and no deductibles may apply.

For more details about any of these HMO-specific benefits, call Member Services at **1-800-213-3224 (TTY: 711)**.

Consumer Choice "Lite" HMOs

Consumer Choice Plans may not include exact coverage of traditionally required health mandates and benefits. Check your plan documents to verify.

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.

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.

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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.

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.

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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 benefit package — Texas

Below is a list of optional benefits your employer may decide to include in your benefits package. 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
- Mental or emotional illness treatment
- In-vitro fertilization
- Serious mental illness, crisis stabilization unit, residential treatment center for children and adolescents, and psychiatric day treatment facilities (applies to small employer groups only)
- 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.

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

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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.

For more information, please contact Member Services at the number on your ID card, or the links below.

- Fact sheet from the U.S. Department of Health and Human Services: **CMS.gov/CCIIO/programs-and-initiatives/other-insurance-protections/whcra_factsheet.html**
- Pamphlet from the U.S. Department of Labor: **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 it does, your plan covers any medically necessary FDA-approved drug that's prescribed to treat chronic, disabling or life-threatening illnesses that are covered under the plan.

Some plans encourage generic drugs over brand-name drugs

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

We may also encourage you to use certain drugs

Some plans encourage you to buy certain prescription drugs over others. The plan may even pay a larger share for those drugs. Go to **TexasHealthAetna.com/en/members/find-a-pharmacy.html** to see those drugs in the prescription drug list (formulary). This guide shows which prescription drugs are covered on a preferred basis. It also explains how we choose medications to be in the guide.

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

Visit **TexasHealthAetna.com/en/members/find-a-pharmacy.html** to access a prescription drug list (formulary). You may also contact Member Services for help or assistance at any time.

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.

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4. Emergency and after-office hours

Emergency care

Emergency care includes health care services provided in a hospital emergency facility, freestanding emergency medical care facility or comparable emergency facility to evaluate and stabilize medical conditions of a recent onset and severity, including severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that the individual's condition, sickness or injury is of such a nature that failure to get immediate medical care could:

- Place the individual's health in serious jeopardy;
- Result in serious impairment to bodily functions;
- Result in serious dysfunction of a bodily organ or part;
- Result in serious disfigurement;
- Or for a pregnant woman, result in serious jeopardy to the health of the fetus.

You are covered for emergency care

Emergency care, including ambulance services, is covered anytime, anywhere in the world. You have this coverage while you are traveling or if you are near your home. That includes students who are away at school. Your copayment or other out-of-pocket costs will be based on in-network benefits, whether or not your plan has a network of providers at the facility or hospital you are treated at. The non-network providers will be reimbursed at the usual and customary rate or at an agreed rate.

Follow-up care after an emergency

Any follow-up care needed after your emergency should be coordinated by your primary care physician (PCP). You will need a referral for follow-up care that is not performed by your PCP. You may also need to preauthorize the services if you go outside the network

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.

5. Out-of-area services and benefits

This plan provides out-of-network benefits only for: (1) emergency care, (2) when medically necessary covered services are not available within the network, (3) when services are provided by an out-of-network provider at an in-network facility, (4) when services are provided by an out-of-network diagnostic imaging provider in connection with medical care or health care services received by an in-network provider and (5) when services provided by an out-of-network laboratory are performed in connection with medical care or health care services received by an in-network provider.

Otherwise, the plan covers health care services only when provided by a doctor who participates in our network. When you have no choice (such as emergency and nonavailable in-network services), we will cover the service as if you got care in network. Any applicable copayments will be due at the time the services are rendered.

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6. Provider balance billing for out-of-network services received

Although health care services may be or have been provided to you at a health care facility that is a member of the provider network used by your health benefit plan, other professional services may be or have been provided at or through the facility by physicians and other health care practitioners, including diagnostic imaging providers and laboratory service providers, who are not members of that network. These out-of-network physicians or practitioners may try to balance bill you for these services, but in certain situations this is prohibited by law. If you receive a balance bill from a provider or practitioner, contact member services, which can help you determine next steps.

7. Your share in the cost of your care

Your medical costs

These are called out-of-pocket costs. Out-of-pocket costs vary by plan, and your plan may not include all of them. Your plan documents show which amounts apply to your specific plan. Those costs may include:

Deductible — The amount you pay for covered health care services before we start to pay. For instance, if your deductible is $1,000, you must pay the first $1,000 of covered services yourself. After your deductible is met, typically you are only responsible for your copayment for covered services. Standard HMO plans pay $0 before we start paying our share of the cost.

Copayment — This could be a percentage of the cost (for example, you pay 25 percent and the plan pays 75 percent). It could also be a set amount (for example, $25) you pay for a covered health care service. You usually pay this when you get the service. The amount can vary by the type of service. For example, you may pay a different amount to see a specialist than you would pay to see your family doctor.

Other copayments may apply at the same time:

Inpatient hospital copayment — This copayment applies when you are a patient in a hospital

Emergency room copayment — 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.

Note on network physicians

Network physicians have agreed to look only to us (the HMO) and not to you (the enrollee) for payment of services, except as set forth in this description of the plan.

Reliance on physician and provider listing in certain cases

We frequently update our provider listings to make sure all providers listed as in-network ones are still contracted with us. However, if ever 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 or on our website, we will pay for out-of-network services at in-network rates.

We will not pay your bill and you will be responsible if:

- You receive treatment from a physician (other than your PCP) or facility in a nonemergency situation without a prior referral from your PCP, except for a direct-access benefit, urgently needed care, emergency care and certain other specific services as described above and/or in your plan documents.
- You go directly to an emergency facility for treatment in your service area when it is not an emergency. Except in certain cases where we are required to pay for screening fees, you will be responsible for the entire bill (see your Certificate of Coverage).
- You receive post emergency follow-up treatment from a nonparticipating physician without a referral, except where payment is required by applicable state law.
- You receive services that are not covered by your health plan. (See Limitations and Exclusions in your plan documents.)

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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.

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 Evidence of Coverage
- 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 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 covered services 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 Evidence of Coverage 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 Evidence of Coverage.
- 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 care covered benefits" section above

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- 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
- 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
- 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

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- 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 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 Evidence of Coverage.
- 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:

- 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, which is defined as "a life-threatening physical condition aggravated by, caused by, or arising from a pregnancy that, as certified by a physician, places the woman in danger of death or a serious risk of substantial impairment of a major bodily function unless an abortion is performed."
- 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), arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies, except for complications of diabetes. See the "Specific conditions" section of the Evidence of Coverage

• 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 plan includes the speech and hearing mandated benefit as referred to on pages 3, 4 and 8 of this handbook). The following services or supplies:

• A replacement of: A hearing aid that is lost, stolen or broken

• A hearing aid installed within the prior 36-month period

• Replacement parts or repairs for a hearing aid

• Batteries or cords

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- 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 Evidence of Coverage
- 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:
  - Improve your hearing: includes hearing aid batteries and auxiliary equipment
  - Enhance other forms of communication to make up for hearing loss or devices that simulate speech
- Home health care
  - Services for infusion therapy (see the "Eligible health services — Outpatient infusion therapy" section under the Evidence of Coverage 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
  - 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

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- Wilderness treatment program or any such related or similar program
- 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, 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 — Other services" section in your Evidence of Coverage
- 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 Evidence of Coverage for obesity screening and weight management interventions. Examples of these are: liposuction, banding, gastric stapling, gastric bypass and other forms of bariatric surgery. These are exclusions regardless of the existence of other medical conditions.
- Surgical procedures, medical treatments, weight control/loss programs that are intended primarily to treat or that are related to the treatment of obesity, including morbid obesity
- Drugs, stimulants, preparations, 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
- 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 they are prescribed or dispensed

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- 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 Evidence of Coverage
- 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
- That are used for the treatment of sexual dysfunction, 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 "Medically necessary and preventive care covered services" section of this disclosure or the Evidence of Coverage for covered immunizations.
- Implantable drugs and associated devices except where stated in the "Eligible health services" section in your Evidence of Coverage
- Preventive care and wellness and outpatient prescription drugs sections
- 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 Evidence of Coverage.
  - Injectable drugs dispensed by out-of-network pharmacies
  - 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 Evidence of Coverage
- Injectable drugs, unless dispensed through the network specialty pharmacy
- Any refill of a designated specialty prescription drug not dispensed by or obtained through the network specialty pharmacy (an updated copy of the list of specialty prescription drugs designated by the Evidence of Coverage 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).

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- Prescription drugs:
  - Dispensed by other than a network retail, home delivery and specialty pharmacy
  - Dispensed by an out-of-network home delivery pharmacy, except in a medical emergency or urgent care situation
  - 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 Evidence of Coverage
  - 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 Evidence of Coverage 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 Evidence of Coverage
  - 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 Evidence of Coverage
  - That are considered oral dental preparations and fluoride rinses, except pediatric fluoride tablets or drops as specified on 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 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
  - 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 Evidence of Coverage.
- Test agents except diabetic test agents

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- Outpatient surgery
  - The services of any other physician who helps the operating physician
  - 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 Evidence of Coverage.)
  - 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 Evidence of Coverage.
- 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
- Any service unless provided in accordance with a specific treatment plan
- 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.

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- Services not given by a physician (or under the direct supervision of a physician) or by a 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 present at birth or where the plan 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 us 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 Evidence of Coverage, 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 Evidence of Coverage.
- Hypnosis and other therapies
- Medications, except where stated in the "Eligible health services — Outpatient prescription drugs" section of the Evidence of Coverage
- 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
  - All charges associated with the treatment of infertility, except as described under the "Eligible health services — Treatment of infertility — Basic infertility" section under the Evidence of Coverage. 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

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- 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 plan 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 Evidence of Coverage does not cover vision care services and supplies, except as described in the “Eligible health services — Other services” section under the Evidence of Coverage).
- 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
- 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.

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- 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. Pre-authorization is not required for PCP visits, emergency services or to go to an urgent care center or after-hours clinic. Pre-authorization is required for hospital care, surgical procedures and certain outpatient services. Your plan documents list all the services that require pre-authorization.

eviCore healthcare provides certain certain utilization review functions for Texas Health | Aetna. Aetna provides other utilization review functions for Texas Health | Aetna.

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.

Network doctors will request any necessary preauthorization for you. Your doctor can call the number shown on your ID card to begin the process. You must get the approval before you receive the care.

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

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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.

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.

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:

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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
- 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.

Notice of special toll-free complaint number

To make a complaint about a private psychiatric hospital, chemical dependency treatment center, or psychiatric or chemical dependency services at a general hospital, call **1-800-832-9623 (TTY: 711)**.

Your complaint will be referred to the state agency that regulates the hospital or chemical dependency treatment center.

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.

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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.

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.

Voluntary arbitration

You, your plan sponsor and the plan may agree to arbitration to resolve any controversy, dispute or claim between them arising out of or relating to the plan, whether stated in tort, contract, statute, claim for benefits, bad faith, professional liability or otherwise ("the Claim"). Arbitration will be administered pursuant to the Texas Arbitration Act before a sole arbitrator ("the Arbitrator"). The arbitration will be conducted in compliance with the Texas Civil Practice and Remedies Code Chapter 171.

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Judgment on the award rendered by the Arbitrator ("the Award") may be entered by any court having jurisdiction thereof. If an administrator declines to oversee the case and the parties do not agree on an alternative administrator, a sole neutral Arbitrator will be appointed upon petition to a court having jurisdiction.

If the parties agree to resolve the Claim arbitration, the arbitration will be held in lieu of any and all other legal remedies and rights that the parties may have regarding the Claim, unless otherwise required by law. If the parties do not agree to arbitration, nothing herein shall limit any legal right or remedy that the parties may otherwise have.

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)**.

You must choose a primary care physician (PCP)

You should choose a PCP who participates in the network and who is accepting new patients. If you do not pick a PCP when required, your benefits may be limited, or we may select a PCP for you.

A PCP is the doctor you go to when you need health care. This one doctor can coordinate all your care. Your PCP will perform physical exams, order tests and screenings and help you when you're sick. Your PCP will also refer you to a specialist when needed. Some PCPs are part of a larger group of doctors. These PCPs will usually refer you to another doctor within that same group. If this group cannot meet your medical needs, you can ask us for a coverage exception to go outside this group. You may also need to precertify these services. If you have an emergency, you don't have to call your PCP first.

Female members may choose an (Ob/Gyn)

You have the right to select an Ob/Gyn to whom you have access without obtaining a referral from your PCP or prior authorization from us. You are not required to select an Ob/Gyn. You may elect to receive your Ob/Gyn services from your PCP. A female member can also choose an Ob/Gyn as her PCP. Note that the right of female members to choose an Ob/Gyn is in addition to the right to choose a PCP. Female members may choose both an Ob/Gyn and a PCP.

Also, an Ob/Gyn can give referrals for covered obstetric or gynecologic services just like a PCP. Just follow your plan's normal rules. Your Ob/Gyn might be part of a larger physician's group. If so, any referral will be to a specialist in that larger group. Check with the Ob/Gyn to see if the group has different referral policies.

Tell us who you chose to be your PCP

Each member of the family may choose a different PCP from our network. Enter the ID number(s) of the PCP you have chosen on your enrollment form. Or, call Member Services after you enroll to tell us your selection. You may change your selected PCP at any time.

Limited Provider Networks

Choosing your doctor

Your PCP will be the one you call when you need medical advice, when you are sick and when you need preventive care such as immunizations. Your PCP may be part of a practice group or association of health professionals who work together to provide a full range of health care services.

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For Limited Provider Networks, when you choose your PCP, you are also choosing that association. Usually, you cannot receive services from any doctor or health care professional, including your obstetrician-gynecologist (Ob/Gyn), who is not also part of your PCP's group or association. You will not be able to select doctors outside of your PCP's group, even if that doctor is listed with your health plan's network. The association to which your PCP belongs will provide or arrange for all of your care, so make sure that your PCP's association includes the specialists and hospitals that you prefer.

Note: PCPs who are part of a Limited Provider Network will have that designation shown in the physician directory immediately following their name (for example, Dr. John Smith, XYZ IPA). If you have questions about whether a PCP is a member of a Limited Provider Network, please call the Member Services toll-free telephone number on your ID card.

Special note for female members

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

Referrals: Your PCP may refer you to a specialist when needed

A referral is a written request for you to see another doctor. Some doctors can send the referral right to your specialist for you. There's no paper involved.

Talk to your doctor to understand why you need to see a specialist. And remember to always get the referral before you receive the care.

Remember these points about referrals:

You do not need a referral for emergency care.

If you do not get a referral when required, you may have to pay the bill yourself.

Your specialist might recommend treatment or tests that were not on the original referral. In that case, you may need to get another referral from your PCP for those services.

Women can go to an Ob/Gyn without a referral. See the "Special note for female members" section above and the "Female members may choose an Ob/Gyn" section above.

Referrals are valid for one year as long as you are still a member of the plan. Your first visit must be within 90 days of the referral issue date.

Referrals within physician groups

Some PCPs are part of a larger group of doctors. These PCPs will usually refer you to another doctor within that same group. If this group cannot meet your medical needs, you can ask us for a coverage exception to go outside this group. You may also need to precertify these services. And you may need permission from the physician group as well.

PCPs and hospital admissions

Your HMO coverage does not require that your PCP use a hospitalist when you are hospitalized. However, your PCP may not oversee your care if you are admitted to a hospital, skilled nursing facility or other inpatient facility, and you may be seen by a doctor who works in the hospital and who will direct your care. Upon admission to the inpatient facility, a physician other than your PCP may direct and oversee your care. These doctors are called hospitalists. The choice is between you and your PCP. Read the "You must choose a primary care physician (PCP)" section above to learn more about the role of a PCP.

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.

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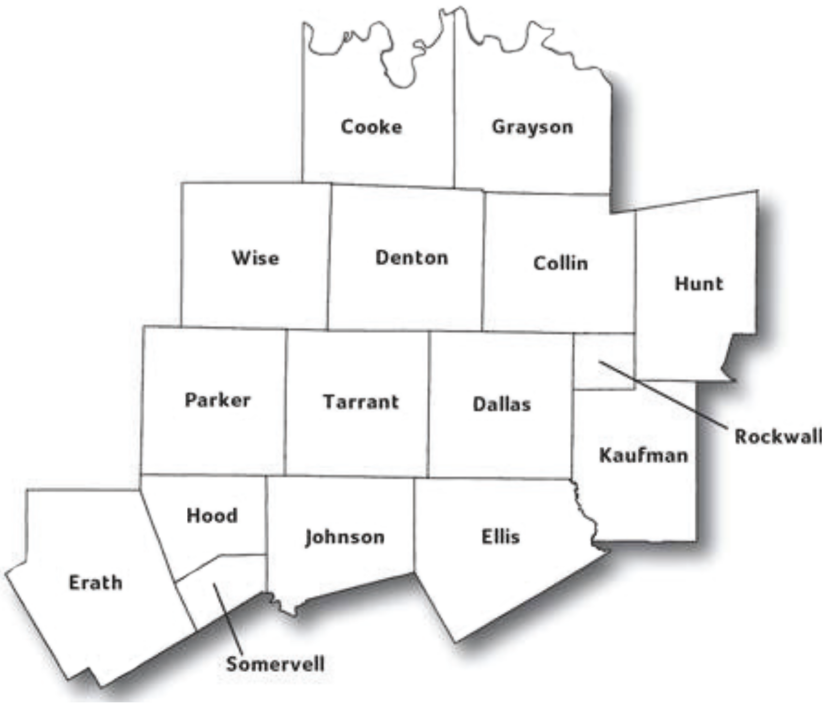
13. Texas Health | Aetna service areas

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 (TDI) disclosures

HMO Notice of Rights Disclosure

A health maintenance organization (HMO) plan provides no benefits for services you receive from out-of-network physicians or providers, with specific exceptions as described in your Evidence of Coverage document and below.

You have the right to an adequate network of in-network physicians and providers (known as network physicians and providers).

If you believe that the network is inadequate, go to **TDI.Texas.gov/consumer/complfrm.html** to file a complaint with the Texas Department of Insurance.

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

You may obtain a current directory of network physicians and 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 network physicians and providers. If you relied on materially inaccurate directory information, you may be entitled to have a claim by an out-of-network physician or provider paid as if it were from a network physician or provider, if you present a copy of the inaccurate directory information to the HMO, dated not more than 30 days before you received the service.

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

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- 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.
- 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).

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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)**.

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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