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Texas Health Aetna Plan Inc. Consumer Disclosure and Member Handbook – Texas

For limited and narrow network Texas Health Aetna plans

This booklet provides information to help you understand the plan you are considering. Before reviewing this booklet, please be aware of these important points about the plan:

Limited or narrow network provider organization benefit plans do not cover services received from health care providers who do not participate in the limited or narrow network, except as described in your policy or this booklet. You have the right to an adequate network of providers.

If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance.

If the limited or narrow network approves a referral for out-of-network services because a network provider is not available, or if you have received out-of-network or out-of-area emergency care, we must resolve the out-of-network provider's bill so that you only have to pay any applicable copayment amounts.

Find a limited or narrow network health care provider

You can use our online search tool at **[www.texashealthaetna.com]** or call **[1-800-213-3224]**.

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

This Consumer Choice health benefits plan, issued pursuant to the Texas Consumer Choice of Benefits Health Insurance Plan Act either in whole or in part, does not provide state mandated health benefits normally required in a Evidence of Coverage in Texas. This standard health benefit plan may provide a more affordable health plan for you, although at the same time it may provide you with fewer health benefits than those normally included as state-mandated health benefits in Texas. Benefits provided under a Consumer Choice Benefits plan are provided at a reduced level from what is mandated or are excluded completely from the plan. Consumer Choice plans may include a deductible. Please consult with your insurance agent to discover which state-mandated health benefits are excluded in the Evidence of Coverage.

[www.texashealthaetna.com]

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A guide to finding information in this handbook

Get plan information online and by phone

Your "plan documents" list all the details for the plan you chose

That information includes what's covered, what's not covered and the specific amounts you will pay for services. Plan document names vary. They may include a Schedule of Benefits, Evidence of Coverage and/or any riders and updates that come with them. If you can't find your plan documents, you can get a copy online or by calling Member Services. See below for details.

For more information, including information about participating health care providers, you may call **[1-800-213-3224]** or write to: **Texas Health Aetna, [612 E Lamar Blvd., Arlington, TX 76011]**. For help understanding how a particular medical plan works, you can also review your Summary of Benefits and Coverage document or contact your employer or benefits administrator.

If you're already enrolled in a Texas Health Aetna health plan

You have two convenient ways to get plan information anytime, day or night:

1. **Log in to your secure member website**
   You can get coverage information for your plan online. You can also get details about any programs, tools and other services that come with your plan. Just register once to create a user name and password.

   Have your member ID card handy to register. Then visit **[www.texashealthaetna.com]** and click "Log In/ Register." Follow the prompts to complete the one-time registration.

   Then you can log in any time to:

   - Verify who's covered and what's covered
   - Access your "plan documents"
   - Track claims or view past copies of Explanation of Benefits statements
   - Use the DocFind® search tool to find in-network care
   - Use our Cost of Care tools so you can *know before you go*
   - Learn more about and access any wellness programs that come with your plan

2. **Call Member Services at the toll-free number on your member ID card**
   As a member you can use our Voice Advantage self-service options to:

   - Verify who's covered under your plan
   - Find out what's covered under your plan
   - Get an address to mail your claim and check a claim status
   - Find out other ways to contact us
   - Order a replacement member ID card
   - Be transferred to behavioral health services

   You can also speak with a representative to:

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

Texas Department of Insurance

If you have a dispute concerning your premium or about a claim you should contact the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance. You may contact the Texas Department of Insurance for information on companies, coverages, rights or complaints at **1-800-252-3439**.

You may also write to the Texas Department of Insurance:

PO Box 149104
Austin, TX 78714-9104
Fax: **(512) 490-1007**
Web: **www.tdi.texas.gov**
Email: **ConsumerProtection@tdi.texas.gov**

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

If you require language assistance, please call the Member Services number on your member ID card, and a representative will connect you with an interpreter. You can also get interpretation assistance for utilization management issues or for registering a complaint or appeal. If you're deaf or hard of hearing, use your TTY and dial **711** for the Telecommunications Relay Service. Once connected, please enter or provide the Texas Health Aetna telephone number you're calling.

Ayuda para las personas que hablan otro idioma y para personas con impedimentos auditivos

Si usted necesita asistencia lingüística, por favor llame al número de Servicios al Miembro que figura en su tarjeta de identificación para el miembro, y un representante le conectará con un intérprete. También puede recibir asistencia de interpretación para asuntos de administración de la utilización o para registrar una queja o apelación. Si usted es sordo o tiene problemas de audición, usar su TTY y marcar **711** para el Servicio de Retransmisión de Telecomunicaciones. Una vez conectado, por favor entrar o proporcionar el número de teléfono de Texas Health Aetna que está llamando.

Medically necessary covered benefits

As a Texas Health Aetna member, you will be entitled to the medically necessary covered benefits as listed in the Evidence of Coverage, also referred to within as "plan documents." You'll receive this document after you enroll.

This plan does not cover all health care expenses and includes exclusions and limitations. Benefits exclusions and limitations are outlined in your plan documents. Read your plan documents carefully to determine which health care services are covered benefits and to what extent.

You'll also find a summary of exclusions and limitations within this document. To find out before you enroll whether your plan documents contain exclusions and limitations different from those listed in this document, contact your employer's benefits manager.

You may also request a sample copy of the Texas Health Aetna Evidence of Coverage from your employer. If you're already a member, you may call us toll-free at **[1-800-213-3224]**.

In order for benefits to be covered, they must be "medically necessary" and, in some cases, must also be preauthorized by Texas Health Aetna. Refer to the "We check if it's medically necessary" and "Preauthorization" sections of this document for more about those topics.

For the purpose of coverage, except for certain specialist benefits (referred to as "direct access" benefits) or in a medical emergency or an urgent care situation outside the service area, you must access covered benefits through your primary care physician (PCP) either directly or with a PCP referral. You are also responsible for cost sharing as outlined in your Evidence of Coverage.

Although listed as covered below, benefits are subject to the exclusions and limitations as listed in the Evidence of Coverage. You are also responsible for cost sharing as outlined in your Evidence of Coverage.

This is a general list of benefits that may be covered. Your employer or plan sponsor decides specifically which to cover and which to omit. That's why it's important to review your official plan documents for the list specific to your group plan.

Medically necessary covered services include:

- Primary care physician and specialist physician (upon referral) outpatient and inpatient visits
- 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 adult physical examinations (including immunizations, routine vision and hearing screenings)
- Routine physical examinations for children under age 18 (including immunizations, hearing and vision screening for all children to determine the need for hearing and vision correction, and hearing screening for all newborns)
- Pediatric vision care services and supplies as listed in the policy
- Certain tests for the early detection of cardiovascular disease
- Routine cancer screenings (which include screening mammograms; prostate specific antigen (PSA) tests; digital-rectal exams (DRE); fecal occult blood tests (FOBT); sigmoidoscopies; double contrast barium enemas (DCBE) and 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
- 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 **[1-800-213-3224]** 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
  - Non-elective 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
- Voluntary sterilizations
- Inpatient hospital & skilled nursing facility benefits, including inpatient physician care. Except in an emergency, all services are subject to preauthorization by Texas Health Aetna. Coverage for skilled nursing facility benefits is subject to the maximum number of days, if any, listed in

your specific health plan. Transplants that are nonexperimental or noninvestigational. Covered transplants must be approved by a Texas Health Aetna medical director before the surgery. The transplant must be performed at a hospital specifically approved and designated by Texas Health Aetna 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 preauthorization Texas Health Aetna
- Chemical dependency/substance abuse benefits
- Outpatient and inpatient care benefits are covered for detoxification
- Outpatient rehabilitation visits are covered to a participating behavioral health provider for diagnostic, medical or therapeutic rehabilitation services for chemical dependency
- Inpatient rehabilitation benefits are covered for medical, nursing, counseling or therapeutic rehabilitation services in an appropriately licensed participating facility for chemical dependency
- Mental health benefits: a member is covered for services for the treatment of mental or behavioral conditions provided through participating behavioral health providers
- Short-term, outpatient evaluative and crisis intervention or home health mental health services
- 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
- 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 Texas Health Aetna HMO service area for treatment.
- Inpatient and outpatient physical, occupational and speech rehabilitation services when they are medically necessary and meet or exceed the treatment goals established for the patient
- Cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing or treatment, neurofeedback therapy, remediation, postacute transition services, or community reintegration services, including outpatient day treatment services, or other post-acute 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. Preauthorization 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 preauthorized
- 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 preauthorized, 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, 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 infusion devices; 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

- Coverage is provided for amino-acid based elemental formulas necessary for the diagnosis, treatment or administration of the following to the same extent as for drugs available only on the orders of a physician:
  - Immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins
  - Severe food protein-induced enterocolitis syndrome
  - Eosinophilic disorders, as evidenced by the results of a biopsy
  - Impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length and motility of the gastrointestinal tract
- Orthotic and prosthetic devices
- 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 EOC.
- Reconstructive surgery for craniofacial abnormalities for a child who is younger than 18 years of age
- Coverage for telemedicine medical services and telehealth 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 certain mandatory benefits

This notice is to advise you of certain coverage and/or benefits provided by your contract with Texas Health + Aetna Health Plans Inc. (Texas Health Aetna).

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, please call us at **[1-800-213-3224],** or write us at:

[Texas Health Aetna
612 E Lamar Blvd.
Arlington, TX 76011]

Coverage and/or benefits for reconstructive surgery after mastectomy-enrollment

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; and

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

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

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

If any person covered by this plan has questions concerning the above, please call us at **[1-800-213-3224]**, or write us at:

[Texas Health Aetna
612 E Lamar Blvd.
Arlington, TX 76011]

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:

(a) a physical examination for the detection of prostate cancer; and

(b) a prostate-specific antigen test for each covered male who is

(1) at least 50 years of age; or

(2) 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 us at **[1-800-213-3224]**, or write us at:

[Texas Health Aetna
612 E Lamar Blvd.
Arlington, TX 76011]

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 breast-feeding and bottle-feeding and the performance of any necessary and appropriate clinical tests. Care will be provided by a physician, registered nurse or other appropriate licensed health care provider, and the mother will have the option of receiving the care at her home, the health care provider's office or a health care facility.

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

Prohibitions: We may not (a) modify the terms of this coverage based on any covered person requesting less than the minimum coverage required; (b) offer the mother financial incentives or other compensation for waiver of the minimum number of hours required; (c) refuse to accept a physician's recommendation for a specified period of inpatient care made in consultation with the mother if the period recommended by the physician does not exceed guidelines for prenatal care developed by nationally recognized professional associations of obstetricians and gynecologists or pediatricians; (d) reduce payments or reimbursements below the usual and customary rate; or (e) penalize a physician for recommending inpatient care for the mother and/or the newborn child.

If any person covered by this plan has questions concerning the above, please call us at **[1-800-213-3224]**, or write us at:

[Texas Health Aetna
612 E Lamar Blvd.
Arlington, TX 76011]

Coverage for tests for detection of colorectal cancer

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

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

(b) a colonoscopy performed every 10 years.

If any person covered by this plan has questions concerning the above, please call us at **[1-800-213-3224]**, or write us at:

[Texas Health Aetna
612 E Lamar Blvd.
Arlington, TX 76011]

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.

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 coverage for acquired brain injury

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

- Cognitive rehabilitation therapy
- Cognitive communication therapy
- Neurocognitive therapy and rehabilitation
- Neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing and treatment
- Neurofeedback therapy and remediation

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

The fact that an acquired brain injury does not result in hospitalization or acute-care treatment does not affect the right of the insured or the enrollee to receive the preceding treatments or services 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 postacute 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 **www.tdi.texas.gov**. Their toll-free telephone number is **1-800-252-3439**. Their address is 333 Guadalupe Street, Austin, TX 78701.

Prescription drug benefit

The plan covers drugs prescribed to treat a chronic, disabling, or life-threatening illness, when the illness is also a covered condition under the plan.

The drug must be:

1. Approved by the United States Food and Drug Administration (FDA) for at least one indication; and
2. Recognized for treatment of the indication for which the drug is prescribed by:
   - a prescription drug reference compendium approved by the commissioner for purposes of this section; or
   - substantially accepted peer-reviewed medical literature.

This includes coverage of medically necessary services associated with the administration of the drug.

Based on "medical necessity," we may not deny coverage of such drugs unless the reason for the denial is unrelated to the legal status of the drug use.

The plan does not cover experimental drugs that are not otherwise approved by the FDA for any disease or condition that is excluded from coverage under the plan, or that the FDA has determined to be contraindicated for treatment of the current indication.

We may encourage you to use certain drugs
Some plans encourage you to buy certain prescription drugs over others. The plan may even pay a larger share for those drugs. We list those drugs in the Texas Health Aetna Pharmacy Drug Guide (also known as a "pharmacy drug guide" or "drug 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.

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. If a generic drug is not available, we will cover a brand-name prescription drug.

Get a copy of the pharmacy drug guide
You can find the Pharmacy Drug Guide on our website at **[www.texashealthaetna.com]**. You can call the toll-free number on your member ID card to ask for a printed copy. We may update the formulary upon plan renewal and will send you notice of any changes 60 days before they are effective. You may contact Pharmacy Member Services toll-free at **[1-888-792-3862]** to determine whether a specific drug is included in your plan's formulary.

How we develop the pharmacy drug guide
Our Pharmacy and Therapeutics (P&T) Committee, which includes licensed pharmacists and doctors, meets regularly to review new drugs and new information about drugs that are already on the market. It reviews available information concerning safety, effectiveness and current use in therapy. The P&T Committee reviews scientific evidence, including relevant findings of federal government agencies, pharmaceutical manufacturers, medical professional associations, national commissions and peer-reviewed journals.

Once the P&T Committee completes its clinical review, we also consider overall value (including cost and manufacturer rebate arrangements) and other factors before adding or removing a drug from the formulary. The Texas Health Aetna Pharmacy Drug Guide shows you recent changes to the guide. For example, it could show what drugs started requiring coverage reviews like precertification, step therapy or quantity limits. Or which drugs no longer do. The P&T Committee can make recommendations to change the tier level of a drug or to place it on our Formulary Exclusions List, designating it as a drug that is no longer covered.

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 may also not cover drugs that we haven't

reviewed yet. You, someone helping you or your doctor may have to get our approval (a medical exception) to use one of these drugs.

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

You may have to try one drug before you can try another
"Step therapy" means you 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 medical exception. Your pharmacist can also ask for an exception for antibiotics and pain medicines.

Drug manufacturers may give us rebates when you buy certain drugs
While rebates apply mostly to drugs in the pharmacy drug guide, they may apply to nonpreferred drugs as well. However, your share of the cost (copayment) is based on the price of the drug before any rebate.

What does that mean to you?
If you pay a flat cost for your prescriptions in your plan, there is no difference. Some plans' members pay a percentage of the drug cost. If you pay a percentage of the cost, your cost for a drug in the pharmacy drug guide could be more than the cost for a nonpreferred drug because the price of the drug is not reduced by any rebate.

Home delivery and specialty drug services from Aetna owned pharmacies
Home delivery and specialty drug services are from pharmacies that Aetna owns. These pharmacies are called Aetna Rx Home Delivery and Aetna Specialty Pharmacy, which are for-profit pharmacies.

Have questions? Get answers.
Ask your doctor about specific medications. Call the number on your member ID card to ask about how your plan pays for them. Your plan documents also spell out what's covered and what is not.

Emergency and urgent care and care after office hours

An emergency medical condition means your symptoms are sudden and severe. If you don't get help right away, an average person with average medical knowledge will expect that you could die or risk your health. For a pregnant woman, that includes her unborn child.

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

- Call **911** or go to the nearest emergency room or freestanding emergency medical care facility. If a delay would not risk your health, call your doctor or PCP.
- Tell your doctor or PCP as soon as possible afterward. A friend or family member may call on your behalf.
- Emergency care services do not require preauthorization.

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

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

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

If you receive emergency care outside your Texas Health Aetna service area, your health care provider may not accept your copay as payment in full. If the provider bills you for an amount above your cost share, you are not responsible for paying the amount. You should send the bill to the address listed on your member ID card and we will resolve any payment dispute with the provider.

Follow-up care for plans that require a PCP
You may need to follow up with a doctor after your emergency. For example, you'll need a doctor to take out stitches, remove a cast or take another set of X-rays to see if you've healed. Your PCP should coordinate all follow-up care. You will need a referral for follow-up care that is not performed by your PCP. You may also need to 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 **[www.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.

What you pay

Your costs when you go outside the network

This plan provides out-of-network benefits only for emergency care and when medically necessary covered services are not available within the network including facility based physicians or other health care practitioners which may not be included in the network. Otherwise, the plan covers health care services only when provided by a doctor who participates in the Texas Health Aetna network. If you receive services from an out-of-network doctor or other health care provider (unless for emergency or if medically necessary

services are not available in the network), you will have to pay all of the costs for the services.

When you have no choice (such as emergency and non-available in-network services), we will pay the bill as if you got care in network. You pay your plan's copayments for your in-network level of benefits. Contact us if your doctor asks you to pay more. We will help you determine if you need to pay that bill.

Your doctor will bill the plan for covered services

All doctors and other health care providers who participate in the Texas Health Aetna HMO network have agreed to file claims with us on your behalf. Doctors have agreed to look to Texas Health Aetna, not to enrollees, for payment of covered services. If you receive a bill for covered services, please contact us at the number on your ID card or at **[1-800-213-3224]**.

You will share in the cost of your health care

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:

Copay – 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 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 copays may apply at the same time:

Inpatient Hospital Copay – This copay applies when you are a patient in a hospital.

Emergency Room Copay – 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.

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

Exclusions

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

Expenses for these health care services and supplies are not covered:

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

Ambulance services

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

Artificial organs

Any device that would perform the function of a body organ

Early intensive behavioral intervention

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

Blood, blood plasma, synthetic blood, blood derivatives or substitutes (except as provided in the Medically necessary 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 policy does not cover clinical trial therapies (experimental or investigational), except where described in the *Eligible health services — Clinical trial therapies (experimental or investigational)* section under your policy.

Clinical trial therapies (routine patient costs)

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

Cosmetic services and plastic surgery

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
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 program, job training and job hardening programs.
- Services provided by a school district.

Emergency services and urgent care
- Non-emergency care in a hospital emergency room facility, freestanding emergency medical care facility or comparable emergency facility
- Non-urgent care in an urgent care facility or at a non-hospital freestanding facility

Examinations
Any health or dental examinations needed:

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

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

Facility charges
For care, services or supplies provided in:

- Rest homes
- Assisted living facilities, except if you have an acquired brain injury. See the Specific therapies and tests section of the policy.
- Similar institutions serving as a person's main residence or providing mainly custodial or rest care
- Health resorts
- Spas or sanitariums
- Infirmaries at schools, colleges, or camps

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

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

Foot care
Services and supplies for:

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

- The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes
- Supplies (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies, except for complications of diabetes. See the Specific conditions section of the policy.

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

Hearing aids and exams
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
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss
- Any ear or hearing exam performed by a physician who is not certified as an otolaryngologist or otologist
- Any hearing aid furnished or ordered because of a hearing exam that was done before the date you became covered under this policy
- Hearing exams given during a stay in a hospital or other facility, except those provided to newborns as part of the overall hospital stay
- Any tests, appliances and devices to:
  - 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 policy for more information)
- Services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities)
- Transportation
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present
- Services are not for applied behavior analysis

Hospice care
- Funeral arrangements
- Pastoral counseling
- 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
- Transportation
- Maintenance of the house

Jaw joint disorder
- Diagnosis and treatment of Temporomandibular joint disorder (TMJ)
- Temporomandibular joint disorder treatment (TMJ) performed by prosthesis placed directly on the teeth, surgical and non-surgical medical and dental services, and diagnostic or therapeutics services related to TMJ

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
- Bedpans
- Syringes, except for treatment of diabetes
- Blood or urine testing supplies, except for treatment of diabetes
- Other home test kits
- Splints
- Neck braces
- Compresses
- Other devices not intended for reuse by another patient

Mental health treatment
- Mental health services for the following categories (or equivalent terms as listed in the most recent version of the *International Classification of Diseases* (ICD)):
  - Dementias and amnesias without behavioral disturbances
  - Sexual deviations and disorders except for gender identity disorders
  - Tobacco use disorders
  - Specific disorders of sleep
  - Antisocial or dissocial personality disorder
  - Pathological gambling, kleptomania, pyromania
  - Specific delays in development (learning disorders, academic underachievement)
  - Intellectual disability
  - Wilderness treatment 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, plus prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition, except as covered in the *Eligible health services under your policy — Other services* section

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

- Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric surgery
- Surgical procedures, medical treatments, weight control/loss programs primarily intended to treat, or are related to the treatment of obesity, including morbid obesity
- Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications
- Hypnosis, or other forms of therapy
- Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement

Orthotic devices
- Services covered under any other benefit
- Repair and replacement due to loss, misuse, abuse or theft

Outpatient infusion therapy
- Specialty prescription drugs and medicines provided by your employer or through a third party vendor contract with your employer
- Drugs that are included on the list of specialty prescription drugs as covered under your outpatient prescription drug plan
- Enteral nutrition
- Blood transfusions and blood products
- Dialysis

Outpatient prescription drugs
- Abortion drugs
- Allergy serum and extracts
- Any services related to the dispensing, injection or application of a drug
- Biological liquids and fluids
- Brand-name prescription drugs and devices when a generic prescription drug equivalent, biosimilar prescription drug or generic prescription drug alternative is available, unless otherwise covered by medical exception
- Cosmetic drugs
- Cosmetic drugs, medications or preparations used for cosmetic purposes
- Compound prescriptions containing bulk chemicals that have not been approved by the U.S. Food and Drug Administration (FDA)
- Devices, products and appliances that do not have a National Drug Code (NDC)
- Dietary supplements including medical foods
- Drugs or medications:
  - Administered or entirely consumed at the time and place it is prescribed or dispensed
  - Which do not, by federal or state law, require a prescription order (i.e. over-the-counter (OTC) drugs), even if a prescription is written, except where stated in the ***Eligible health services — Outpatient prescription drugs*** section under your policy
  - That includes the same active ingredient or a modified version of an active ingredient
  - That is therapeutically equivalent or a therapeutic alternative to a covered prescription drug unless a medical exception is approved
  - That is therapeutically equivalent or a therapeutic alternative to an over-the-counter (OTC) product unless a medical exception 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 includes 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 preauthorization 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 make-up, or the expression of the body's genes except for the correction of congenital birth defects
- Immunizations related to travel or work

- Immunization or immunological agents. See the *Preventive care immunizations* section of the policy for covered immunizations.
- Implantable drugs and associated devices except where stated in the *Eligible health services* under your policy — *Preventive care and wellness* and *Outpatient prescription drugs* sections
- Infertility
  - Injectable prescription drugs used primarily for the treatment of infertility
- Injectables:
  - Any charges for the administration or injection of prescription drugs or injectable insulin and other injectable drugs covered by us. See the *Eligible health services — Diabetic equipment, supplies and education for covered equipment and supplies* section of the policy.
  - 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 policy.
  - Injectable drugs, unless dispensed through the network specialty pharmacy
  - For 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 policy to be refilled by or obtained through the network specialty pharmacy is available upon request or may be accessed by logging in to your secure member website at **[www.texashealthaetna.com]**.
- Insulin pumps or tubing or other ancillary equipment and supplies for insulin pumps
- Prescription drugs:
  - Dispensed by other than a network retail, home delivery and specialty pharmacies
  - 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
  - Filled prior to the effective date or after the end date of coverage under the policy
  - Dispensed by a home delivery pharmacy that includes prescription drugs that cannot be shipped by mail due to state or federal laws or regulations, or when the policy considers shipment through the mail to be unsafe. Examples of these types of drugs include, but are not limited to, narcotics, amphetamines, DEA controlled substances and anticoagulants
  - That include an active metabolite, stereoisomer, prodrug (precursor) or altered formulation of another drug and is not clinically superior to that drug as determined by the policy
  - That are ordered by a dentist or prescribed by an oral surgeon in relation to the removal of teeth, or prescription drugs for the treatment of a dental condition unless dental benefits are provided under the policy
  - That are considered oral dental preparations and fluoride rinses, except pediatric fluoride tablets or drops as specified on the pharmacy drug guide
  - That are non-preferred drugs, unless non-preferred drugs are specifically covered as described in your schedule of benefits. However, a non-preferred 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 non-covered 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
  - Progesterone for the treatment of premenstrual syndrome (PMS) and compounded natural hormone therapy replacement
- Prophylactic drugs for travel
- Refills
  - Refills dispensed more than one year from the date the latest prescription order was written, or as otherwise permitted by applicable law of the area in which the drug is dispensed
- Replacement of lost or stolen prescriptions
- Tobacco use
  - Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including medications, nicotine patches and gum unless recommended by the United States Preventive Services Task Force (USPSTF). See the *Eligible health services — Outpatient prescription drugs* section of the policy.
- Test agents except diabetic test agents

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

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

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

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

Physician surgical services
- The services of any other physician who helps the operating physician
- A stay in a hospital (See the *Eligible health services — Hospital and other facility care* section under the 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, step-child, brother, sister, in-law or any household member

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

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

Short-term rehabilitation services
Outpatient cognitive rehabilitation, physical, occupational and speech therapy

- Except for physical therapy, occupational therapy or speech therapy provided for the treatment of autism spectrum disorder, therapies to treat delays in development and/or chronic conditions. Examples of non-covered diagnoses that are considered both developmental and/or chronic in nature are:
  - Down syndrome
  - Cerebral palsy
- Any service unless provided in accordance with a specific treatment plan
- Services you get from a home health care agency
- Services provided by a physician, or treatment covered as part of the spinal manipulation benefit
  - This applies whether or not benefits are paid under the spinal manipulation section
- Services not given by a physician (or under the direct supervision of a physician), physical, occupational or speech therapist
- Services for the treatment of delays in development, including speech development, unless as a result of a gross anatomical defect present at birth

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 Texas Health Aetna as telemedicine or telehealth providers
- Any services that are not provided during an internet-based consult or via telephone

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

Tobacco cessation
Except where described in the policy, any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including, medications, nicotine patches and gum unless recommended by the United States Preventive Services Task Force (USPSTF). This also includes:

- Counseling, except where stated in the *Eligible health services — Preventive care and wellness* section of the policy
- Hypnosis and other therapies
- Medications, except where stated in the *Eligible health services — Outpatient prescription drugs* section of the policy
- Nicotine patches
- Gum

Transplant services
- Services and supplies furnished to a donor when the recipient is not a covered person
- Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing illness
- Outpatient drugs including bio-medicals and immunosuppressant 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 policy. This includes:

- All charges associated with:
  - Surrogacy for you or the surrogate. A surrogate is a female carrying her own genetically related child where the child is conceived with the intention of turning the child over to be raised by others, including the biological father
  - Cryopreservation of eggs, embryos, or sperm
  - Storage of eggs, embryos, or sperm
  - Thawing of cryopreserved eggs, embryos or sperm
  - The care of the donor in a donor egg cycle. This includes, but is not limited to, any payments to the donor, donor screening fees, fees for lab tests, and any charges associated with care of the donor required for donor egg retrievals or transfers
  - The use of a gestational carrier for the female acting as the gestational carrier. A gestational carrier is a female carrying an embryo to which she is not genetically related
- Home ovulation prediction kits or home pregnancy tests
- Injectable infertility medication, including but not limited to menotropins, hCG, and GnRH agonists
- The purchase of donor embryos, donor oocytes, or donor sperm
- Reversal of voluntary sterilizations, including follow-up care
- Any charges associated with obtaining sperm for ART services
- Ovulation induction with menotropins, intrauterine insemination and any related services, products or procedures
- In vitro fertilization (IVF), 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, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes

Adult vision care
Routine vision exam provided by an ophthalmologist or optometrist including refraction and glaucoma testing and vision care services and supplies

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

- Special supplies such as non-prescription sunglasses
- Eyeglass frames, non-prescription lenses and non-prescription 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.
- 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 "non-occupational" regardless of cause.

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. For example, if you receive care while traveling in another country and the health care provider is a blocked person or is in a sanctioned country, the plan cannot pay for those services. For more information on U.S. trade sanctions, visit **www.treasury.gov/resource-center/sanctions/Pages/default.aspx**.

Preauthorization: Getting approvals for services

Sometimes we will pay for care only if we have given an approval before you get it. We call that "preauthorization."

Preauthorization is usually limited to more serious care like surgery or being admitted to a hospital or skilled nursing facility. Preauthorization is not required for PCP visits, emergency services, or to go to an urgent care center or after-hours clinic. Preauthorization is required for hospital care, surgical procedures, and certain outpatient services. Your plan documents list all the services that require preauthorization.

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

If you have a chronic condition or an upcoming hospital stay

You may qualify for one of our care management programs. A Texas Health Aetna nurse can be the extra support you need. After you enroll, just call the number on your ID card to learn more.

What we look for when reviewing a preauthorization 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. Preauthorization does not, however, verify if you have reached any plan dollar limits or visit maximums for the service requested. That means preauthorization is not a guarantee that the service will be covered.

"Preauthorization," when used in this document, means the utilization review process to determine whether the requested service, procedure, prescription drug or medical device meets our clinical criteria for coverage.

Preauthorization 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.

We will notify you and your doctor of our decision

Preauthorization 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 "Complaints, appeals and external review" section to learn more.

Our review process after precertification (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."

We follow specific rules to help us make your health a top concern during our reviews

- We do not reward Texas Health Aetna employees for denying coverage.
- We do not encourage denials of coverage. In fact, we train staff look at the risk of members not adequately using certain services. Where such use is appropriate, our staff uses nationally recognized guidelines and resources, such as MCG (formerly Milliman Care Guidelines) to review requests for coverage. Physician groups, such as independent practice associations, may use other resources they deem appropriate.
- We do not encourage utilization decisions that result in underutilization.

In Texas, Med Solutions performs utilization review for certain high-tech radiology procedures including, but not limited to, MRIs, CTs and PET scans.

Complaints, appeals and independent review

Call Member Services to file a verbal complaint or to ask for the appropriate address to mail a written complaint. The phone number is on your member ID card. You can also email Member Services through the secure member website at **[www.texashealthaetna.com]**, or write to:

Texas Health Aetna
[612 E Lamar Blvd.
Arlington, TX 76011]

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.

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.

Only medical professionals can deny coverage if the reason is medical necessity. We do not give financial incentives or otherwise to Texas Health Aetna employees for denying coverage. Sometimes a physicians' group will determine medical necessity. Those groups might use different resources than we do.

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

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

To file an appeal, follow the directions in the letter or explanation of benefits statement that explains that your claim was denied. The letter also tells you what we need from you and how soon we will respond. 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. The website for the Texas

What happens if your doctor leaves the health plan

For network-only plans, 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.

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

Continuation of Care applies as follows:	If you have this condition:	You can be covered with this doctor for an extra:
	A disability, acute condition, life threatening illness or 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

Department of Insurance is **www.tdi.texas.gov**. Their toll-free telephone number is **1-800-252-3439**.

Expedited internal appeal
You are entitled to an expedited internal appeal process for emergency care denials, denials of care for life-threatening conditions, and denials of continued stays in a hospital. You can also ask for an expedited internal appeal if we deny a request for step therapy exception or a request for prescription drugs or intravenous infusions you are currently receiving.

Get a review from someone outside Texas Health Aetna
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 the Texas 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, prescription drugs, intravenous infusions, 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.

We will follow the independent 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 ("Claim"). Arbitration will be administered pursuant to the Texas Arbitration Act before a sole arbitrator ("Arbitrator").

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

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

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

Use our DocFind® 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 **[www.texashealthaetna.com]** and log in. From your secure member website home page, select "Find Care."

Considering enrollment: Visit **[www.texashealthaetna.com]** and scroll down to "Find a Doctor" from the home page. You'll need to select the plan you're interested in from the drop-down box.

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

- Where the physician attended medical school
- Board certification status
- Language spoken
- Hospital affiliations
- Gender
- Driving directions

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

Get a FREE printed directory

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

Our provider directory will identify hospitals that have contractually agreed to facilitate the use of preferred doctors. Our network hospitals will exercise good faith effort to accommodate your request to use a network doctor. If you are assigned a facility based physician or physician group at least 48 hours prior to the services being rendered, the hospital will provide you with information at least 24 hours prior to services being rendered enough information for you to determine if the assigned facility based physician or physician group is a preferred/network provider.

You must choose a primary care physician (PCP)

You must choose a PCP who participates in the Texas Health Aetna 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. If it's an emergency, you don't have to call your PCP first. 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.

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. You are not required to select an Ob/Gyn. You may elect to receive your Ob/Gyn services from your PCP.

Tell us who you chose to be your PCP
Each member of the family may choose a different PCP from the Texas Health Aetna network. Enter the name 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 primary care physician (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. That means 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.

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.

Your rights to an adequate network

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

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

- If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance at: www.tdi.texas.gov/consumer/complfrm.html.
- If your HMO approves a referral for out-of-network services because no network provider is available, or if you have received out-of-network emergency care, the HMO must, in most cases, resolve the out-of-network provider's bill so that you only have to pay any applicable copayment, coinsurance, and out-of-network deductible amounts.

You may obtain a current directory of network providers at the following website: (website address to be filled out by the HMO) or by calling (to be filled out by the HMO) for assistance in finding available network providers. If you relied on materially inaccurate directory information, you may be entitled to have a claim by an out-of-network provider paid as if it were from a network provider.

Information about doctors who participate in the Texas Health Aetna network
Participating doctors, specialists and other health care providers are independent contractors in private practice and are neither employees nor agents of Texas Health Aetna or its affiliates. We cannot guarantee that any particular provider will be available or is accepting new patients.

Although we have identified providers who were not accepting patients as known to us at the time we added that provider to our network listing, the status of a provider's practice may have changed. For the most current information, please contact the selected physician or Member Services at the toll-free number on your ID card.

The status of the doctor's practice may have changed
Although we have identified providers who were not accepting patients as known to us at the time we added that provider to our network listing, the status of a provider's practice may have changed. For the most current information, please contact the selected physician or Member Services at the toll-free number on your ID card.

We must pay for out-of-network services at in-network rates if you reasonably relied (w/in 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
- Provider information on our website

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 "PCP and referral rules for Ob/Gyns" below.
- 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.

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

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

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.

PCP and referral rules for Ob/Gyns

A female member can choose an Ob/Gyn as her PCP. Women can also go to any obstetrician or gynecologist who participates in the Texas Health Aetna network without a referral or prior authorization. Visits can be for checkups, including breast exams, mammograms and Pap smears, and for obstetric or gynecologic problems.

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.

How we contract with doctors

If you have any question about how your doctor or other health care providers are compensated, call Member Services at the toll-free number on your ID card. We encourage you to discuss this issue with your doctor.

One of the goals of managed care is to reduce and control the costs of health care. We offer financial incentives in some compensation arrangements with doctors in an attempt to reduce and control the costs of health care. Only appropriate financial incentives will be used to compensate physicians and providers treating Texas Health Aetna members.

Capitation is an example of a financial incentive arrangement that we may use to compensate your doctors. Under capitation, a physician, physician group, independent practice association, or other health care provider is paid a predetermined set amount to cover all costs of providing certain medically necessary benefits to members whether or not the actual costs of providing those medically necessary covered benefits is greater or less than the amount we pay. In our capitation arrangements with an individual doctor, we provide capitation payments only for those services the doctor provides to you. However, in a capitation arrangement with a group of physicians or providers, also known as a "delegated entity," we may provide capitation payments for other health care services such as hospitalization, use of specialists, tests and prescription drugs. Under either capitation arrangement, your doctor has a financial incentive to reduce and control the costs of providing medical care.

Fee for service is a different method of payment. A doctor charges a fee for each patient visit, medical procedure, or medical service provided. For example, Mrs. Smith, a Texas Health Aetna member, goes to Dr. Jones for maternity care. Mrs. Smith's baby is delivered by Cesarean section. Dr. Jones' contract with us states she will be paid a fee for each patient visit and each service she provides. The amount of payment Dr. Jones receives will depend on the number, types and complexity of services, and the time she spends providing services to Mrs. Smith. Because Cesarean deliveries are more complicated than vaginal deliveries, Dr. Jones is paid more to deliver Mrs. Smith's baby than she would be paid for a vaginal delivery. Mrs. Smith may be responsible for paying some portion of Dr. Jones' bill.

Texas law prohibits financial incentives that act directly or indirectly as an inducement to limit medically necessary services. An improperly used incentive may encourage a doctor to provide a patient with a less effective treatment because it is less expensive. We will not improperly use incentives to compensate doctors for treatments and services provided to Texas Health Aetna members.

If you are considering enrolling in our plan, you are entitled to ask if the plan, or any provider group that serves Texas Health Aetna members, has compensation arrangements with participating doctors that can create a financial incentive to reduce or control the costs of providing medically necessary covered services. Upon request, we will send you a summary of the compensation arrangements known to us relating to a particular doctor. To request this summary, call the Member Services telephone number on your ID card. Or, you may contact the provider group directly to find out about compensation arrangements between the provider group and any participating doctor. You may also wish to ask your doctor about what financial incentive arrangements are included in his or her compensation.

If you receive a bill

Two of the advantages of being a Texas Health Aetna HMO member are:

1. You generally do not have to submit claim forms.
2. You should not receive any bills for covered services.

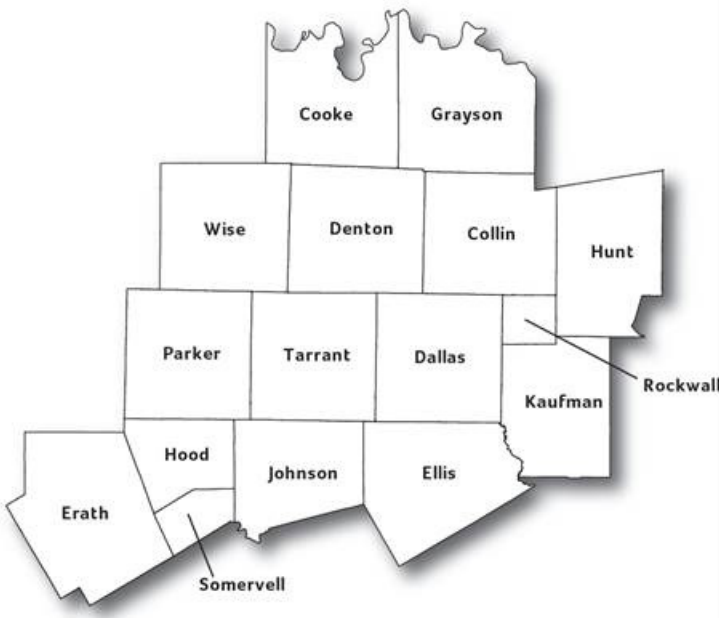
We will not pay your bill if:

- 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 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 Evidence 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.)

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



If you are admitted to a hospital

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 will direct your care. These doctors are called "hospitalists." The choice is between you and your PCP. Read "Choose a primary care physician (PCP)" in this booklet to learn more about the role of a PCP.

Other covered benefits

Mental health and addiction benefits

Here's how to get inpatient and outpatient services, partial hospitalization and other mental health services:

- Call **911** if it's an emergency.
- Call the toll-free Behavioral Health number on your member ID card.
- Call Member Services if no other number is listed.
- Employee Assistance Program (EAP) professionals can also help you find a mental health specialist.

Get information about using network therapists
We want you to feel good about using the Texas Health Aetna network for mental health services. Visit **[www.texashealthaetna.com]** and click "Find a Doctor" from the home page. After you complete your search, click the "Quality and Cost Information" link. No Internet? Call Member Services instead. Use the toll-free number on your member ID card to ask for a printed copy.

Texas Health Aetna offers two behavioral health screening and prevention programs for our members

- **Beginning Right® Depression Program**: Perinatal and Postpartum Depression Education, Screening and Treatment Referral
- **OORS Program**: Opioid Overdose Risk Screening Program

Call Member Services for more information on either of these programs.

Important benefits for women

Women's Health and Cancer Rights Act of 1998
Your Texas Health Aetna health plan provides benefits for mastectomy and mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between breasts; prosthesis; and treatment of physical complications of all stages of mastectomy, including lymphedema. Coverage is provided in accordance with your plan design and is subject to plan limitations, copays, deductibles, coinsurance and referral requirements, if any, as outlined in your plan documents.

Please contact Member Services for more information, or visit the Centers for Medicaid & Medicare website, **www.cms.gov/CCIIO/Programsand-Initiatives/Other-InsuranceProtections/whcra_factsheet.html**, and the U.S. Department of Labor website, **www.dol.gov/ebsa/consumer_info_health.html**.

Transplants and other complex conditions

Our National Medical Excellence Program® (NME) is for members who need a transplant or have a condition that can only be treated at a certain hospital. You usually need to use an 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.

How we determine what is covered

You can avoid receiving an unexpected bill with a simple call to Member Services. You can find out if your preventive care service, diagnostic test or other treatment is a covered benefit — before you receive care — just by calling the toll-free number on your ID card.

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

We check if it's "medically necessary"

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

The product or service:

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

Only medical professionals can deny coverage if the reason is medical necessity. We do not give financial incentives or otherwise to Texas Health Aetna employees for denying coverage. Sometimes a physician's group will determine medical necessity. Those groups might use different resources than we do.

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

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

Determinations that we make of whether care is medically necessary under this definition also include determinations of whether the services and supplies are cost-effective, timely, and sufficient in quality, quantity and frequency, consistent with the applicable standard of care.

For purposes of this definition, "cost-effective" means the least expensive medically necessary treatment selected from two or more treatments that are equally effective. That means the care can reasonably be expected to produce the intended results and to have expected benefits that outweigh

potential harmful effects, in achieving a desired health outcome for that particular member. Medical necessity, when used in relation to services, has the same meaning as medically necessary services. This definition applies only to our determination of whether health care services are medically necessary covered benefits under your Evidence of Coverage.

The determination of medically necessary care is an analytical process applied on a case-by-case basis by qualified professionals who have the appropriate training, education, and experience and who possess the clinical judgment and case-specific information necessary to make these decisions.

The determination of whether proposed care is a covered benefit is independent of, and should not be confused with, the determination of whether proposed care is medically necessary. We will not use any decision-making process that operates to deny medically necessary care that is a covered benefit under your certificate. Since we have authority to determine medical necessity for purposes of the plan, a determination under the plan that a proposed course of treatment, health care service or supply is not medically necessary may be made by Texas licensed physicians other than the your own doctor.

This means that, even if your doctor determines in his or her clinical judgment that a treatment, service or supply is medically necessary for you, our Texas-licensed physician may determine that it is not medically necessary under this plan. If we determine that a service or supply is not medically necessary, you (or your authorized representative) may appeal to the Texas independent review organization, as described in the section entitled "Complaints, appeals and independent review."

We study the latest medical technology

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

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

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

We publish our decisions in our Clinical Policy Bulletins.

We post our findings on [www.texashealthaetna.com]

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

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

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

You and your doctor can read our CPBs on our website at **[www.texashealthaetna.com]**. No Internet? Call Member Services at the toll-free number on your ID card. Ask for a copy of a CPB for any product or service.

Member rights and responsibilities

Know your rights as a member

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

Below are just some of your rights. We also publish a list of rights and responsibilities on our website. Visit **[www.texashealthaetna.com/en/legal-notices/rights-and-resources/member-rights-and-responsibilities.html]** to view the list. You can also call Member Services at the number on your ID card to ask for a printed copy.

Making medical decisions before your procedure

An "advance directive" tells your family and doctors what to do when you can't tell them yourself. You don't need an advance directive to receive care. But you have the right to create one. Hospitals may ask if you have an advance directive when you are admitted.

There are three types of advance directives:

- Durable power of attorney – name the person you want to make medical decisions for you.
- Living will – spells out the type and extent of care you want to receive.
- Do-not-resuscitate order – states you don't want CPR if your heart stops or a breathing tube if you stop breathing.

You can create an advance directive in several ways:

- Ask your doctor for an advance directive form.
- Write your wishes down by yourself.
- Pick up a form at state or local offices on aging, bar associations, legal service programs, or your local health department.

- Work with a lawyer to write an advance directive.
- Create an advance directive using computer software designed for this purpose.

Source: American Academy of Family Physicians. Advance Directives and Do Not Resuscitate Orders. January 2012. Available at ***http://familydoctor.org/familydoctor/en/healthcare-management/end-of-life-issues/advance-directives-and-do-not-resuscitate-orders.html.*** *Accessed June 10, 2016.*

Learn about care management and quality management programs

We make sure your doctor provides quality care for you and your family. To learn more about these programs, please visit **[www.aetna.com]**. Enter "commitment to quality" in the search bar. You can also call Member Services to ask for a printed copy. The toll-free number is on your member ID card.

We protect your privacy

We consider personal information to be private. Our policies protect your personal information from unlawful use. By "personal information," we mean information that can identify you as a person, as well as your financial and health information.

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

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

- Your doctors, dentists, pharmacies, hospitals and other caregivers
- Other insurers
- Vendors
- Government departments
- Third-party administrators (TPAs), (this includes plan sponsors and/or employers)

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

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

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

We consider these activities key for the operation of our plans. When allowed by law, we use and disclose your personal information in the ways explained above without your permission. Our privacy notice includes a complete explanation of the ways we use and disclose your information. It also explains when we need your permission to use or disclose your information.

We are required to give you access to your information. If you think there is something wrong or missing in your personal information, you can ask that it be changed. We must complete your request within a reasonable amount of time. If we don't agree with the change, you can file an appeal.

For more information about our privacy notice or if you'd like a copy, call the toll-free number on your ID card or visit us at **[www.texashealthaetna.com]**.

Anyone can get health care

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

We must comply with these laws:

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

How we use information about your race, ethnicity and the language you speak

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

Your rights to enroll later if you decide not to enroll now

When you lose your other coverage
You might choose not to enroll now because you already have health insurance. You may be able to enroll later if you lose that other coverage or if your employer stops contributing to the cost. This includes enrolling your spouse or children and other dependents. If that happens, you must apply within 60 days before you expect to lose coverage and 60 days after your coverage has ended.

When you have a new dependent
Getting married? Having a baby? A new dependent changes everything. And you can change your mind. You can enroll within 60 days after certain life events if you chose not to enroll during the normal open enrollment period. These life events include:

- Marriage
- Birth
- Adoption
- Placement for adoption

Call Member Services for more information or to request special enrollment.

Get help to understand your enrollment materials

Non-Discrimination

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

Texas Health Aetna provides 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 the number on your ID card.

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

Civil Rights Coordinator
PO Box 14462, Lexington, KY 40512
1-800-648-7817, TTY: **711**
Fax: **859-425-3379**
Email: **CRCoordinator@aetna.com**

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

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call **1-800-213-3224**.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Language Assistance

TTY: 711

To access language services at no cost to you, call **[1-800-213-3224]**

Para acceder a los servicios de idiomas sin costo, llame al **[1-800-213-3224]** (Spanish)

Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số **[1-800-213-3224]** (Vietnamese)

如欲使用免費語言服務，請致電 **[1-800-213-3224]**。(Chinese)

무료 언어 서비스를 이용하려면 **[1-800-213-3224]**번으로 전화해 주십시오. (Korean)

للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم **[1-800-213-3224]** . (Arabic)

بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے **[1-800-213-3224]** پر بات کریں۔ (Urdu)

Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa **[1-800-213-3224]** (Tagalog)

Afin d'accéder aux services langagiers sans frais, composez le **[1-800-213-3224]** (French)

आपके लिए बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, **[1-800-213-3224]** पर कॉल करें। (Hindi)

برای دسترسی به خدمات زبان به طور رایگان، با شماره **[1-800-213-3224]** تماس بگیرید. (Persian-Farsi)

Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie **[1-800-213-3224]** an. (German)

તમારે કોઇ જાતના ખર્ચ વિના ભાષાની સેવાઓની પહોંચ માટે, કોલ કરો **[1-800-213-3224]** (Gujarati)

Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону **[1-800-213-3224]** (Russian)

言語サービスを無料でご利用いただくには、**[1-800-213-3224]**までお電話ください。(Japanese)

ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາເບີ **[1-800-213-3224]**

We are committed to Health Plan Accreditation by the National Committee for Quality Assurance (NCQA) as a means of demonstrating a commitment to continuous quality improvement and meeting customer expectations. You can find a complete list of health plans and their NCQA status on the NCQA website located at **www.ncqa.org**. Click on the "Report Cards" tab to search on "Health Plans." To refine your search for other health care providers, click on "Clinicians" or "Other Healthcare Organizations." The link for "Clinicians" includes doctors recognized by NCQA in the areas of heart/stroke care, diabetes care, patient centered medical home and patient centered specialty practice. The recognition programs are built on evidence-based, nationally recognized clinical standards of care; therefore, NCQA provider recognition is subject to change. You can access the official NCQA directory of recognized clinicians at **http://recognition.ncqa.org**. The link for "Other Healthcare Organizations" includes "Managed Behavioral Healthcare Organizations" for behavioral health accreditation and "Credentials Verifications Organizations" for credentialing certification.

If you need this material translated into another language, please call Member Services at [1-800-213-3224].
Si usted necesita este material en otro lenguaje, por favor llame a Servicios al Miembro al [1-800-213-3224].

[www.texashealthaetna.com]

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