TAKE CHARGE OF YOUR HEALTH.

CHOOSE AETNA,
CHOOSE AFFORDABLE COVERAGE

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

63.43.300.1 (1/11)

LEARN ABOUT YOUR PLAN CHOICES

AETNA ADVANTAGE PLANS FOR INDIVIDUALS, FAMILIES AND THE SELF-EMPLOYED

Aetna Advantage Plans for Individuals, Families and the Self-Employed are underwritten by Aetna Life Insurance Company directly and/or through an out-of-state blanket trust or Aetna Health Inc. (together, "Aetna") In some states, individuals may qualify as a business group of one and may be eligible for guaranteed issue, small group health plans. To the extent permitted by law, these plans are medically underwritten and you may be declined coverage in accordance with your health condition

63.44.312.1 A (8/12)

HEALTH CARE REFORM —
WHAT YOU NEED TO KNOW

THE FEDERAL HEALTH CARE REFORM LEGISLATION, KNOWN AS THE PATIENT PROTECTION AND AFFORDABLE CARE ACT, WAS SIGNED INTO LAW ON MARCH 23, 2010 BY PRESIDENT OBAMA.

Since then, Aetna has periodically updated the Aetna Advantage Plans for Individuals, Families and the Self-Employed to include any necessary changes. It is important for you to know that your Aetna Advantage Plan will always comply with all of the federal health care reform legislation.

WOMEN'S PREVENTIVE HEALTH BENEFITS – NEW CHANGES EFFECTIVE AUGUST 1, 2012

As you may know, the legislation includes changes that are being phased in over a number of years. The latest set of changes now includes coverage of Women's Preventive Health Benefits.

As of August 1, 2012, all of the following women's health services are considered preventive and therefore generally covered at no cost share, when provided in-network:

- Well-woman visits (annual routine physical, annual routine GYN exam and prenatal visits)
- Screening for gestational diabetes
- Human Papillomavirus (HPV) DNA testing
- Counseling for sexually transmitted infections
- Counseling and screening for human immunodeficiency virus (HIV)
- Screening and counseling for interpersonal and domestic violence
- Breastfeeding support, supplies and counseling
- Contraceptive methods and counseling

IF YOU WOULD LIKE TO COMPARE ADDITIONAL PLANS, OR FOR MORE DETAILED PLAN INFORMATION, YOU MAY ALSO VISIT **WWW.HEALTHCARE.GOV.**

THANK YOU

FOR CONSIDERING THE AETNA ADVANTAGE PLANS FOR INDIVIDUALS, FAMILIES AND THE SELF-EMPLOYED. WE ARE PLEASED TO PRESENT THIS INFORMATION KIT, WHICH YOU CAN USE TO FIND A HEALTH INSURANCE PLAN THAT'S RIGHT FOR YOU.

APPLY/ENROLL INSTRUCTIONS

Once you choose a plan, there are two options for you to apply/enroll.

1) If you are working with a broker:

BROKER

You have an ally in the process. Get personalized assistance from your broker, who can answer your questions, help you choose the plan that's right for you and guide you through the application process.

2) If you are applying/enrolling on your own:

ONLINE

You can visit us online at **www.AetnaIndividual.com**. This website offers easy ways to find the plan that is best for you. You can browse our DocFind® online provider directory and apply online.

MAIL

Complete and mail the enclosed application/enrollment form, in the envelope provided, with one form of payment selected.

PHONE

Any questions? Just call 1-800-MY-HEALTH (1-800-694-3258) and we'll be happy to answer your questions as well as help you complete the application.

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TOP REASONS TO **CHOOSE AETNA**

ROBUST COVERAGE, COMPETITIVE COSTS

We offer plans with valuable features, which may include:

- An excellent combination of quality coverage and competitively priced premiums
- The freedom to see doctors whenever you need to – without referrals
- Coverage for preventive care, prescription drugs, doctor visits, hospitalization and immunizations
- No copayments for well-women exams when you visit a network provider
- No claim forms to fill out when you use a network provider
- National provider networks offer you a vast selection of participating physicians and hospitals

COVERAGE WHEN YOU TRAVEL

Like to travel? You have access to covered services from a national network of doctors and hospitals that accept our negotiated fees.

FAMILY COVERAGE

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

TAX ADVANTAGES

We also offer high-deductible plans that are compatible with tax-advantaged health savings accounts (HSAs). You can contribute money to your HSA tax free. That money earns interest tax free. And qualified withdrawals for medical expenses are tax free, too.

ONLINE HEALTH TOOLS AND RESOURCES

Need health information fast? We offer secure Internet access to reliable health information tools and resources through our secure member website. Also, here are three examples of our online tools that will help make it easier for you to make informed decisions about your health care:

- **Member Payment Estimator**
  Our group of Web-based decision-support tools is designed to help you plan for your health care expenses by giving you health care costs and other information you need to make better decisions. For tools that provide both in- and out-of-network cost information, you can see the potential cost savings when a participating in-network provider (physician, dentist and facility) is used.
- **Aetna SmartSource℠**
  Aetna SmartSource will change the way you research conditions, symptoms and more. Unlike most search engines and general health websites, Aetna SmartSource delivers information that is specific to you based on where you live, your selected Aetna insurance plan and other information.
- **Mobile Web**
  Mobile access to the most popular and useful features of Aetna.com is simplified for on-the-go use. Our health-related mobile applications can help you save money and easily access health information.

LET'S TALK

HAVE QUESTIONS?

Call
your broker

or

Email
AetnaAdvantagePlans@aetna.com

WANT A QUOTE NOW?

Visit
www.AetnaIndividual.com

or

Call
1-800-MY-HEALTH
(1-800-694-3258)

MORE REASONS TO CHOOSE AN AETNA ADVANTAGE PLAN

AFFORDABLE QUALITY AND CHOICES

Our plans are designed to offer you quality coverage at an excellent value. You can choose from a wide range of health insurance plans that offer varying amounts of coverage depending on you or your family's specific needs.

Generally speaking, the lower your "premiums," or monthly payments, the higher your "deductible," which is the amount you pay out of pocket before the plan begins paying for covered expenses.

You'll pay less by using "in-network" doctors, hospitals, pharmacies and other health care providers who participate in the Aetna network than by using "out-of-network" providers.

This allows you to be in control of how much you spend by matching the type of coverage you desire with the premium that matches your budget.

ABOUT HEALTH SAVINGS ACCOUNTS (HSAs)

Many of our high-deductible plans are health savings account (HSA) compatible. That means you pay lower premiums and get tax-advantaged savings. An HSA is a personal account that lets you pay for qualified medical expenses with tax-advantaged funds. You or an eligible family member make contributions to your HSA tax free, and those dollars earn interest tax free. Then, when you make withdrawals from your account to pay for qualified health care expenses, they're tax free, too.

OUR PLANS ARE DESIGNED TO OFFER YOU QUALITY COVERAGE AT AN EXCELLENT VALUE

FAMILY COVERAGE

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

IT'S EASY TO ESTABLISH AN HSA

Once you are enrolled in a qualifying High Deductible Health Plan, Aetna will send you a letter outlining how to enroll in an HSA with Bank of America.

There is no additional charge to you for opening up this account.

WHY CHOOSE AN AETNA HEALTHFUND HSA?

- No set-up fees
- No monthly administration fee
- No withdrawal forms required
- Convenient access to HSA funds via debit card or online payments
- Track HSA activity online

You can track your HSA activity through Bank of America, too. Bank of America is the HSA administrator. Just log in to **www.bankofamerica.com/ benefitslogin**.

ADD DENTAL PDN MAX

With the Aetna Advantage Dental PDN Max insurance plan, you can obtain services from either a participating or non-participating dentist. Participating dentists have agreed to provide services at a negotiated rate for both covered services, as well as non-covered services such as cosmetic tooth whitening and orthodontic care, so you generally pay less out-of-pocket. You also have the flexibility to visit a dentist who does not participate in Aetna's network, though you will not have access to negotiated fees.

Note: Dental coverage is available only if you purchase medical coverage. Discounts for non-covered services may not be available in all states.

WHAT DOES THAT MEAN?

Here are a few definitions of terms you'll see throughout this brochure. For a more in-depth list of terms, please visit **www.planforyourhealth.com.***

Coinsurance – The dollar amount that the plan and you pay for covered benefits after the deductible is paid.

Copayment (Copay) – A fixed dollar amount that you must contribute toward the cost of covered medical services under a health plan. For HSA compatible plans, copayment will apply to your out-of-pocket max.

Deductible – A fixed yearly dollar amount you pay before the benefits of the plan policy start.

Exclusions and Limitations — Specific conditions or circumstances that are not covered under a plan.

Out-of-Pocket Maximum – The amounts such as coinsurance and deductibles that you are required to contribute toward the cost of health services covered by the benefits plan before the plan pays 100% of additional out-of-pocket costs.

Premium – The amount charged for a health insurance policy or health benefits plan on a monthly basis.

Pre-existing Condition – A health condition or medical problem that was diagnosed or treated (including the use of prescription drugs) before getting coverage under a new insurance health plan.

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

VALUE-ADDED PROGRAMS

AETNA ADVANTAGE PLANS INCLUDE SPECIAL PROGRAMS[1]
TO COMPLEMENT OUR HEALTH COVERAGE

These programs include health information programs and tools, and offer you access to substantial savings on products to help you stay healthy. These programs are offered in addition to your Aetna Advantage Plan and are NOT insurance.

Following is a description of some of the discount programs included with our plans. For more information on any of these programs, please visit us online at **www.aetna.com.**

DISCOUNT PROGRAMS

Aetna Fitness℠ Discount Program

Members can save with preferred rates on gym memberships and discounts on at-home weight-loss programs, home fitness options and one-on-one health coaching services through GlobalFit®.

Aetna Hearing℠ Discount Program

Offers members and their families savings on hearing exams, hearing aids and other hearing services.

Aetna Natural Products and Services℠ Discount Program

Members can access reduced rates on acupuncture, chiropractic care, massage therapy and dietetic counseling through the ChooseHealthy® program.** Members can also get discounts on over-the-counter vitamins, herbal and nutritional supplements, and natural products. Through Vital Health Network, members can receive a discount on online consultations and alternative remedies provided by medical doctors for a variety of conditions.

Aetna Vision℠ Discount Program

Offers discounts on vision exams, lenses and frames. A member must use a provider in the EyeMed Select Network. LASIK surgery discounts are also available.

Aetna Weight Management℠ Discount Program

Offers savings on the CalorieKing® Program and products, eDiets® diet plans and products, Jenny® weight loss programs and Nutrisystem® weight loss meal plans. Members can choose from a variety of programs and plans to meet their specific weight loss goals and save money.

HEALTH MANAGEMENT **TOOLS**

INFORMED HEALTH® LINE

Our 24-hour toll-free number that puts you in touch with experienced registered nurses and an audio library for information on thousands of health topics.

THE AETNA SECURE MEMBER WEBSITE

Register and log on to our secure member website to check claims status, contact Aetna Member Services, estimate the costs of health care services, and more. The secure member website provides a starting point to find answers about health care, types of treatment, cost of services and more to help members make more informed decisions. Plus, members have access to their own Personal Health Record*, a single, secure place where they can view their medical history and add other health information.

While only your doctor can diagnose, prescribe or give medical advice, the Informed Health Line nurses can provide information on more than 5,000 health topics. Contact your doctor first with any questions or concerns regarding your health care needs.

Discount programs provide access to discounted prices and are NOT insured benefits. The member is responsible for the full cost of the discounted services. Aetna may receive a percentage of the fee you pay to the discount vendor.

1 Availability varies by plan. Talk with your Aetna representative for details.
* The Aetna Personal Health Record should not be used as the sole source of information about your health conditions or medical treatment.
** The ChooseHealthy program is made available through American Specialty Health Systems, Inc. (ASH Systems), a subsidiary of American Specialty Health Incorporated (ASH). ChooseHealthy is a federally registered trademark of ASH and used with permission herein.

HOW CAN I SAVE MONEY ON MY HEALTH CARE BENEFITS EXPENSES?

It's a sign of the times — people are looking to trim household expenses wherever they can. Aetna is here to help. We've prepared special tips to help you save money on health care benefits — without compromising your health.

Healthy Savings from Aetna gives you eight ways to start saving now with your Aetna health insurance plan. Take advantage of easy-to-follow tips, tools and charts that show you how you may save. Check out all the ways you can save at **www.aetna.com/healthysavings.**

AETNA NETWORK PROVIDERS **SAVE YOU MONEY**

KEEP ACCESS TO QUALITY CARE AFFORDABLE WITH THE AETNA PROVIDER NETWORK

IS YOUR DOCTOR IN THE AETNA NETWORK?

Our provider network is quite extensive throughout the country, including your state. In fact, your doctor may already be part of the Aetna Advantage Plan network. To check which local physicians, hospitals, pharmacies and eyewear providers participate in your area, please visit **www.AetnaIndividual.com** and select "Find a Doctor", or call 1-800-694-3258 and ask for a directory of providers.

By using providers in the Aetna network, you can take advantage of the significant discounts we have negotiated to help lower your out-of-pocket costs for medically necessary care. This can help you get the care you need at an affordable price.

Let's look at some examples, so you can see your network savings in action.

These examples are based on the following Aetna plan features and assume you've already met your deductible (the fixed amount that you must pay for covered medical services before your plan will pay benefits):

What your plan pays (plan coinsurance):

80% in network / 60% out of network

What you pay (coinsurance):

20% in network / 40% out of network

IMPORTANT ADDITIONAL INFORMATION

The "recognized amount":

When you receive services from a provider who is not in the Aetna network, the plan pays based on the "recognized" amount/charge, which is described in your benefit plan. In these examples, if you use a health care provider who is not in the Aetna network, you may be responsible for the entire difference between what the provider bills and the recognized amount/charge. As the examples show, that difference can be large.

EXAMPLE 1

You have been getting care for an ongoing condition from a specialist who is not in the Aetna network. You are thinking about switching to a specialist in the Aetna network. This example illustrates what you may save if you switch.

OFFICE VISIT

		In-Network	Out-of-Network+
Doctor bill	Amount billed	$150	$150
Amount Aetna uses to calculate payment	Aetna's rate* in-network	$90*	
	Recognized amount** out-of-network		$90**
What your plan will pay	Aetna's negotiated rate/ recognized amount	$90	$90
	Percent your plan pays	80%	60%
	Amount of Aetna's negotiated rate/recognized amount covered under plan	$72*	$54**
What you owe	Your coinsurance responsibility	$18	$36
	Amount that can be balance billed to you	$0	$60
YOUR TOTAL RESPONSIBILITY		**$18*****	**$96*****

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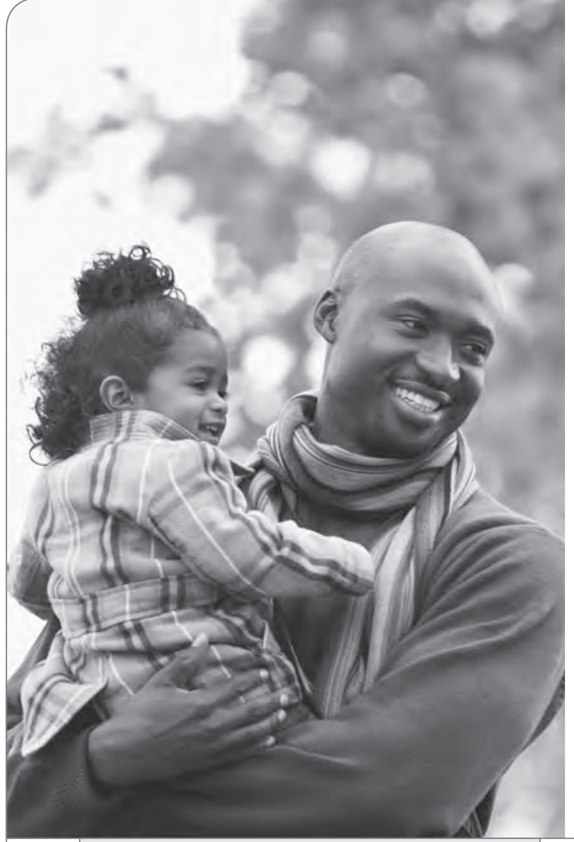

EXAMPLE 2

You need outpatient surgery for a simple procedure and are deciding if you will have it done by a physician in the Aetna network. This example gives you an idea of how much you might owe depending on your choice.

OUTPATIENT SURGERY		In-Network	Out-of-Network+
Surgery bill†	Amount billed	$2,000	$2,000
Amount Aetna uses to calculate payment	Aetna's rate* in-network	$600*	
	Recognized amount** out-of-network		$600**
What your plan will pay	Aetna's negotiated rate/recognized amount	$600	$600
	Percent your plan pays	80%	60%
	Amount of Aetna's negotiated rate/recognized amount covered under plan	$480*	$360**
What you owe	Your coinsurance responsibility	$120	$240
	Amount that can be balance billed to you	$0	$1,400*
YOUR TOTAL RESPONSIBILITY		**$120*** **	**$1,640*** **

EXAMPLE 3

You need to go to the hospital but it is not an emergency. It turns out that you have to stay in the hospital for five days. This example gives you an idea of how much you might owe to the hospital depending on whether it is in the Aetna network.

FIVE-DAY HOSPITAL STAY		In-Network	Out-of-Network+
Hospital bill	Amount billed	$25,000	$25,000
Amount Aetna uses to calculate payment	Aetna's rate* in-network	$8,750*	
	Recognized amount** out-of-network		$8,750**
What your plan will pay	Aetna's negotiated rate/ recognized amount	$8,750	$8,750
	Percent your plan pays	80%	60%
	Amount of Aetna's negotiated rate/recognized amount covered under plan	$7,000*	$5,250**
What you owe	Your coinsurance responsibility	$1,750	$3,500
	Amount that can be balance billed to you	$0	$16,250*
YOUR TOTAL RESPONSIBILITY		**$1,750*** **	**$19,750*** **

BY USING PROVIDERS IN THE AETNA NETWORK, YOU CAN TAKE ADVANTAGE OF THE SIGNIFICANT DISCOUNTS WE HAVE NEGOTIATED TO HELP LOWER YOUR OUT-OF-POCKET COSTS FOR MEDICALLY NECESSARY CARE.

† You also may be responsible for a portion of fees charged by the facility in which the surgery takes place. The figures in the example do not include those facility fees.
* Doctors, hospitals and other health care providers in the Aetna network accept our payment rate and agree that you owe only your deductible and coinsurance.
** When you go out of network, the plan determines a recognized amount. You may be responsible for the difference between the billed amount and the recognized amount. See your plan documents for details. Your plan may instead call the recognized amount the recognized charge.
*** Most plans cap out-of-pocket costs for covered services. The deductible and coinsurance you owe count toward that cap. But when you go outside the network, the difference between the health care provider's bill and the recognized amount does not count toward that cap.

SAVE EVEN MORE

MORE WAYS TO CONTROL HEALTH CARE COSTS

ENJOY THE VALUE OF GENERIC PRESCRIPTION DRUGS

Generic prescription drugs can save you money. They go through rigorous testing as required by the Food and Drug Administration. So you can be sure they are as safe and effective as their brand-name counterparts.

If a generic prescription drug is right for you, we offer many ways to help you access them:

- Tools to compare the costs of brand-name and generic drugs
- Outreach efforts that show how you can save with generic drugs
- Prescriptions filled with a generic, when appropriate
- Plan options that may include special terms about use of generics

AETNA RX HOME DELIVERY®

With this mail-order prescription drug program, order generic and brand prescription medications through our convenient and easy-to-use mail order pharmacy. To learn more or to download order forms, visit **www.AetnaRxHomeDelivery.com.**

SAVE ON LAB WORK

With your Aetna medical plan, you can save on testing and other lab services when you use Quest Diagnostics.

Here's how it works:

- If your doctor is collecting your sample in the office, ask him or her to send your testing to Quest.
- If your doctor is sending you outside the office to collect your sample, ask for a lab requisition form to Quest, and visit your nearest Quest office.

LOOK HOW MUCH YOU CAN SAVE!

	In-network lab	In-network hospital lab	Out-of-network lab
Cost of lab test	$30.00	$60.00	$300.00
Patient's copay	x20%	x20%	x40%
Patient pays	$6.00	$12.00	$120.00

BE A BETTER HEALTH CARE CONSUMER. ASK YOUR DOCTOR TO ONLY USE IN-NETWORK LABS, AND PAY LESS.

YOU'RE MOBILE. **SO ARE WE.**

Aetna Mobile puts our most popular online features at your fingertips. No matter where you are, you still want easy access to your health information to make the best decisions you can.

Want to look up a claim while you're waiting in line? Find a doctor and make an appointment while you're out shopping? Research the price of your medication during your train ride to work?

When you go to Aetna.com from your mobile phone's web browser, you can:

- Find a doctor, dentist or facility
- Buy health insurance
- Register for your secure member site
- Access your personal health record (PHR)
- View your member ID card
- Contact us by phone or email

Explore a smarter health plan.
Visit us at **www.aetna.com**.

AETNA'S AEXCEL® DESIGNATED SPECIALISTS

FIND OUT MORE ABOUT THE AETNA PERFORMANCE NETWORK

Certain areas in your state include the Aetna Performance Network, which features Aexcel designated specialists who have demonstrated cost-effectiveness in the delivery of care and met certain clinical performance measures. The Aexcel designation applies to select specialists in 12 specialty areas: Cardiology, Cardiothoracic Surgery, Gastroenterology, General Surgery, Obstetrics and Gynecology, Orthopedics, Otolaryngology/ ENT, Neurology, Neurosurgery, Plastic Surgery, Urology and Vascular Surgery. **Aetna members in the designated counties, described on the Rating Areas page of this brochure, must choose Aexcel designated specialists or they will incur out-of-network charges for any other provider in these 12 specialty areas.**

Our performance network gives you access to some high-performing specialists. Specialty doctors and doctor groups with the Aexcel designation:

- Are part of the Aetna network of health care providers
- Have met certain industry-accepted practices for clinical performance
- Have met our efficiency standards

EFFICIENCY

We also review the costs of treating Aetna members in each of the 12 Aexcel areas of care. We try to include all costs — not just visits to the doctor's office.

We review inpatient, outpatient, diagnostic, lab and pharmacy claims. Then we compare the total costs of care from each doctor to the costs of other doctors in the same region.

The doctors who best meet these qualifications are chosen to receive the Aexcel designation.

How can I find an Aexcel-designated doctor?

You can look in your printed Aetna directory to find doctors with this designation. Aexcel-designated doctors have an asterisk next to their name.

Or you can check our DocFind® online provider directory. Please visit **www.AetnaIndividual.com** and select "Find a Doctor". Aexcel-designated doctors have a blue star ★ next to their name.

More information is available on our secure Aetna Navigator® member website, at **www.aetna.com**. Just log on, go to the "Provider Details" page, and click on the "View Clinical Quality and Efficiency" tab. It shows if the doctor meets standards for Aexcel designation.

Aexcel information we offer you is intended to be only a guide for when you choose a specialist within the Aexcel specialist categories. There are many ways to evaluate doctor practices and you should consult with your existing doctor before making a decision. Please note that all ratings have a risk of error and, therefore, should not be the sole basis for selecting a doctor.

You can find more information on Aexcel designation in our Understanding Aexcel brochure. For a complete description of performance measures and how we evaluate doctors (data sources, statistical significance and other technical information) refer to the Aexcel Methodology guide. It's all available online on **www.aetna.com**. Just do a search for "performance networks."

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BETTER MANAGE YOUR HEALTH AND HEALTH CARE.

Aetna Navigator® Secure Member Website

Aetna Navigator helps you do what you want to do — more easily.

As a member, you can log in to manage your:

- Health coverage
- Claims
- Care and treatment
- Health records
- Health and wellness

You even get personalized information. And extra help is just a click or phone call away!

Visit Aetna Navigator anytime, anywhere. Log in using any mobile phone with web access – **www.aetna.com**.

We look forward to welcoming you as a member!

Explore a smarter health plan. Visit us at **www.aetna.com**.

RATING AREAS*

TEXAS

YOUR RATES WILL DEPEND ON THE AREA IN WHICH YOUR COUNTY IS LOCATED.
FOR MORE INFORMATION OR A QUOTE ON WHAT YOUR RATE WOULD BE,
CALL YOUR BROKER OR 1-800-MY-HEALTH.

AREA 1+

Blanco
Bosque
Brazos
Brooks
Brown
Burleson
Coleman
Comanche
De Witt
Dimmit
Edwards
Frio
Gillespie
Goliad
Gonzales
Hamilton
Jim Hogg
Jones
Karnes
Kenedy
Kerr
Kimble
Kinney
La Salle
Lavaca
Llano (except Horseshoe Bay)
Madison
Mason
Maverick
McMullen
Milam
Mills
Real
Refugio
Robertson
San Saba
Taylor
Uvalde
Washington
Webb
Zapata
Zavala

AREA 2+

Ector
Jasper (Brookeland)
Lubbock
McLennan
Midland
Tom Green
Wichita

AREA 3+

Aransas
Armstrong
Bee
Briscoe
Calhoun
Cameron
Carson
Castro
Childress
Collingsworth
Dallam
Deaf Smith
Donley
Duval
Gray
Hall
Hansford
Hartley
Hemphill
Hidalgo
Hutchinson
Jackson
Jim Wells
Kleberg
Lipscomb
Live Oak
Moore
Nueces
Ochiltree
Oldham
Parmer
Potter
Randall
Roberts
San Patricio
Sherman
Starr
Swisher
Victoria
Wheeler
Willacy

AREA 4+

Anderson
Andrews
Angelina
Archer
Bailey
Baylor
Borden
Bowie
Brewster
Callahan
Cass
Clay
Cochran
Coke
Concho
Cottle
Crane
Crockett
Crosby
Culberson
Dawson
Dickens
Eastland
Falls
Fisher
Floyd
Foard
Gaines
Garza
Glasscock
Hale
Hardeman
Haskell
Henderson (except Mabank)
Hockley
Houston
Howard
Hudspeth
Irion
Jack
Jeff Davis
Kent
King
Knox
Lamb
Leon
Limestone
Loving
Lynn
Martin
McCulloch
Menard
Mitchell
Motley
Nacogdoches
Nolan
Panola
Pecos
Polk
Presidio
Reagan
Reeves
Runnels
Rusk
Sabine
San Augustine
Schleicher
Scurry
Shackelford
Shelby
Stephens
Sterling
Stonewall
Sutton
Terrell
Terry
Throckmorton
Trinity
Upton
Val Verde
Ward
Wilbarger
Winkler
Yoakum
Young

AREA 5+: **Aexcel Specialist Network****

Camp
Cherokee
Collin
Cooke
Dallas
Delta
Denton
Ellis
Erath
Fannin
Franklin
Freestone
Grayson
Gregg
Harrison
Henderson (Mabank)
Hill
Hood
Hopkins
Hunt
Johnson
Kaufman
Lamar
Marion
Montague
Morris
Navarro
Palo Pinto
Parker
Rains
Red River
Rockwall
Smith
Somervell
Tarrant
Titus
Upshur
Van Zandt
Wise
Wood

AREA 6++: **Aexcel Specialist Network****

Austin
Brazoria
Chambers
Colorado
Fort Bend
Galveston
Grimes
Hardin
Harris
Jasper (except Brookeland)
Jefferson
Liberty
Matagorda
Montgomery
Newton
Orange
San Jacinto
Tyler
Walker
Waller
Wharton

AREA 7+: **Aexcel Specialist Network****

Atascosa
Bandera
Bexar
Comal
Guadalupe
Kendall
Medina
Wilson

AREA 8++: **Aexcel Specialist Network****

Bastrop
Bell
Burnet
Caldwell
Coryell
Fayette
Hays
Lampasas
Lee
Llano (Horseshoe Bay)
Travis
Williamson

AREA 9++

El Paso

AEXCEL®-DESIGNATED SPECIALISTS**

The Aetna Performance Network features Aexcel-designated specialists who have demonstrated cost-effectiveness in the delivery of care and met certain clinical performance measures. The Aexcel designation applies to select specialists in 12 specialty areas: Cardiology, Cardiothoracic Surgery, Gastroenterology, General Surgery, Obstetrics and Gynecology, Orthopedics, Otolaryngology/ENT, Neurology, Neurosurgery, Plastic Surgery, Urology, and Vascular Surgery. **Aetna members in the designated counties must choose Aexcel designated specialists or they will incur out-of-network charges. There is no additional cost when members use Aexcel specialists.** You'll find them by looking for the star next to the doctors' names at **www.aetna.com/docfind/custom/advplans** or in your printed directory.

* Networks may not be available in all ZIP codes and are subject to change.
** Aetna members in the designated counties must choose Aexcel designated specialists or they will incur out-of-network charges.
\+ Areas 1-5 and Area 7 are Preferred Provider Benefits Plans (PPO)
++ Area 6 and Areas 8-9 are Managed Choice Open Access Plans

63.02.300.1-TX (1/11)

HOW DO I MAKE **SMART HEALTH CARE DECISIONS?**

Sure, health care options can sometimes be confusing. But it's important to understand your health and personal finance choices, so you can plan ahead and make wise decisions. **PlanforYourHealth.com** can help you choose the best health care alternatives for you and your family.

This website offers useful tips on different insurance products, plus interactive tools that show how big life changes will affect your health care options.

Visit **www.planforyourhealth.com**, and get guidance for different stages in your life — and in your health.

YOUR AETNA OPEN ACCESS® MANAGED CHOICE® AND PREFERRED PROVIDER ORGANIZATION (PPO) **PLAN OPTION(S)**

ROBUST COVERAGE AND THE FLEXIBILITY OF LOWER MONTHLY PAYMENTS BALANCED WITH A DEDUCTIBLE... WHERE YOU DON'T PAY A LOT FOR FREQUENT DOCTOR VISITS

FEATURING:

- Robust coverage with a choice of varying deductible levels

63.06.300.1-TX D (9/12)

AETNA OPEN ACCESS® MANAGED CHOICE® AND PPO 2500

TEXAS

AETNA ADVANTAGE PLAN OPTIONS

MEMBER BENEFITS	In-Network	Out-of-Network+
Deductible Individual Family	$2,500 $5,000	$5,000 $10,000
Coinsurance (Member's responsibility)	20% after deductible up to out-of-pocket max.	50% after deductible up to out-of-pocket max.
	$0 once out-of-pocket max. is satisfied	
Coinsurance Maximum Individual Family	$2,500 $5,000	$5,000 $10,000
Out-of-Pocket Maximum Individual Family	$5,000 $10,000	$10,000 $20,000
	Includes deductible	
Non-Specialist Office Visit *Unlimited visits* General Physician, Family Practitioner, Pediatrician or Internist	$35 copay deductible waived	50% after deductible
Specialist Visit *Unlimited visits*	$50 copay deductible waived	50% after deductible
Hospital Admission	20% after deductible	50% after deductible
Outpatient Surgery	20% after deductible	50% after deductible
Urgent Care Facility	$50 copay deductible waived	50% after deductible
Emergency Room	$350 copay** (waived if admitted)	
Annual Routine Gyn Exam *No waiting period, no calendar year max.* Annual Pap/Mammogram	$0 copay deductible waived	50% after deductible
Maternity	Not covered *Except for pregnancy complications*	
Preventive Health — Routine Physical *No waiting period*	$0 copay deductible waived	50% after deductible
	Includes lab work and X-rays	
Lab/X-Ray (Non-Preventive)	20% after deductible	50% after deductible
Skilled Nursing — instead of hospital *30 days per calendar year**	20% after deductible	50% after deductible
Physical/Occupational Therapy *24 visits per calendar year**	20% after deductible	50% after deductible
Home Health Care — instead of hospital *30 visits per calendar year**	20% after deductible	50% after deductible
Durable Medical Equipment *Aetna will pay up to $2,000 per calendar year**	20% after deductible	50% after deductible

PHARMACY	In-Network	Out-of-Network+
Pharmacy Deductible per individual	$500	$500
	Does not apply to generic	
Generic	$15 copay deductible waived	$15 copay plus 50% deductible waived
Preferred Brand	$35 copay after deductible	$35 copay plus 50% after deductible
Non-Preferred Brand	$65 copay after deductible	$65 copay plus 50% after deductible
Self-Injectable	25% after deductible	Not covered

* Maximum applies to combined in and out-of-network benefits.

** Copay is billed separately and not due at time of service. Copay does not count towards coinsurance or out-of-pocket maximum.

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63.06.300.1-TX D (9/12)

AETNA OPEN ACCESS® MANAGED CHOICE® AND PPO 3500

TEXAS

AETNA ADVANTAGE PLAN OPTIONS

MEMBER BENEFITS	In-Network	Out-of-Network+
Deductible Individual Family	$3,500 $7,000	$7,000 $14,000
Coinsurance (Member's responsibility)	20% after deductible up to out-of-pocket max.	50% after deductible up to out-of-pocket max.
	$0 once out-of-pocket max. is satisfied	
Coinsurance Maximum Individual Family	$3,500 $7,000	$3,000 $6,000
Out-of-Pocket Maximum Individual Family	$7,000 $14,000	$10,000 $20,000
	Includes deductible	
Non-Specialist Office Visit *Unlimited visits* General Physician, Family Practitioner, Pediatrician or Internist	$35 copay deductible waived	50% after deductible
Specialist Visit *Unlimited visits*	$50 copay deductible waived	50% after deductible
Hospital Admission	20% after deductible	50% after deductible
Outpatient Surgery	20% after deductible	50% after deductible
Urgent Care Facility	$50 copay deductible waived	50% after deductible
Emergency Room	$350 copay** (waived if admitted)	
Annual Routine Gyn Exam *No waiting period, no calendar year max.* Annual Pap/Mammogram	$0 copay deductible waived	50% after deductible
Maternity	Not covered *Except for pregnancy complications*	
Preventive Health — Routine Physical *No waiting period*	$0 copay deductible waived	50% after deductible
Lab/X-Ray (Non-Preventive)	20% after deductible	50% after deductible
Skilled Nursing — instead of hospital *30 days per calendar year**	20% after deductible	50% after deductible
Physical/Occupational Therapy *24 visits per calendar year**	20% after deductible	50% after deductible
Home Health Care — instead of hospital *30 visits per calendar year**	20% after deductible	50% after deductible
Durable Medical Equipment *Aetna will pay up to $2,000 per calendar year**	20% after deductible	50% after deductible

PHARMACY	In-Network	Out-of-Network+
Pharmacy Deductible per individual	$500	$500
	Does not apply to generic	
Generic	$15 copay deductible waived	$15 copay plus 50% deductible waived
Preferred Brand	$35 copay after deductible	$35 copay plus 50% after deductible
Non-Preferred Brand	$65 copay after deductible	$65 copay plus 50% after deductible
Self-Injectable	25% after deductible	Not covered

* Maximum applies to combined in and out-of-network benefits.

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63.06.300.1-TX D (9/12)

AETNA OPEN ACCESS® MANAGED CHOICE® AND PPO 5000

TEXAS

AETNA ADVANTAGE PLAN OPTIONS

MEMBER BENEFITS	In-Network	Out-of-Network+
Deductible Individual Family	$5,000 $10,000	$10,000 $20,000
Coinsurance (Member's responsibility)	20% after deductible up to out-of-pocket max.	50% after deductible up to out-of-pocket max.
	$0 once out-of-pocket max. is satisfied	
Coinsurance Maximum Individual Family	$5,000 $10,000	$2,500 $5,000
Out-of-Pocket Maximum Individual Family	$10,000 $20,000	$12,500 $25,000
	Includes deductible	
Non-Specialist Office Visit *Unlimited visits* General Physician, Family Practitioner, Pediatrician or Internist	$40 copay deductible waived	50% after deductible
Specialist Visit *Unlimited visits*	$50 copay deductible waived	50% after deductible
Hospital Admission	20% after deductible	50% after deductible
Outpatient Surgery	20% after deductible	50% after deductible
Urgent Care Facility	$50 copay deductible waived	50% after deductible
Emergency Room	$350 copay** (waived if admitted)	
Annual Routine Gyn Exam *No waiting period, no calendar year max.* Annual Pap/Mammogram	$0 copay deductible waived	50% after deductible
Maternity	Not covered *Except for pregnancy complications*	
Preventive Health — Routine Physical *No waiting period*	$0 copay deductible waived	50% after deductible
	Includes lab work and X-rays	
Lab/X-Ray (Non-Preventive)	20% after deductible	50% after deductible
Skilled Nursing — instead of hospital *30 days per calendar year**	20% after deductible	50% after deductible
Physical/Occupational Therapy *24 visits per calendar year**	20% after deductible	50% after deductible
Home Health Care — instead of hospital *30 visits per calendar year**	20% after deductible	50% after deductible
Durable Medical Equipment *Aetna will pay up to $2,000 per calendar year**	20% after deductible	50% after deductible

PHARMACY	In-Network	Out-of-Network+
Pharmacy Deductible per individual	$500	$500
	Does not apply to generic	
Generic	$15 copay deductible waived	$15 copay plus 50% deductible waived
Preferred Brand	$35 copay after deductible	$35 copay plus 50% after deductible
Non-Preferred Brand	$65 copay after deductible	$65 copay plus 50% after deductible
Self-Injectable	25% after deductible	Not covered

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AETNA OPEN ACCESS® MANAGED CHOICE® AND PPO 7500

TEXAS

AETNA ADVANTAGE PLAN OPTIONS

MEMBER BENEFITS	In-Network	Out-of-Network+
Deductible Individual Family	$7,500 $15,000	$10,000 $20,000
Coinsurance (Member's responsibility)	20% after deductible up to out-of-pocket max.	50% after deductible up to out-of-pocket max.
	$0 once out-of-pocket max. is satisfied	
Coinsurance Maximum Individual Family	$2,500 $5,000	$2,500 $5,000
Out-of-Pocket Maximum Individual Family	$10,000 $20,000	$12,500 $25,000
	Includes deductible	
Non-Specialist Office Visit *Unlimited visits* General Physician, Family Practitioner, Pediatrician or Internist	$45 copay deductible waived	50% after deductible
Specialist Visit *Unlimited visits*	$50 copay deductible waived	50% after deductible
Hospital Admission	20% after deductible	50% after deductible
Outpatient Surgery	20% after deductible	50% after deductible
Urgent Care Facility	$50 copay deductible waived	50% after deductible
Emergency Room	$350 copay** (waived if admitted)	
Annual Routine Gyn Exam *No waiting period, no calendar year max.* Annual Pap/Mammogram	$0 copay deductible waived	50% after deductible
Maternity	Not covered *Except for pregnancy complications*	
Preventive Health — Routine Physical *No waiting period*	$0 copay deductible waived	50% after deductible
	Includes lab work and X-rays	
Lab/X-Ray (Non-Preventive)	20% after deductible	50% after deductible
Skilled Nursing — instead of hospital *30 days per calendar year**	20% after deductible	50% after deductible
Physical/Occupational Therapy *24 visits per calendar year**	20% after deductible	50% after deductible
Home Health Care — instead of hospital *30 visits per calendar year**	20% after deductible	50% after deductible
Durable Medical Equipment *Aetna will pay up to $2,000 per calendar year**	20% after deductible	50% after deductible

PHARMACY	In-Network	Out-of-Network+
Pharmacy Deductible per individual	$500	$500
	Does not apply to generic	
Generic	$15 copay deductible waived	$15 copay plus 50% deductible waived
Preferred Brand	$35 copay after deductible	$35 copay plus 50% after deductible
Non-Preferred Brand	$65 copay after deductible	$65 copay plus 50% after deductible
Self-Injectable	25% after deductible	Not covered

* Maximum applies to combined in and out-of-network benefits.
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YOUR HIGH DEDUCTIBLE **PLAN OPTION(S)**

LOWER PREMIUM COSTS ... AND A HEALTH SAVINGS ACCOUNT (HSA) COMPATIBLE PLAN THAT OFFERS TAX-ADVANTAGED SAVINGS

FEATURING:

- 0% or 10% coinsurance in network after your deductible is met, depending on which plan you choose.

AETNA OPEN ACCESS® MANAGED CHOICE® AND PPO HIGH DEDUCTIBLE 3500 (HSA COMPATIBLE)

TEXAS

AETNA ADVANTAGE PLAN OPTIONS

MEMBER BENEFITS	In-Network	Out-of-Network+
Deductible Individual Family	$3,500 $7,000	$7,000 $14,000
Coinsurance (Member's responsibility)	10% after deductible up to out-of-pocket max.	50% after deductible up to out-of-pocket max.
	$0 once out-of-pocket max. is satisfied	
Coinsurance Maximum Individual Family	$2,450 $4,900	$5,500 $11,000
Out-of-Pocket Maximum Individual Family	$5,950 $11,900	$12,500 $25,000
	Includes deductible	
Non-Specialist Office Visit *Unlimited visits* General Physician, Family Practitioner, Pediatrician or Internist	10% after deductible	50% after deductible
Specialist Visit *Unlimited visits*	10% after deductible	50% after deductible
Hospital Admission	10% after deductible	50% after deductible
Outpatient Surgery	10% after deductible	50% after deductible
Urgent Care Facility	10% after deductible	50% after deductible
Emergency Room	10% after deductible	
Annual Routine Gyn Exam *No waiting period, no calendar year max.* Annual Pap/Mammogram	$0 copay deductible waived	50% after deductible
Maternity	Not covered *Except for pregnancy complications*	
Preventive Health — Routine Physical *No waiting period*	$0 copay deductible waived	50% after deductible
	Includes lab work and X-rays	
Lab/X-Ray (Non-Preventive)	10% after deductible	50% after deductible
Skilled Nursing — instead of hospital *30 days per calendar year**	10% after deductible	50% after deductible
Physical/Occupational Therapy *24 visits per calendar year**	10% after deductible	50% after deductible
Home Health Care — instead of hospital *30 visits per calendar year**	10% after deductible	50% after deductible
Durable Medical Equipment *Aetna will pay up to $2,000 per calendar year**	10% after deductible	50% after deductible

PHARMACY	In-Network	Out-of-Network+
Pharmacy Deductible per individual	Integrated Medical/Rx Deductible	
Generic	10% after Medical/ Rx deductible	50% after Medical/ Rx deductible
Preferred Brand	10% after Medical/ Rx deductible	50% after Medical/ Rx deductible
Non-Preferred Brand	Not covered	Not covered
Self-Injectable	Not covered	Not covered

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AETNA OPEN ACCESS® MANAGED CHOICE® AND PPO HIGH DEDUCTIBLE 5500 (HSA COMPATIBLE)

TEXAS

AETNA ADVANTAGE PLAN OPTIONS

MEMBER BENEFITS	In-Network	Out-of-Network+
Deductible Individual Family	$5,500 $11,000	$10,000 $20,000
Coinsurance (Member's responsibility)	0% after deductible up to out-of-pocket max.	50% after deductible up to out-of-pocket max.
	$0 once out-of-pocket max. is satisfied	
Coinsurance Maximum Individual Family	$0 $0	$2,500 $5,000
Out-of-Pocket Maximum Individual Family	$5,500 $11,000	$12,500 $25,000
	Includes deductible	
Non-Specialist Office Visit *Unlimited visits* General Physician, Family Practitioner, Pediatrician or Internist	0% after deductible	50% after deductible
Specialist Visit *Unlimited visits*	0% after deductible	50% after deductible
Hospital Admission	0% after deductible	50% after deductible
Outpatient Surgery	0% after deductible	50% after deductible
Urgent Care Facility	0% after deductible	50% after deductible
Emergency Room	0% after deductible	
Annual Routine Gyn Exam *No waiting period, no calendar year max.* Annual Pap/Mammogram	$0 copay deductible waived	50% after deductible
Maternity	Not covered *Except for pregnancy complications*	
Preventive Health — Routine Physical *No waiting period*	$0 copay deductible waived	50% after deductible
	Includes lab work and X-rays	
Lab/X-Ray (Non-Preventive)	0% after deductible	50% after deductible
Skilled Nursing — instead of hospital *30 days per calendar year**	0% after deductible	50% after deductible
Physical/Occupational Therapy *24 visits per calendar year**	0% after deductible	50% after deductible
Home Health Care — instead of hospital *30 visits per calendar year**	0% after deductible	50% after deductible
Durable Medical Equipment *Aetna will pay up to $2,000 per calendar year**	0% after deductible	50% after deductible

PHARMACY	In-Network	Out-of-Network+
Pharmacy Deductible per individual	Integrated Medical/Rx Deductible	
Generic	0% after Medical/ Rx deductible	50% after Medical/ Rx deductible
Preferred Brand	0% after Medical/ Rx deductible	50% after Medical/ Rx deductible
Non-Preferred Brand	0% after Medical/ Rx deductible	50% after Medical/ Rx deductible
Self-Injectable	0% after Medical/ Rx deductible	Not covered

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63.06.300.1-TX D (9/12)

YOUR VALUE
PLAN OPTION(S)

AFFORDABILITY — A BALANCE OF LOWER MONTHLY PREMIUMS AND GREATER COST SHARING WITH QUALITY COVERAGE

FEATURING:

- Coverage for routine and major services with lower monthly premiums (that's the "Value" part)

AETNA OPEN ACCESS® MANAGED CHOICE® AND PPO VALUE 1750

TEXAS

AETNA ADVANTAGE PLAN OPTIONS

MEMBER BENEFITS	In-Network	Out-of-Network+
Deductible Individual Family	$1,750 $3,500	$3,500 $7,000
Coinsurance (Member's responsibility)	30% after deductible up to out-of-pocket max.	50% after deductible up to out-of-pocket max.
	$0 once out-of-pocket max. is satisfied	
Coinsurance Maximum Individual Family	$10,750 $21,500	$9,000 $18,000
Out-of-Pocket Maximum Individual Family	$12,500 $25,000	$12,500 $25,000
	Includes deductible	
Non-Specialist Office Visit *Unlimited visits* General Physician, Family Practitioner, Pediatrician or Internist	$40 copay deductible waived	50% after deductible
Specialist Visit *Unlimited visits*	30% after deductible	50% after deductible
Hospital Admission	30% after deductible	50% after deductible
Outpatient Surgery	30% after deductible	50% after deductible
Urgent Care Facility	$75 copay deductible waived	50% after deductible
Emergency Room	$500 copay** (waived if admitted)	
Annual Routine Gyn Exam *No waiting period, no calendar year max.* Annual Pap/Mammogram	$0 copay deductible waived	50% after deductible
Maternity	Not covered *Except for pregnancy complications*	
Preventive Health — Routine Physical *No waiting period*	$0 copay deductible waived	50% after deductible
	Includes lab work and X-rays	
Lab/X-Ray (Non-Preventive)	30% after deductible	50% after deductible
Skilled Nursing — instead of hospital *30 days per calendar year**	30% after deductible	50% after deductible
Physical/Occupational Therapy *24 visits per calendar year**	30% after deductible	50% after deductible
Home Health Care — instead of hospital *30 visits per calendar year**	30% after deductible	50% after deductible
Durable Medical Equipment *Aetna will pay up to $2,000 per calendar year**	30% after deductible	50% after deductible

PHARMACY	In-Network	Out-of-Network+
Pharmacy Deductible per individual	$500	$500
	Does not apply to generic	
Generic	$20 copay deductible waived	$20 copay plus 50% deductible waived
Preferred Brand	$45 copay after deductible	$45 copay plus 50% after deductible
Non-Preferred Brand	Not covered	Not covered
Self-Injectable	Not covered	Not covered

* Maximum applies to combined in and out-of-network benefits.

** Copay is billed separately and not due at time of service. Copay does not count towards coinsurance or out-of-pocket maximum.

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63.06.300.1-TX D (9/12)

AETNA OPEN ACCESS® MANAGED CHOICE® AND PPO VALUE 3000

TEXAS

AETNA ADVANTAGE PLAN OPTIONS

MEMBER BENEFITS	In-Network	Out-of-Network+
Deductible Individual Family	$3,000 $6,000	$6,000 $12,000
Coinsurance (Member's responsibility)	30% after deductible up to out-of-pocket max.	50% after deductible up to out-of-pocket max.
	$0 once out-of-pocket max. is satisfied	
Coinsurance Maximum Individual Family	$4,500 $9,000	$6,500 $13,000
Out-of-Pocket Maximum Individual Family	$7,500 $15,000	$12,500 $25,000
	Includes deductible	
Non-Specialist Office Visit General Physician, Family Practitioner, Pediatrician or Internist	Visits 1-2 $30 copay, deductible waived. Thereafter 30% coinsurance after deductible. Specialist and Primary share visits.	50% after deductible
Specialist Visit	Visits 1-2 $30 copay, deductible waived. Thereafter 30% coinsurance after deductible. Specialist and Primary share visits.	50% after deductible
Hospital Admission	30% after deductible	50% after deductible
Outpatient Surgery	30% after deductible	50% after deductible
Urgent Care Facility	$75 copay deductible waived	50% after deductible
Emergency Room	$500 copay** (waived if admitted)	
Annual Routine Gyn Exam *No waiting period, no calendar year max.* Annual Pap/Mammogram	$0 copay deductible waived	50% after deductible
Maternity	Not covered *Except for pregnancy complications*	
Preventive Health — Routine Physical *No waiting period*	$0 copay deductible waived	50% after deductible
	Includes lab work and X-rays	
Lab/X-Ray (Non-Preventive)	30% after deductible	50% after deductible
Skilled Nursing — instead of hospital *30 days per calendar year**	30% after deductible	50% after deductible
Physical/Occupational Therapy *24 visits per calendar year**	30% after deductible	50% after deductible
Home Health Care — instead of hospital *30 visits per calendar year**	30% after deductible	50% after deductible
Durable Medical Equipment *Aetna will pay up to $2,000 per calendar year**	30% after deductible	50% after deductible

PHARMACY	In-Network	Out-of-Network+
Pharmacy Deductible per individual	$500	$500
	Does not apply to generic	
Generic	$20 copay deductible waived	$20 copay plus 50% deductible waived
Preferred Brand	$45 copay after deductible	$45 copay plus 50% after deductible
Non-Preferred Brand	Not covered	Not covered
Self-Injectable	Not covered	Not covered

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63.06.300.1-TX D (9/12)

AETNA OPEN ACCESS® MANAGED CHOICE® AND PPO VALUE 5000

TEXAS

AETNA ADVANTAGE PLAN OPTIONS

MEMBER BENEFITS	In-Network	Out-of-Network+
Deductible Individual Family	$5,000 $10,000	$10,000 $20,000
Coinsurance (Member's responsibility)	30% after deductible up to out-of-pocket max. *$0 once out-of-pocket max. is satisfied*	50% after deductible up to out-of-pocket max.
Coinsurance Maximum Individual Family	$7,500 $12,500	$2,500 $5,000
Out-of-Pocket Maximum Individual Family	$12,500 $25,000 *Includes deductible*	$12,500 $25,000
Non-Specialist Office Visit General Physician, Family Practitioner, Pediatrician or Internist	Visit 1-2 $30 copay, deductible waived; Thereafter 30% coinsurance after deductible. Specialist and Primary share visits	50% after deductible
Specialist Visit	Visit 1-2 $30 copay, deductible waived; Thereafter 30% coinsurance after deductible. Specialist and Primary share visits	50% after deductible
Hospital Admission	30% after deductible	50% after deductible
Outpatient Surgery	30% after deductible	50% after deductible
Urgent Care Facility	$75 copay deductible waived	50% after deductible
Emergency Room	$500 copay** (waived if admitted)	
Annual Routine Gyn Exam *No waiting period, no calendar year max.* Annual Pap/Mammogram	$0 copay deductible waived	50% after deductible
Maternity	Not covered *Except for pregnancy complications*	
Preventive Health — Routine Physical *No waiting period*	$0 copay deductible waived *Includes lab work and X-rays*	50% after deductible
Lab/X-Ray (Non-Preventive)	30% after deductible	50% after deductible
Skilled Nursing — instead of hospital *30 days per calendar year**	30% after deductible	50% after deductible
Physical/Occupational Therapy *24 visits per calendar year**	30% after deductible	50% after deductible
Home Health Care — instead of hospital *30 visits per calendar year**	30% after deductible	50% after deductible
Durable Medical Equipment *Aetna will pay up to $2,000 per calendar year**	30% after deductible	50% after deductible

PHARMACY	In-Network	Out-of-Network+
Pharmacy Deductible per individual	$500 *Does not apply to generic*	$500
Generic	$20 copay deductible waived	$20 copay plus 50% deductible waived
Preferred Brand	$45 copay after deductible	$45 copay plus 50% after deductible
Non-Preferred Brand	Not covered	Not covered
Self-Injectable	Not covered	Not covered

* Maximum applies to combined in and out-of-network benefits.

** Copay is billed separately and not due at time of service. Copay does not count towards coinsurance or out-of-pocket maximum.

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63.06.300.1-TX D (9/12)

AETNA OPEN ACCESS® MANAGED CHOICE® AND PPO VALUE 10000

TEXAS

AETNA ADVANTAGE PLAN OPTIONS

MEMBER BENEFITS	In-Network	Out-of-Network+
Deductible Individual Family	$10,000 $20,000	$10,000 $20,000
Coinsurance (Member's responsibility)	30% after deductible up to out-of-pocket max.	50% after deductible up to out-of-pocket max.
	$0 once out-of-pocket max. is satisfied	
Coinsurance Maximum Individual Family	$2,500 $5,000	$2,500 $5,000
Out-of-Pocket Maximum Individual Family	$12,500 $25,000	$12,500 $25,000
	Includes deductible	
Non-Specialist Office Visit General Physician, Family Practitioner, Pediatrician or Internist	Visits 1-2 $30 copay, deductible waived. Thereafter 30% coinsurance after deductible. Specialist and Primary share visits.	50% after deductible
Specialist Visit	Visits 1-2 $30 copay, deductible waived. Thereafter 30% coinsurance after deductible. Specialist and Primary share visits.	50% after deductible
Hospital Admission	30% after deductible	50% after deductible
Outpatient Surgery	30% after deductible	50% after deductible
Urgent Care Facility	$75 copay deductible waived	50% after deductible
Emergency Room	$500 copay** (waived if admitted)	
Annual Routine Gyn Exam *No waiting period, no calendar year max.* Annual Pap/Mammogram	$0 copay deductible waived	50% after deductible
Maternity	Not covered *Except for pregnancy complications*	
Preventive Health — Routine Physical *No waiting period*	$0 copay deductible waived	50% after deductible
	Includes lab work and X-rays	
Lab/X-Ray (Non-Preventive)	30% after deductible	50% after deductible
Skilled Nursing — instead of hospital *30 days per calendar year**	30% after deductible	50% after deductible
Physical/Occupational Therapy *24 visits per calendar year**	30% after deductible	50% after deductible
Home Health Care — instead of hospital *30 visits per calendar year**	30% after deductible	50% after deductible
Durable Medical Equipment *Aetna will pay up to $2,000 per calendar year**	30% after deductible	50% after deductible

PHARMACY	In-Network	Out-of-Network+
Pharmacy Deductible per individual	$500	$500
	Does not apply to generic	
Generic	$20 copay deductible waived	$20 copay plus 50% deductible waived
Preferred Brand	$45 copay after deductible	$45 copay plus 50% after deductible
Non-Preferred Brand	Not covered	Not covered
Self-Injectable	Not covered	Not covered

* Maximum applies to combined in and out-of-network benefits.

** Copay is billed separately and not due at time of service. Copay does not count towards coinsurance or out-of-pocket maximum.

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63.06.300.1-TX D (9/12)

YOUR PREVENTIVE AND HOSPITAL CARE **PLAN OPTION(S)**

AFFORDABILITY IS ONE OF YOUR TOP PRIORITIES
AND YOU USE ONLY BASIC HEALTH CARE SERVICES ...
AND WANT TO KEEP YOUR MONTHLY PREMIUMS LOWER

FEATURING:

- Coverage for preventive care and major health care services with a lower monthly premium

PREVENTIVE AND HOSPITAL CARE 2750
(HSA COMPATIBLE)
TEXAS
AETNA ADVANTAGE PLAN OPTIONS

MEMBER BENEFITS	In-Network	Out-of-Network+
Deductible Individual Family	$2,750 $5,500	$5,500 $11,000
Coinsurance (Member's responsibility)	20% after deductible up to out-of-pocket max.	50% after deductible up to out-of-pocket max.
	$0 once out-of-pocket max. is satisfied	
Coinsurance Maximum Individual Family	$3,200 $6,400	$4,500 $9,000
Out-of-Pocket Maximum Individual Family	$5,950 $11,900	$10,000 $20,000
	Includes deductible	
Non-Specialist Office Visit General Physician, Family Practitioner, Pediatrician or Internist	Not covered	Not covered
Specialist Visit	Not covered	Not covered
Hospital Admission	20% after deductible	50% after deductible
Outpatient Surgery	20% after deductible	50% after deductible
Urgent Care Facility	Not covered	Not covered
Emergency Room	$150 copay after deductible** (waived if admitted)	
Annual Routine Gyn Exam *No waiting period, no calendar year max.* Annual Pap/Mammogram	$0 copay deductible waived	50% after deductible
Maternity	Not covered *Except for pregnancy complications*	
Preventive Health — Routine Physical *No waiting period*	$0 copay deductible waived	50% after deductible
Lab/X-Ray (Non-Preventive)	Not covered	Not covered
Skilled Nursing — instead of hospital *30 days per calendar year**	20% after deductible	50% after deductible
Physical/Occupational Therapy	Not covered	Not covered
Home Health Care — instead of hospital *30 visits per calendar year**	20% after deductible	50% after deductible
Durable Medical Equipment	Not covered (except coverage for Diabetic Equipment and Supplies)	

PHARMACY	In-Network	Out-of-Network+
Pharmacy Deductible per individual	Not Applicable	Not Applicable
Generic	Not covered	Not covered
Preferred Brand	Not covered	Not covered
Non-Preferred Brand	Not covered	Not covered
Self-Injectable	Not covered	Not covered

* Maximum applies to combined in and out-of-network benefits.
** Copay is billed separately and not due at time of service. Copay does not count towards coinsurance or out-of-pocket maximum.
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63.06.300.1-TX D (9/12)

YOUR AETNA OPEN ACCESS® MANAGED CHOICE® SAVINGS PLUS **PLAN OPTION(S)**

SAVINGS — THE SAME TYPES OF COVERAGE AS OTHER AETNA MEDICAL PLANS, BUT AT A LOWER PREMIUM COST

FEATURING:

- Highest benefit level and the lowest out-of-pocket costs when you access care through the Savings Plus network

AETNA OPEN ACCESS® MANAGED CHOICE® SAVINGS PLUS 3000

TEXAS

AETNA ADVANTAGE PLAN OPTIONS

MEMBER BENEFITS	Maximum Savings (Designated Providers and Non-Designated Providers)++	Out-of Network++
Deductible Individual Family	$3,000/$6,000 Designated Providers $6,000/$12,000 Non-Designated Providers	$6,000 $12,000
Coinsurance (Member's responsibility)	20%/40% after deductible up to out-of-pocket max.	50% after deductible up to out-of-pocket max.
	$0 once out-of-pocket max. is satisfied	
Coinsurance Maximum Individual Family	$7,000/$14,000 Designated Providers $6,500/$13,000 Non-Designated Providers	$6,500 $13,000
Out-of-Pocket Maximum Individual Family	$10,000/$20,000 Designated Providers $12,500/$25,000 Non-Designated Providers	$12,500 $25,000
	Includes deductible	
Non-Specialist Office Visit General Physician, Family Practitioner, Pediatrician or Internist	Visits 1-3:$35 copay, deductible waived; Visits 4+ member pays 100%. Aetna pays 100% once out-of-pocket maximum is reached	50% after deductible
Specialist Visit *Unlimited visits*	20% after deductible Designated Providers 40% after deductible Non-Designated Providers	50% after deductible
Hospital Admission	40% after deductible Designated Providers 45% after $150 copay per day (3 day max. per admission); deductible applies Non-Designated Providers	50% after deductible
Outpatient Surgery	40% after deductible Designated Providers 45% after $150 copay; deductible applies Non-Designated Providers	50% after deductible
Urgent Care Facility	$100 copay deductible waived	50% after deductible
Emergency Room	$500 copay** (waived if admitted)	
Annual Routine Gyn Exam *No waiting period* Annual Pap/Mammogram	$0 copay deductible waived	50% after deductible
Maternity	Not covered *Except for pregnancy complications*	
Preventive Health — Routine Physical *No waiting period*	$0 copay deductible waived	50% after deductible
	Includes lab work and X-rays	
Lab/X-Ray (Non-Preventive)	20% after deductible	50% after deductible
Skilled Nursing — instead of hospital *30 days per calendar year**	40% after deductible	50% after deductible
Physical/Occupational Therapy *24 visits per calendar year**	20% after deductible	50% after deductible
Home Health Care — instead of hospital *30 visits per calendar year**	20% after deductible	50% after deductible
Durable Medical Equipment *Aetna will pay up to $2,000 per calendar year**	20% after deductible	50% after deductible

PHARMACY	In-Network	Out-of-Network+
Pharmacy Deductible per individual	Not Applicable	Not Applicable
Generic	$15 copay deductible waived	$15 copay plus 50% deductible waived
Preferred Brand	Not covered	Not covered
Non-Preferred Brand	Not covered	Not covered
Self-Injectables	Not covered	Not covered

* Maximum applies to combined in and out-of-network benefits.

** Copay is billed separately and not due at time of service. Copay does not count towards coinsurance or out-of-pocket maximum.

\+ For important information on your costs and how Aetna pays for out-of-network care, read "What you need to know about your out-of-network costs."

++ For important information on what you will pay for Maximum Savings and Out-of-Network Providers, read "How do the Savings Plus plans work"?

This plan provides preferred benefit coverage and access to covered services and supplies through a designated network of health care providers and facilities that are unique to your plan.

This Plan includes different benefit levels based upon the type of network provider that you use (designated or non-designated) or if you choose to see a non-preferred care provider. It is designed to lower your out-of-pocket costs when you use these designated network providers for covered expenses. These designated network providers are identifi ed in the printed directory and the on-line version of the directory. Aetna also contracts with other network providers that are available to you under the plan (referred to as non-designated network providers), but your cost sharing will be at a much higher level when you use these providers.

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AETNA OPEN ACCESS® MANAGED CHOICE® SAVINGS PLUS 5000

TEXAS

AETNA ADVANTAGE PLAN OPTIONS

MEMBER BENEFITS	Maximum Savings (Designated Providers and Non-Designated Providers)++	Out-of Network++
Deductible Individual Family	$5,000/$10,000 Designated Providers $10,000/$20,000 Non-Designated Providers	$10,000 $20,000
Coinsurance (Member's responsibility)	20%/40% after deductible up to out-of-pocket max.	50% after deductible up to out-of-pocket max.
	$0 once out-of-pocket max. is satisfied	
Coinsurance Maximum Individual Family	$7,500/$15,000 Designated Providers $2,500/$5,000 Non-Designated Providers	$2,500 $5,000
Out-of-Pocket Maximum Individual Family	$12,500 $25,000 (Designated Providers and Non-Designated Providers)	$12,500 $25,000
	Includes deductible	
Non-Specialist Office Visit General Physician, Family Practitioner, Pediatrician or Internist	Visits 1-3:$35 copay, deductible waived; Visits 4+ member pays 100%. Aetna pays 100% once out-of-pocket maximum is reached	50% after deductible
Specialist Visit *Unlimited visits*	20% after deductible Designated Providers 40% after deductible Non-Designated Providers	50% after deductible
Hospital Admission	40% after deductible Designated Providers 45% after $150 copay per day (3 day max. per admission); deductible applies Non-Designated Providers	50% after deductible
Outpatient Surgery	40% after deductible Designated Providers 45% after $150 copay; deductible applies Non-Designated Providers	50% after deductible
Urgent Care Facility	$100 copay deductible waived	50% after deductible
Emergency Room	$500 copay** (waived if admitted)	
Annual Routine Gyn Exam *No waiting period* Annual Pap/Mammogram	$0 copay deductible waived	50% after deductible
Maternity	Not covered *Except for pregnancy complications*	
Preventive Health — Routine Physical *No waiting period*	$0 copay deductible waived	50% after deductible
	Includes lab work and X-rays	
Lab/X-Ray (Non-Preventive)	20% after deductible	50% after deductible
Skilled Nursing — instead of hospital *30 days per calendar year**	40% after deductible	50% after deductible
Physical/Occupational Therapy *24 visits per calendar year**	20% after deductible	50% after deductible
Home Health Care — instead of hospital *30 visits per calendar year**	20% after deductible	50% after deductible
Durable Medical Equipment *Aetna will pay up to $2,000 per calendar year**	20% after deductible	50% after deductible

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PHARMACY	In-Network	Out-of-Network+
Pharmacy Deductible per individual	Not Applicable	Not Applicable
Generic	$15 copay deductible waived	$15 copay plus 50% deductible waived
Preferred Brand	Not covered	Not covered
Non-Preferred Brand	Not covered	Not covered
Self-Injectables	Not covered	Not covered

* Maximum applies to combined in and out-of-network benefits.

** Copay is billed separately and not due at time of service. Copay does not count towards coinsurance or out-of-pocket maximum.

\+ For important information on your costs and how Aetna pays for out-of-network care, read "What you need to know about your out-of-network costs."

++ For important information on what you will pay for Maximum Savings and Out-of-Network Providers, read "How do the Savings Plus plans work"?

This plan provides preferred benefit coverage and access to covered services and supplies through a designated network of health care providers and facilities that are unique to your plan.

This Plan includes different benefit levels based upon the type of network provider that you use (designated or non-designated) or if you choose to see a non-preferred care provider. It is designed to lower your out-of-pocket costs when you use these designated network providers for covered expenses. These designated network providers are identifi ed in the printed directory and the on-line version of the directory. Aetna also contracts with other network providers that are available to you under the plan (referred to as non-designated network providers), but your cost sharing will be at a much higher level when you use these providers.

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

Aetna Advantage Plans for Individuals, Families and the Self-Employed are underwritten by Aetna Life Insurance Company directly and/or through an out-of-state blanket trust or Aetna Health Inc. (together, "Aetna") In some states, individuals may qualify as a business group of one and may be eligible for guaranteed issue, small group health plans. To the extent permitted by law, these plans are medically underwritten and you may be declined coverage in accordance with your health condition.

INDIVIDUAL DENTAL
PDN MAX PLAN
PLAN OPTION

INDIVIDUAL DENTAL PDN MAX PLAN

TEXAS

AETNA ADVANTAGE PLAN OPTIONS

MEMBER BENEFITS	Preferred	Non-Preferred
Annual Deductible per Member (Does not apply to Diagnostic and Preventive Services)	$25; $75 family maximum	$25; $75 family maximum
Annual Maximum Benefit	Unlimited	Unlimited
DIAGNOSTIC SERVICES		
Oral exams		
Periodic oral exam	100% deductible waived	100% deductible waived
Comprehensive oral exam	100% deductible waived	100% deductible waived
Problem-focused oral exam	100% deductible waived	100% deductible waived
X-rays		
Bitewing — single film	100% deductible waived	100% deductible waived
Complete series	100% deductible waived	100% deductible waived
PREVENTIVE SERVICES		
Adult cleaning	100% deductible waived	100% deductible waived
Child cleaning	100% deductible waived	100% deductible waived
Sealants — per tooth	Discount	Not covered
Fluoride application — with cleaning	100% deductible waived	100% deductible waived
Space maintainers	Not covered	Not covered
BASIC SERVICES		
Amalgam fillings — 2 surfaces	100% after deductible	100% after deductible
Resin fillings — 2 surfaces	Not covered	Not covered
Oral Surgery		
Extraction — exposed root or erupted tooth	Not covered	Not covered
Extraction of impacted tooth — soft tissue	Not covered	Not covered
MAJOR SERVICES		
Complete upper denture	Not covered	Not covered
Partial upper denture (resin based)	Not covered	Not covered
Crown — Porcelain with noble metal	Not covered	Not covered
Pontic — Porcelain with noble metal	Not covered	Not covered
Inlay — Metallic (3 or more surfaces)	Not covered	Not covered
Oral Surgery		
Removal of impacted tooth — partially bony	Not covered	Not covered
Endodontic Services		
Bicuspid root canal therapy	Not covered	Not covered
Molar root canal therapy	Not covered	Not covered
Periodontic Services		
Scaling & root planing — per quadrant	Not covered	Not covered
Osseous surgery — per quadrant	Not covered	Not covered
ORTHODONTIC SERVICES	Not covered	Not covered

Nonpreferred (Out-of-Network) Coverage is limited to a maximum of the Plan's payment, which is based on the contracted maximum fee for participating providers in the particular geographic area.

This list of covered services is representative. A summary of exclusions is listed in the Aetna Advantage Plan brochure. For a full list of benefit coverage and exclusions refer to the plan documents.

All products not available in all counties.

This material is for information only. Dental insurance plans contain exclusions and limitations. Not all dental services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location and are subject to change. Information is believed to be accurate as of the production date; however, it is subject to change.

Aetna Advantage Plans for Individuals, Families and the Self-Employed are underwritten by Aetna Life Insurance Company directly and/or through an out-of-state blanket trust or Aetna Health Inc. (together, "Aetna") In some states, individuals may qualify as a business group of one and may be eligible for guaranteed issue, small group health plans. To the extent permitted by law, these plans are medically underwritten and you may be declined coverage in accordance with your health condition.

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WHAT YOU NEED TO KNOW ABOUT **YOUR OUT-OF-NETWORK COSTS**

We cover the cost of care differently based on whether health care providers, such as doctors and hospitals, are "in network" or "out of network." We want to help you understand how much Aetna pays for your out-of-network care. At the same time, we want to make it clear how much more you will need to pay for this out-of-network care.

As an example, you may choose a doctor in our network. You may choose to visit an out-of-network doctor. If you choose a doctor who is out of network, your Aetna health plan may pay some of that doctor's bill.

Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor or hospital.

When you choose out-of-network care, Aetna limits the amount it will pay. This limit is called the "recognized" or "allowed" amount. For medical plans, Aetna recognizes an amount based on what Medicare pays for these services. The government sets the Medicare rate.

Your out-of-network doctor sets the rate to charge you. It may be higher—sometimes much higher—than what your Aetna plan "recognizes" or "allows."

Your doctor may bill you for the dollar amount that Aetna doesn't recognize. You must also pay any copayments, coinsurance and deductibles under your plan.

No dollar amount above the recognized charge counts toward your deductible or out-of-pocket maximums. To learn more about how we pay out-of-network benefits visit **www.Aetna.com**. Type "how Aetna pays" in the search box.

You can avoid these extra costs by getting your care from Aetna's broad network of health care providers. Go to **www.Aetna.com** and click on "Find a Doctor" on the left side of the page. If you are already a member, sign on to your Aetna Navigator member site.

This way of paying out-of-network doctors and hospitals applies when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident), we will pay the bill as if you got care in network. You pay your plan's copayments, coinsurance and deductibles for your in-network level of benefits. Contact Aetna if your provider asks you to pay more. You are not responsible for any outstanding balance billed by your providers for emergency services beyond your copayments, coinsurance and deductibles.

For dental plans, your share of costs for care is determined in a similar way as your medical plan, which is outlined in detail above. If you choose an out-of-network dentist, you will pay a lot more money out of your own pocket most of the time.

But the amount Aetna recognizes for out-of-network dentists is based on different rates than the medical plan. Aetna bases payments to out-of-network dentists on rates we use to begin contract negotiations with dentists in our network.

HOW DO THE SAVINGS PLUS PLANS WORK?

THE AETNA SAVINGS PLUS PLANS† OFFER YOU ACCESS TO HEALTH SERVICES THAT FIT YOUR NEEDS AND BUDGET. THEY GIVE YOU ACCESS TO AN AFFORDABLE NETWORK OF HEALTH PROVIDERS IN YOUR OWN COMMUNITY.

The Aetna Savings Plus insurance plans provide you with the same types of coverage as other Aetna medical plans, but at a lower premium cost. Savings are generated by using the Savings Plus network, a network of local health care providers.

The plans also:

- cover doctor's visits, hospital stays and preventive care.
- include prescription drugs.
- provide access to a secure member self-service website.

Each Savings Plus plan has three levels of benefits:

- **Level 1:** when you use the Savings Plus network, you realize **maximum savings**.
- **Level 2:** when you use the non-designated network providers, you realize **standard savings.**
- **Level 3:** when you use out-of-network providers, you will pay the **highest member cost.**

You have the freedom to receive care from any hospital or specialist. However, you realize the highest benefit level and the lowest out-of-pocket costs when you access care through the Savings Plus network.

All Savings Plus plans include coverage for doctor visits, hospital stays, preventive care, pharmacy and more.

Premiums and out-of-pocket expense levels vary. So select the plan that's right for you and your family.

EXAMPLE

The following is an example* of what you might typically pay for each of the levels based on which network you choose.

	Maximum Savings (Designated Providers)	Maximum Savings (Non-Designated Providers)	Out-of-network provider
Cost of service	$1,750	$1,750	$1,750
Aetna's negotiated rate/ recognized amount	$1,000	$1,000	N/A
Amount covered by your plan (Aetna pays)	$800	$500	$500
Coinsurance (you pay)	$200	$500	$500
Amount that can be balance billed to you	$0	$0	$750
TOTAL COST YOU ARE RESPONSIBLE TO PAY	**$200**	**$500**	**$1,250**

* This is an example of how the Savings Plus plans work after a member meets their deductible.

†This plan provides preferred benefit coverage and access to covered services and supplies through a designated network of health care providers and facilities that are unique to your plan.

This Plan includes different benefit levels based upon the type of network provider that you use (designated or non-designated) or if you choose to see a non-preferred care provider. It is designed to lower your out-of-pocket costs when you use these designated network providers for covered expenses. These designated network providers are identified in the printed directory and the on-line version of the directory. Aetna also contracts with other network providers that are available to you under the plan (referred to as non-designated network providers), but your cost sharing will be at a much higher level when you use these providers.

THINGS YOU **NEED TO KNOW**

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

- At least age 19 and under age 64 3/4 (If applying as a couple, both you and your spouse must be at least age 19 and under 64 3/4)
- Legal residents in a state with products offered by the Aetna Advantage Plans
- Legal U.S. residents for at least six continuous months

If you qualify for an Aetna Advantage Plan, we offer dependent coverage under your policy for dependent children up to age 26 (except in Florida, where dependent coverage is up to age 30; and in Ohio, where dependent coverage is up to age 28).

MEDICAL UNDERWRITING REQUIREMENTS

The Aetna Advantage Plans are not guaranteed issue plans and require medical underwriting. Some individuals may qualify as eligible under the Health Insurance Portability Accountability Act (HIPAA) for guaranteed issue plans.

All applicants, enrolling spouses and dependents are subject to medical underwriting to determine eligibility and appropriate premium rate level.

We offer various premium rate levels based on the medical underwriting of each applicant.

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10-DAY RIGHT TO REVIEW

Do not cancel your current insurance until you are notified that you have been accepted for coverage. We'll review your enrollment form or application to determine if you meet underwriting requirements. If your application or enrollment form is denied, you'll be notified by mail. If your application or enrollment form is approved, you'll be notified by mail and sent an Aetna Advantage Plan contract and ID card.

If, after reviewing the contract, you find that you're not satisfied for any reason, simply return the contract to us within 10 days. We will refund any premium you've paid (including any contract fees or other charges) less the cost of any medical or dental services paid on behalf of you or any covered dependent.

YOUR COVERAGE REMAINS IN EFFECT AS LONG AS YOU PAY THE REQUIRED PREMIUM CHARGES ON TIME, AND AS LONG AS YOU MAINTAIN ELIGIBILITY IN THE PLAN.

CONVENIENT PREMIUM PAYMENTS

You can make simple automatic payments via Electronic Funds Transfer (EFT) or by Visa, MasterCard or American Express credit cards.

Registration: Complete the payment section of the Aetna Advantage Plans enrollment form or application. Select the appropriate payment method (EFT or credit card) to approve the automatic withdrawal of your initial premium and all subsequent premium payments. (Please note: The initial premium payment is debited UPON APPROVAL of your application).

Invoices: You will not receive a paper invoice when you are enrolled in EFT. Payments will appear on your bank statement as "Aetna Autodebit Coverage."

Terminating: To terminate EFT or the automatic credit card payment option, Aetna requires 10 days written notice before the date your next scheduled payment is due to be processed. Without this written notice, your bank account or credit card may be debited for the next month's premium payment. You would then need to contact us to have a refund processed to your bank account or credit card.

Refunds: To process an EFT refund (placing money back in member's checking account), we need at least five days after the withdrawal was made to ensure valid payment. Credit card refunds will be returned to the credit card charged within 3-5 business days from the date it is processed.

Rejected transactions: If the EFT (checking account) or credit card payment rejects for any reason, we will send you a letter requesting corrected information. If we receive corrected information, you will have the full amount due debited on the next billing cycle. If you fail to send corrected information, we will continue to attempt to debit your bank account or charge your credit card for the full amount due. Failure to supply correct account information may result in your policy being terminated for non-payment.

Timing: Please note the following dates when automatic payments are processed:

- Payments for Cycle 1 accounts (1st of the month effective date):
  - EFT (checking accounts) will be debited between the 3rd and 10th of each month the premium is due.
  - Credit Cards will be debited between the 5th and 12th of each month the premium is due.
- Payments for Cycle 2 accounts (15th of the month effective date):
  - EFT (checking accounts) will be debited between the 18th and 23rd of each month the premium is due.
  - Credit Cards will be debited between the 20th and 25th of each month the premium is due.

YOUR COVERAGE

Your coverage remains in effect as long as you pay the required premium charges on time, and as long as you maintain eligibility in the plan. Coverage will be terminated if you become ineligible due to any of the following circumstances:

- Non-payment of premiums
- Becoming a resident of a state or location in which Aetna Advantage Plans are not available
- Obtaining duplicate coverage
- For other reasons permissible by law

Levels of coverage and enrollment

These plans are subject to medical underwriting. To the extent that you are subject to medical underwriting, the following may occur once we have evaluated your application or enrollment form:

- You may be enrolled in your selected plan at the lowest rate available (known as the standard premium charge)
- You may be enrolled in your selected plan at a higher premium
- You may be declined coverage (except for dependents under age 19)

Duplicate coverage

If you are currently covered by another carrier, you must agree to discontinue the other coverage before or on the effective date of the Aetna Advantage Plan. However, do not cancel your current insurance until you are notified that you have been accepted for coverage and are certain that you are keeping your Aetna Advantage Plan coverage.

LIMITATIONS & EXCLUSIONS

Medical

These medical plans do not cover all health care expenses and include exclusions and limitations. You should refer to your plan documents to determine which health care services are covered and to what extent.

The following is a partial list of services and supplies that are generally not covered. However, your plan documents may contain exceptions to this list based on state mandates or the plan design or rider(s). Services and supplies that are generally not covered include, but are not limited to:

- All medical and hospital services not specifically covered in, or which are limited or excluded by your plan documents, including costs of services before coverage begins and after coverage terminates
- Cosmetic surgery
- Custodial care
- Donor egg retrieval
- Infertility services and other related reproductive services unless specifically listed as covered in your plan documents
- Over-the-counter medications and supplies
- Weight control services including surgical procedures for the treatment of obesity, medical treatment, and weight control/loss programs
- Experimental and investigational procedures, (except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial)
- Charges in connection with pregnancy care other than for pregnancy complications (unless otherwise mandated by your state)
- Immunizations for travel or work
- Implantable drugs and certain injectable drugs including injectable infertility drugs
- Orthotics
- Radial keratotomy or related procedures
- Reversal of sterilization
- Services, supplies or counseling related to the treatment of sexual dysfunction
- Special or private duty nursing
- Therapy or rehabilitation other than those listed as covered in the plan documents
- Mental health and substance abuse coverage (unless otherwise mandated by your state)

Dental

Listed below are some of the charges and services for which our dental plans do not provide coverage.
For a complete list of exclusions and limitations, refer to plan documents.

- Dental services or supplies that are primarily used to alter, improve or enhance appearance (negotiated rates for cosmetic procedures may be available when a participating dentist is accessed)
- Experimental services, supplies or procedures
- Treatment of any jaw joint disorder, such as temporomandibular joint disorder
- Replacement of lost or stolen appliances and certain damaged appliances
- Services that Aetna defines as not necessary for the diagnosis, care or treatment of a condition involved
- All other limitations and exclusions in your plan documents

PRE-EXISTING CONDITIONS

For Applicants 19 and older: During the first 12 months* following your effective date of coverage, no coverage will be provided for the treatment of a pre-existing condition unless you have prior creditable coverage.

A pre-existing condition is an illness, disease, physical condition, or injury for which medical advice, or treatment was recommended or received and/or the use of prescription drugs of any kind within six months preceding the effective date of coverage. Services or supplies for the treatment of a pre-existing condition are not covered for the first 12 months after the member's effective date. If the member had continuous prior creditable coverage within the 63 days** immediately preceding the signature on the application and meets certain other requirements, then the pre-existing condition exclusion of 12 months* may not apply.

* Six months in California
** 90 days in Alaska; 120 days in Connecticut

WANT TO MAKE THE MOST OF YOUR MONEY? **THE MORE YOU KNOW, THE BETTER IT GETS**.

Compare and save with the Member Payment Estimator

Before thinking about health care services, you should know what they will cost. With this tool, you can find out what you'll be paying, what you're getting and what you can expect when you have office visits or tests. By planning ahead, you can get the most from your money.

No matter where you are or what time of day, we've designed helpful and practical tools to make your life a little easier. It's what we call people care.

- Review costs for tests and procedures by type and locations
- See cost details based on your health insurance plan, including copays and deductibles
- Access the comparison feature so you can shop around
- Get ready for your upcoming procedure with helpful advice

Explore a smarter health plan.
Visit us at **www.aetna.com**.

IMPORTANT DISCLOSURE INFORMATION FOR TEXAS

TYPE OF COVERAGE

Your plan contains preferred provider benefits and is underwritten or administered by Aetna Life Insurance Company.

ADDITIONAL INFORMATION

You may call 1-888-982-3862 or write to Aetna Life Insurance Company, 151 Farmington Avenue, Hartford, CT 06156, if you wish to obtain additional information about Aetna* or your plan. Additional information concerning your coverage, Aetna coverage plan bulletins, and Aetna's network of participating providers can be accessed via the internet at: **www.aetna.com.**

PREFERRED AND NONPREFERRED PROVIDERS

This plan offers two levels of benefits: preferred and nonpreferred. You can choose which level of benefits you would like to utilize at the time health care services are needed.

The preferred level of benefits utilizes a network of contracted providers who have agreed to negotiated rates, utilization and quality management programs. You have complete access to any participating provider, including specialists, without a referral and do not need to designate a primary care physician. If you utilize participating providers you will incur a lower out-of-pocket cost for medical care because of Aetna's negotiated rates, modest copays and lower deductibles.

You may decide to utilize an out-of-network provider at the nonpreferred benefit level. This would result in a lower level of benefits and shifts the responsibility for preauthorization and claims filing to you. If seeking care from nonparticipating providers you must usually meet the plan deductible before coinsurance takes effect. Charges are subject to reasonable and customary limits.

COVERED SERVICES AND BENEFITS

Your plan covers the same wide range of services regardless of whether you use a participating provider or a nonparticipating provider. Standard covered services include:

- Physician office visits.
- Hospitalization and surgery.
- Diagnostic testing.
- Emergency care.
- Home health care.
- Durable medical equipment.
- Prescription drugs.
- Preventive care.

ADVANCE DIRECTIVES

An advance directive is a legal document that states your wishes for medical care. It can help doctors and family members determine your medical treatment if, for some reason, you can't make decisions about it yourself.

There are three types of advance directives:

- Living will - spells out the type and extent of care you want to receive.
- Durable power of attorney - appoints someone you trust to make medical decisions for you.
- Do-not-resuscitate order - states that you don't want to be given CPR if your heart stops or if you stop breathing.

You can create an advance directive in several ways:

- Get an advance medical directive form from a health care professional. Certain laws require health care facilities that receive Medicare and Medicaid funds to ask all patients at the time they are admitted if they have an advance directive. You don't need an advance directive to receive care. But we are required by law to give you the chance to create one.
- Ask for an advance directive 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.

Advanced Directives and Do Not Resuscitate Orders. American Academy of Family Physicians, March 2005. (Available at **http://familydoctor.org/003.xml?printxml**)

*Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies.

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EMERGENCY CARE SERVICES AND BENEFITS

Your plan covers emergency care services provided by preferred or nonpreferred providers. In the event of a medical emergency, you should seek treatment at the nearest emergency facility or call the local emergency hotline (e.g. 911).

AFTER-HOURS CARE

You may call your doctor's office 24 hours a day, 7 days a week if you have medical questions or concerns. You may also consider visiting participating Urgent Care facilities.

OUT OF AREA SERVICES AND BENEFITS

Your plan provides coverage for eligible expenses you incur when you travel out of the service area. The plan pays nonpreferred benefits for health care services incurred by nonpreferred providers.

YOUR FINANCIAL RESPONSIBILITY

You are responsible for paying copayments and deductibles for preferred benefits. You are responsible for coinsurance, deductibles for nonpreferred benefits. Additionally, you may be financially responsible for other ineligible expenses incurred by a nonpreferred provider such as charges above the reasonable and customary limit.

EXCLUSIONS AND LIMITATIONS

The plan does not cover all health care expenses and it contains exclusions and limitations. You must refer to your plan documents to determine what expenses are covered and to what extent.

CONTINUITY OF CARE

In the event a preferred provider terminates from the plan while you are under going an active course of treatment with that provider, Aetna will cooperate with your physician and approve a transition period for you to either complete the plan of treatment or transition to another preferred provider.

COMPLAINTS, APPEALS AND EXTERNAL REVIEW

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

FILING A COMPLAINT OR APPEAL

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

If you are dissatisfied with the outcome of your initial contact, you may file an appeal. Your appeal will be decided in accordance with the procedures applicable to your plan and applicable state law. Refer to your plan documents for further details regarding your plan's appeal procedure.

ABOUT COVERAGE DECISIONS

Sometimes we receive claims for services that may not be covered by your health benefits plan or that aren't in line with the terms of your plan. It can be confusing - even to your doctors. Our job is to make coverage decisions based on your specific benefits plan.

If a claim is denied, we'll send you a letter to let you know. If you don't agree you can file an appeal. To file an appeal, follow the directions in the letter that explains that your claim was denied. Our appeals decisions will be based on your plan provisions and any state and federal laws or regulations that apply to your plan. You can learn more about the appeal procedures for your plan from your plan documents.

SERVICE AREA

Aetna has preferred providers located in every county in the state of Texas.

ADDITIONAL IMPORTANT INFORMATION PLAN OF BENEFITS

The plan you choose is underwritten or administered by Aetna Life Insurance Company, located at 151 Farmington Avenue, Hartford, CT 06156 Aetna's main toll free telephone number is 1-888-982-3862. Covered services include most types of treatment. However, the health benefit plan does exclude and/ or include limits on coverage for some services, including but not limited to, cosmetic surgery and experimental procedures. In addition, in order to be covered, all services, including the location (type of facility), duration and costs of services, must be medically necessary as defined in the provisions below and as determined by Aetna. The information that follows provides a general overview regarding Aetna health benefit plans. For a complete description of the benefits available to you, including procedures, exclusions and limitations, refer to your specific plan documents, which may include the Group Agreement, Group Insurance Certificate, Group Policy and any applicable riders and amendments included with your health benefit plan.

UTILIZATION REVIEW/ PATIENT MANAGEMENT

Aetna has developed a patient management program to assist in determining what health care services are covered under the health plan and the extent of such coverage. The program assists you in receiving appropriate healthcare and maximizing coverage for those healthcare services. You can avoid receiving an unexpected bill with a simple call to Aetna's Member Services team. 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.

In certain cases, Aetna reviews your request to be sure the service or supply is consistent with established guidelines and is included or a covered benefit under your plan. We call this "utilization management review."

We follow specific rules to help us make your health a top concern:

- Aetna employees are not compensated based on denials of coverage.
- We do not encourage denials of coverage. In fact, our utilization review staff is trained to focus on the risks of members not adequately using certain services.

Where such use is appropriate, our Utilization Review/Patient Management staff uses nationally recognized guidelines and resources, such as The Milliman Care Guidelines® to guide the preauthorization, concurrent review and retrospective review processes. To the extent certain Utilization Review/Patient Management functions are delegated to IDSs, IPAs or other provider groups ("Delegates"), such Delegates utilize criteria that they deem appropriate. Utilization Review/Patient Management policies may be modified to comply with applicable state law.

Only medical directors make decisions denying coverage for services for reasons of medical necessity. Coverage denial letters for such decisions delineate any unmet criteria, standards and guidelines, and inform the provider and you of the appeal process.

For more information concerning utilization management, you may request a free copy of the criteria we use to make specific coverage decisions by contacting Member Services.

You may also visit **www.aetna.com/about/cov_det_policies.html** to find our Clinical Policy Bulletins and some utilization review policies. Doctors or health care professionals who have questions about your coverage can write or call our Patient Management department. The address and phone number are on your ID card.

PRESCRIPTION DRUGS

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

Your prescription drug benefit is generally not limited to drugs listed on the preferred drug list. Medications that are not listed on the preferred drug list (nonpreferred or nonformulary drugs) may be covered subject to the limits and exclusions set forth in your plan documents.

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

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

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

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

If you use the Aetna Specialty Pharmacy[SM] specialty drug program, you will be acquiring these prescriptions through Aetna Specialty Pharmacy, LLC, which is jointly owned by Aetna and Priority Healthcare, Inc. Aetna's negotiated charge with Aetna Specialty Pharmacy may be higher than Aetna Specialty Pharmacy's cost of purchasing drugs and providing specialty pharmacy services. For these purposes, Aetna Specialty Pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that it may receive from wholesalers, manufacturers, suppliers and distributors.

UPDATES TO THE DRUG FORMULARY

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

BEHAVIORAL HEALTH NETWORK

Behavioral health care services are managed by Aetna, who is responsible for, in part, making initial coverage determinations and coordinating referrals to Aetna's provider network. As with other coverage determinations, you may appeal adverse behavioral health care coverage determinations in accordance with the terms of your health plan.

The type of behavioral health benefits available to you depends upon the terms of your health plan. If your health plan includes behavioral health services, you may be covered for mental health conditions and/or drug and alcohol abuse services. You can determine the type of behavioral health coverage available under the terms of your plan by calling the Aetna Member Services number listed on your ID card.

If you have an emergency, call 911 or your local emergency hotline, if available. For routine services, access covered behavioral health services available under your health plan by the following methods:

- Call the toll-free Behavioral Health number (where applicable) listed on your ID card or, if no number is listed, call the Member Services number listed on your ID card for the appropriate information.
- Where required by your plan, call your PCP for a referral to the designated behavioral health provider group.
- When applicable, an employee assistance or student assistance professional may refer you to your designated behavioral health provider group.

You can access most outpatient therapy services without a referral or pre-authorization. However, you should first consult with Member Services to confirm that any such outpatient therapy services do not require a referral or preauthorization.

BEHAVIORAL HEALTH PROVIDER SAFETY DATA AVAILABLE

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

BEHAVIORAL HEALTH PREVENTION PROGRAMS

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

HOW AETNA PAYS IN-NETWORK PROVIDERS

All the providers in our network directory are independent. They are free to contract with other health plans. Providers join our network by signing contracts with us. Or they work for organizations that have contracts with us. We pay network providers in many different ways. Sometimes we pay a rate for a specific service and sometimes for an entire course of care (for example, a flat fee for a pregnancy without complications). In certain circumstances, some providers are paid a pre-paid amount per month per Aetna member (capitation). We may also provide additional incentives to reward physicians for delivering cost-effective quality care.

We pay some network hospitals by the day (per diem) and we pay others in a different way, such as a percentage of their standard billing rates. We encourage you to ask your providers how they are paid for their services.

HOW AETNA PAYS OUT-OF-NETWORK PROVIDERS

Some of our plans pay for services from providers who are not in our network. Many plans pay for services based on what is called the "reasonable," "usual and customary" or "prevailing" charge. Other plans pay based on our standard fees for care received from a network provider, or based on a percentage of Medicare's fees. ***When we pay less than what your provider charges, your provider may require you to pay the difference. This is true even if you have reached your plan's out-of-pocket maximum***. Here is how we figure out what we will pay for each type of plan.

Prevailing Charge Plans

Step 1: We review the data.
We get information from Ingenix, which is owned by United HealthCare. Health plans send Ingenix copies of claims for services they received from providers. The claims include the date and place of the service, the procedure code, and the provider's charge. Ingenix combines this information into databases that show how much providers charge for just about any service in any zip code.

Step 2: We calculate the portion we pay.
For most of our health plans, we use the 80th percentile to calculate how much to pay for out-of-network services. Payment at the 80th percentile means 80 percent of charges in the database are the same or less for that service in a particular zip code.

If there are not enough charges (less than 9) in the databases for a service in a particular zip code, we may use "derived charge data" instead. "Derived charge data" is based on the charges for comparable procedures, multiplied by a factor that takes into account the relative complexity of the procedure that was performed. We also use derived charge data for our student health plans and Aetna Affordable Health Choices® plans.

We also may consider other factors to determine what to pay if a service is unusual or not performed often in your area. These factors can include:

- The complexity of the service
- The degree of skill needed
- The provider's specialty
- The prevailing charge in other areas
- Aetna's own data

Step 3: We refer to your health plan.
We pay our portion of the prevailing charge as listed in your health plan. You pay your portion (called "coinsurance") and any deductible. For example, your out of network doctor charges $120 for an office visit. Your plan covers 70 percent of the "reasonable," "usual and customary" or "prevailing" charge. Let's say the prevailing charge is $100. And let's say you already met your deductible. Aetna would pay $70. You would pay the other $30. Your doctor may also bill you for the $20 difference between the prevailing charge ($100) and the billed charge ($120). In this case, your doctor could bill you for a total of $50.

The Prevailing Charge Databases
The New York State Attorney General (NYAG) investigated the conflicts of interest related to the ownership and use of Ingenix data. Under an agreement with the NYAG, UnitedHealth Group agreed to stop using the Ingenix databases when an independent database (not owned by a health insurer) is created. In a separate agreement with NYAG in January 2009, Aetna agreed to use this new database when it is ready. We also will work with the new database owner to create online tools to give you better information about the cost of your care when using providers outside our network.

Fee Schedule Plans

Step 1: We compare the provider's bill to our fee schedule and your health plan.
Your plan may say that we will pay the provider based on our fee schedule for network doctors, or a certain percentage of that fee schedule, or a certain percentage of what Medicare pays. For example, your plan may say we pay 125 percent of what we pay a network doctor for the same service.

Let's say you have your appendix removed. Our network rate for that surgery is $1,600. We multiply $1,600 by 125 percent to get $2,000. We call this the "recognized" or "allowed" amount.

Step 2: We calculate the portion we pay.
Your plan also says that you must pay "coinsurance." This is your share of the "recognized" or "allowed" amount. For example, your share may be 30 percent. In that case, we pay 70 percent of the $2,000 allowed amount, which is $1,400. You pay your provider your 30 percent coinsurance, which is $600. Your provider may also ask you to pay the $500 difference between the $2,500 bill and the $2,000 "recognized" or "allowed" amount. In this case, your provider could bill you $1,100 in total.

Exceptions
Some "prevailing charge" plans set the prevailing charge at a different percentile. For some claims (like those from hospitals and outpatient centers) we may use other information and data sources to determine the charge.

And some of our plans pay based on a different kind of fee schedule. Also, for some non-participating providers we may pay based on other contractual arrangements. Our provider claims codes and payment policies may also affect what we pay for a claim. Aetna may use computer software (including ClaimCheck®) and other tools to take into account factors such as the complexity, amount of time needed and manner of billing. The effects of these policies will be reflected in your Explanation of Benefits documents.

HOW AETNA PAYS FOR OUT-OF-NETWORK BEHAVIORAL HEALTH BENEFITS

We negotiate rates with psychiatrists, psychologists, counselors and other appropriately licensed and credentialed behavioral health care providers to help you save money. We refer to these providers as being "in our network."

TECHNOLOGY REVIEW

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

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

- Determine whether the technologies are experimental or investigational.

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

MEMBER RIGHTS & RESPONSIBILITIES

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

INTERPRETER/ HEARING IMPAIRED

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

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

Spanish-speaking hotline - 1-800-533-6615

Multilingual hotline - 1-888-982-3862 (140 languages are available. You must ask for an interpreter.)

TDD 1-800-628-3323 (hearing impaired only)

QUALITY MANAGEMENT PROGRAMS

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

MEMBER SERVICES

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

PRIVACY NOTICE

Aetna considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By “personal information,” we mean information that relates to your physical or mental health or condition, the provision of health care to you, or payment for the provision of health care to you. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify you.

When necessary or appropriate for your care or treatment, the operation of our health plans, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), payors (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your plan), other insurers, third party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. Participating network providers are also required to give you access to your medical records within a reasonable amount of time after you make a request.

Some of the ways in which personal information is used include claims payment; utilization review and management; medical necessity reviews; coordination of care and benefits; preventive health, early detection, and disease and case management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; health claims analysis and reporting; health services research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health plans.

To the extent permitted by law, we use and disclose personal information as provided above without your consent. However, we recognize that you may not want to receive unsolicited marketing materials unrelated to your health benefits. We do not disclose personal information for these marketing purposes unless you consent. We also have policies addressing circumstances in which you are unable to give consent. To obtain a hard copy of our Notice of Privacy Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please write to Aetna's Legal Support Services Department at 151 Farmington Avenue, W121, Hartford, CT 06156.
You can also visit our Internet site at **www.aetna.com**. You can link directly to the Notice of Privacy Practices by selecting the "Privacy Notices" link at the bottom of the page.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

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

SPECIAL ENROLLMENT RIGHTS:

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).
In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.
To request special enrollment or obtain more information, contact your benefits administrator.

REQUEST FOR CERTIFICATE OF CREDITABLE COVERAGE

If you are a member of an insured plan sponsor or a member of a self insured plan sponsor who have contracted with us to provide Certificates of Prior Health Coverage, you have the option to request a certificate. This applies to you if you are a terminated member, or are a member who is currently active but who would like a certificate to verify your status. As a terminated member, you can request a certificate for up to 24 months following the date of your termination. As an active member can request a certificate at any time. To request a Certificate of Prior Health Coverage, please contact Member Services at the telephone number on the back of your ID card. Consumer Choice health benefit plans issued pursuant to the Texas Consumer Choice of Benefits Health Insurance Plan Act do not include all state mandated health insurance benefits. Benefits provided under a Consumer Choice Benefit plan are provided at a reduced level from what is mandated or are excluded completely from the plan. The following list of covered benefits may not be available under a Consumer Choice health benefit plan.

NOTICE OF CERTAIN **MANDATORY BENEFITS**

THIS NOTICE IS TO ADVISE YOU OF CERTAIN COVERAGE AND/OR BENEFITS PROVIDED BY YOUR CONTRACT WITH AETNA. IF YOU HAVE ANY QUESTIONS CONCERNING THIS NOTICE, PLEASE CALL US AT THE MEMBER SERVICES NUMBER ON THE BACK OF YOUR ID CARD, OR WRITE US AT THE FOLLOWING ADDRESS:

AETNA PATIENT MANAGEMENT
P.O. BOX 569440
DALLAS, TEXAS 75356-9440

COVERAGE OF TESTS FOR DETECTION OF HUMAN PAPILLOMAVIRUS AND CERVICAL CANCER

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

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.

PROSTATE CANCER SCREENING

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

(a) Physical examination for the detection of prostate cancer

(b) Prostate-specific antigen test for each covered male who is at least 40 years of age

BREAST RECONSTRUCTION*

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

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

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

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

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

***Not Included in Consumer Choice Health Benefit Plans.**

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.

MASTECTOMY OR LYMPH NODE DISSECTION MINIMUM INPATIENT STAY*

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

(a) 48 hours following a mastectomy, and

(b) 24 hours following a lymph node dissection.

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

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

***Not Included in Consumer Choice Health Benefit Plans.**

If you need this material translated into another language, please call Member Services at 1-888-982-3862.

Si usted necesita este documento en otro idioma, por favor llame a Servicios al Miembro al 1-888-982-3862.

Health insurance plans are underwritten by Aetna Life Insurance Company. For self-funded accounts, benefits coverage is offered by your employer, with administrative services only provided by Aetna Life Insurance Company. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services. Information subject to change.

The NCQA Accreditation Seal is a recognized symbol of quality. The seal, located on the front cover of your provider directory, signifies that your plan has earned this accreditation for service and clinical quality that meets or exceeds the NCQA's rigorous requirements for consumer protection and quality improvement. The number of stars on the seal represents the accreditation level the plan has achieved.

Providers who have been duly recognized by the NCQA Recognition Programs are annotated in the provider listings section of this directory. Providers, in all settings, achieve recognition by submitting data that demonstrates they are providing quality care. The program constantly assesses key measures that were carefully defined and tested for their relationship to improved care, therefore, NCQA provider recognition is subject to change. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services. For up-to-date information, please visit our DocFind® directory at **www.aetna.com** or, if applicable, visit the NCQA's new top level recognition listing at **http://web.ncqa.org/tabid/58/Default.aspx.**

WHERE CAN I FIND TIPS AND TOOLS FOR **STAYING HEALTHY**?

Aetna InteliHealth® is your trusted, one-stop source for online health and wellness information. This helpful website is filled with valuable tips and tools, all in an easy-to-read format.

You'll find all kinds of great information on InteliHealth.com, including: health news; a medical dictionary; a drug resource center; fitness, nutrition and weight management information; daily and weekly health-related e-mails; and much more. Check it out at **www.intelihealth.com**.

I ALWAYS NEED SOME INCENTIVE TO GET IN SHAPE.
WHAT CAN YOU OFFER ME?

A fit body is a healthier body. Aetna can help you stay in shape. Access the Aetna Fitness℠ discount program and you'll receive preferred rates on gym memberships as well as discounts on at-home weight loss programs, home fitness options, and one-on-one health coaching services through GlobalFit™.

So get ready to start exercising — and feeling good.

With these savings, it's a great time to join the Fitness Program from Aetna.

Explore a smarter health plan. Visit us at **www.aetna.com**.

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Aetna has been in business for more than 150 years.

In 2010, for the third year in a row, Aetna was named the most admired health care insurance company by *Fortune* magazine.*

* *Fortune* magazine, March 22, 2010, March 16, 2009, and March 17, 2008

This material is for information only. Plan features and availability may vary by location. Plans may be subject to medical underwriting or other restrictions. Rates and benefits may vary by location. Health benefits and insurance plans and dental insurance plans contain exclusions and limitations. Investment services are independently offered by the HSA Administrator. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services. Not all health/dental services are covered. See plan documents for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features are subject to change. Aetna receives rebates from drug makers that may be taken into account in determining Aetna's Preferred Drug List. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a licensed pharmacy subsidiary of Aetna Inc., that operates through mail order. [Aexcel designation is only a guide to choosing a physician. Members should confer with their existing physicians before making a decision. Designations have the risk of error and should not be the sole basis for selecting a doctor. Aexcel is not available for HMO plans.] Health information programs provide general health information and are not a substitute for diagnosis or treatment by a physician or other health care professional. Information is believed to be accurate as of production date, however, it is subject to change.

IN CT, THIS PLAN IS ISSUED ON AN INDIVIDUAL BASIS AND IS REGULATED AS AN INDIVIDUAL HEALTH INSURANCE PLAN.

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

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

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