

Quality health plans & benefits
Healthier living
Financial well-being
Intelligent solutions

aetna®

Take charge of your health

Choose Aetna, choose affordable coverage

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



First things first. Is my doctor covered?

We believe a healthier experience begins with what matters most to you. And we have helpful tools like our online provider directory to help you find your doctor or hospital.



◀ Just visit **www.aetnaindividualdocfind.com**
to find the doctors and hospitals you trust most.

Aetna individual health benefits and health insurance plans are offered and/or underwritten by Aetna Health Inc. and/or Aetna Life Insurance Company (Aetna). Each insurer has sole financial responsibility for its own products.

Aetna does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in the administration of the plan, including enrollment and benefit determinations.



Thank you for your interest in Aetna individual health plans

We know how important it is for you to make the right choice. Take a look at the information in this plan brochure. It contains important tips and tools that will help you along the way. If you have questions or want to talk, just call us.

We're here to help

Call **1-844-829-8875**.

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Nondiscrimination Notice

Aetna complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Aetna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Aetna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact our Civil Rights Coordinator.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with our Civil Rights Coordinator at:

Address: P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779)

Telephone: **1-800-648-7817 (TTY: 711)**, Fax: **1-859-425-3379** (CA HMO customers: 860-262-7705)

Email: CRCoordinator@aetna.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

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

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

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, and its affiliates.

TTY: 711

For language assistance in English call 855.208.4606 at no cost. (English)

Para obtener asistencia lingüística en español, llame sin cargo al 855.208.4606. (Spanish)

欲取得繁體中文語言協助，請撥打 855.208.4606，無需付費。(Chinese)

Pour une assistance linguistique en français appeler le 855.208.4606 sans frais. (French)

Para sa tulong sa wika na nasa Tagalog, tawagan ang 855.208.4606 nang walang bayad. (Tagalog)

T'áá shí shizaad k'ehjí bee shíká a'doowoł nínízingo Diné k'ehjí kojí' t'áá jíík'e hólne' 855.208.4606 (Navajo)

Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 855.208.4606 an. (German)

Për asistencë në gjuhën shqipe telefononi falas në 855.208.4606. (Albanian)

በ አጭሮ የድንቁ አገዛ ለማግኘት በ 855.208.4606 በነጻ ይደውሉ (Amharic)

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 855.208.4606 (Arabic)

Niba urondera uwugufasha mu Kirundi, twakure kuri iyi numero 855.208.4606 ku busa. (Bantu-Kirundi)

বাংলায় ভাষা সহায়তার জন্য বিনামূল্যে 855.208.4606-তে কল করুন। (Bengali-Bangala)

ငွေကုန်ကျခံစရာမလိုဘဲ (မြန်မာဘာသာစကား)ဖြင့် ဘာသာစကားအကူအညီရယူရန် 855.208.4606 ကို ခေါ်ဆိုပါ။ (Burmese)

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Gargaarsa afaan Oromiffa hiikuu argachuuf lakkokkofsa bilbilaa 855.208.4606 irratti bilisaan bilbilaa. (Cushite)

Bel voor tolk- en vertaaldiensten in het Nederlands gratis naar 855.208.4606. (Dutch)

Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 855.208.4606 gratis. (French Creole)

Για γλωσσική βοήθεια στα Ελληνικά καλέστε το 855.208.4606 χωρίς χρέωση. (Greek)

(Gujarati) ગુજરાતીમાં ભાષામાં સહાય માટે કોઈ પણ ખર્ચ વગર 855.208.4606 પર કોલ કરો.

(Hindi) हिन्दी में भाषा सहायता के लिए, 855.208.4606 पर मुफ्त कॉल करें।

Yog xav tau kev pab txhais lus Hmoob hu dawb tau rau 855.208.4606. (Hmong)

Maka enyemaka asụsụ na Igbo kpọọ 855.208.4606 na akwughị ụgwọ ọ bụla (Ibo)

Para iti tulong ti pagsasao iti pagsasao tawagan ti 855.208.4606 nga awan ti bayadanyo. (Ilocano)

Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 855.208.4606. (Italian)

日本語で援助をご希望の方は、855.208.4606まで無料でお電話ください。 (Japanese)

လၢတၢ်မၤစၢၤတၢ်ကတိၤကျိၣ်အဂီၢ် ကျိၣ် နိး 855.208.4606 လၢတၢ်အိၣ်ဒီးတၢ်လၢတၢ်ကျိၣ်လၢတၢ်စ့ၤဘၣ် (Karen)

한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 855.208.4606번으로 전화해 주십시오. (Korean)

Bé m ké gbo-kpá-kpá dyé pídyi dé Bāsòò-wùdùùn wěe, dǎ 855.208.4606 (Kru-Bassa)

بو وەرگرتنی رینۆینی پینۆنیدار به زمان به زمان به ژماره‌ی 855.208.4606 به خۆراییی پهیۆندی بکەن. (Kurdish)

ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນການແປພາສາລາວ, ກະລຸນາໂທຫາ 855.208.4606 ໂດຍບໍ່ເສຍຄ່າໂທ. (Laotian)

Ñan bök jipañ ilo Kajin Majol, kallok 855.208.4606 ilo ejjelok wōnān. (Marshallese)

សម្រាប់ជំនួយភាសាជា ភាសាខ្មែរ សូមទូរស័ព្ទទៅកាន់លេខ 855.208.4606 ដោយឥតគិតថ្លៃ។ (Mon-Khmer, Cambodian)

(नेपाली) मा निःशुल्क भाषा सहायता पाउनका लागि 855.208.4606 मा फोन गर्नुहोस्। (Nepali)

Tën kuwoɲy ë thok ë Thuɔŋjäŋ cɔl 855.208.4606 kecin ayöc. (Nilotic-Dinka)

For språkassistanse på norsk, ring 855 208 4606 kostnadsfritt. (Norwegian)

(Panjabi) ਪੰਜਾਬੀ ਵਿੱਚ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਲਈ, 855.208.4606 'ਤੇ ਮੁਫਤ ਕਾਲ ਕਰੋ।

Fer Hefje in Deitsch, ruf: 855.208.4606 aa. Es Aaruf koschtet nix. (Pennsylvanian Dutch)

برای راهنمایی به زبان فارسی با شماره 855.208.4606 بدون هیچ هزینه ای تماس بگیرید. انگلیسی (Persian)

Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 855.208.4606. (Polish)

Para obter assistência linguística em português ligue para o 855.208.4606 gratuitamente. (Portuguese)

Pentru asistență lingvistică în românește telefonați la numărul gratuit 855.208.4606 (Romanian)

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 855.208.4606. (Russian)

Mo fesoasoani tau gagana I le Gagana Samoa vala'au le 855.208.4606 e aunoa ma se totoi. (Samoan)

Za jezičnu pomoć na hrvatskom jeziku pozovite besplatan broj 855.208.4606. (Serbo-Croatian)

Fii yo on hebu balal e ko yowitii e haala Pular noddee e oo numero doo 855.208.4606. Njodi woo fawaaki on. (Sudanic-Fulfulde)

Ukihitaji usaidizi katika lugha ya Kiswahili piga simu kwa 855.208.4606 bila malipo. (Swahili)

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(Syriac-Assyrian) ܩܘܼܠܘܼܬܘܼܢܘܼܢ 855.208.4606 ܩܘܼܠܘܼܬܘܼܢܘܼܢ ܩܘܼܠܘܼܬܘܼܢܘܼܢ ܩܘܼܠܘܼܬܘܼܢܘܼܢ

భాషతో సాయం కొరకు ఎలాంటి ఖర్చు లేకుండా 855.208.4606కు కాల్ చేయండి. (తెలుగు) (Telugu)

สำหรับความช่วยเหลือทางด้านภาษาเป็นภาษาไทย โทร 855.208.4606 ฟรีไม่มีค่าใช้จ่าย (Thai)

Kapau 'oku fiema'u hā tokoni 'i he lea faka-Tonga telefoni 855.208.4606 'o 'ikai hā tōtōngi. (Tongan)

Щоб отримати допомогу перекладача української мови, зателефонуйте за безкоштовним номером 855.208.4606. (Ukrainian)

اُردو ميں لساني معاونت کے لیے 855.208.4606 پر مفت کال کریں۔ (Urdu)

Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 855.208.4606. (Vietnamese)

פאר שפראך הילף אין אידיש רופט 855.208.4606 פריי פון אפצאל. (Yiddish)

Fún ìrànḽọwọ nípa èdè (Yorùbá) pe 855.208.4606 láí san owó kankan rárá. (Yoruba)

Focusing on what matters most

We know there are few things more important than making the best choice for your health coverage. That's why every benefits and insurance plan we provide begins with what matters most:



Your doctors

Just use our tools to find your doctor or a new one in your area. Your doctor will help you get the most out of your benefits.



Your prescriptions

All of our plans include prescription drug coverage and medical care.



A plan that works for you

Good news. You can choose a plan that meets your needs and offers you more control over how you manage your health. Whether you want to do that by phone, online, in print or in person — the choice is yours.



Your confidence

We've been in business for more than 160 years. We strive to direct our business — and our industry — toward more simple and honest services.

For 2017 benefits, the open enrollment period is November 1, 2016, through January 31, 2017.

If you miss this window, you must wait until the next open enrollment period, unless you qualify for a special enrollment period.

If you have a qualifying life event after the open enrollment period has ended, you may be eligible for a special enrollment period. Some examples of qualifying life events are getting married or having a baby. See a full list of qualifying events at www.healthcare.gov.

What does that mean?

Here are a few definitions of terms you'll see throughout this brochure.

Benefit

A covered service, medical supply or drug that health insurance helps pay for. Some examples are doctor visits, tests and X-rays.

Coinsurance

The amount you pay after you meet your yearly deductible.

Copayment (copay)

A set cost you pay when you receive a covered service. Most plans have copays for doctor visits. You pay your copay to the physician or other health care provider. Copays may differ by type of service.

Deductible

A set amount that you must pay for your covered services before the health plan starts to pay.

Exclusions and limitations

Specific conditions or circumstances that aren't covered under a plan.

Health insurance exchange

The health insurance exchange (or marketplace) is a new way to shop for health insurance. Online stores help you find, compare and choose a health insurance plan that fits your needs.

Out-of-pocket maximum

The limit on the amount an individual has to pay for health care services their benefits plan covers.

Premium

The amount a health insurer charges for a health insurance policy. It's a set amount that you pay each month. If you have a health plan through your employer, you and your employer may share this cost. If you buy a health plan yourself, you pay the full amount.

Provider network

A group of health care providers that works with us to offer services to our members at a discounted price. Network benefits apply when you receive care from physicians or facilities that are part of our network.



Top reasons to choose Aetna

Quality coverage, competitive costs

We offer health benefits and health insurance plans with valuable features. They include an excellent combination of quality coverage and competitively priced premiums. Most plans also include:

- 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 preventive care when you visit a network provider
- No claims forms to fill out when you use a network provider

Walk-in clinics

These health care clinics are located in retail stores, supermarkets and pharmacies. They treat minor illnesses. They also provide preventive health care services. Walk-in clinics (or convenient care clinics) are often open nights, weekends and holidays when you can't see your regular doctor.

E-visits

These are electronic visits between you and your health care providers. You can send a medical concern to them, and they can securely give you medical advice and/or care. They can also prescribe medication/therapy online.

Family coverage

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

Tax breaks with health savings accounts (HSAs)

It's easy—you set up a personal account that lets you pay for qualified medical expenses. Then, you or an eligible family member makes contributions. That money earns interest. All contributions and withdrawals for qualifying expenses are tax free, so you pay less.

Once you enroll in a qualifying high-deductible health plan, we'll send you a letter outlining how to enroll in an HSA. Once you're enrolled in an HSA, we'll send you a welcome letter. Review the material so we can help you start using your HSA.

Embedded deductible

An embedded deductible means one person on a plan with two or more members can meet the individual deductible and start receiving covered benefits.

Example:

Let's say you have a plan with four family members, John, Jane, Billy and Katie. Each family member has a \$500 individual deductible OR \$1,000 for the family. John meets his \$500 individual deductible; therefore, he can start receiving covered plan benefits. The remaining three family members can contribute any portion to satisfy the \$1,000 family deductible. Jane can contribute \$125, Billy can contribute \$275 and Katie can contribute the final \$100. Or Jane can contribute the entire \$500. Then the family deductible is met.

Note: This is an example for illustrative purposes only. The amounts above don't reflect an actual plan deductible.

Case management/disease management

Once you are a member, you can check to see if you qualify for our chronic disease or case management programs by calling the number on your ID card.

*Referrals are required for health maintenance organization (HMO) plans and all plans in New Jersey.

We're here to help

Many people have never had to shop for health insurance. An employer often provides it. But if you have to buy health insurance on your own, it's important to understand the process.



Online

Go online for easy ways to find the plan that's best for you. Then, follow the step-by-step guide to enroll in the plan you choose.

For off-exchange plans, go to www.aetnaindividual.com.



By mail

Applies only if you are applying for off-exchange plans.



By phone

Call us toll-free at **1-844-829-8875**.

We can also help you complete the application.











Broker

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



What happens next?

After you enroll, you can use this checklist to keep track of your new plan.

Material name	Description	Delivery	When to expect
Welcome letter	The welcome letter lets you know when to expect your member ID card and plan documents. It'll also tell you how to sign up for your Aetna Navigator® secure member website.	 	7 – 10 days
Quick start guide	This will remind you to register for your Aetna Navigator secure member website. You can also download our mobile app and find out how to talk with a registered nurse. The guide also includes your member ID card and a copy of our privacy notice.	 	7 – 10 days
Summary of Benefits and Coverage (SBC)	An easy-to-read summary of the benefits for the plan you selected.	 	7 days
Plan documents	You'll get a postcard that directs you to your Aetna Navigator secure member website. There you can find plan documents like your Certificate of Coverage. Think of these documents as your owner's manual. They'll tell you about how to use your plan, what's covered and who to call if you have questions.	 	30 days

Health care reform — What you need to know

Since President Obama signed the Affordable Care Act, we regularly update the Aetna individual health insurance plans to include required changes.

Be assured — your Aetna individual health plan meets the federal health care reform legislation requirements.

Quick facts about health care reform

- Most people must have insurance or risk paying a fine. For more information about how much the fine will be in 2017, visit www.healthcare.gov.
- You can get preventive care (including immunizations) without cost share. This includes enhanced coverage of women's preventive health benefits.
- Coverage includes essential health benefits.
- You can see if you qualify for a lower cost or tax credit through the exchanges. They help cover monthly payments.
- There are no annual or lifetime limits on essential health benefits.
- There are no pre-existing condition exclusions.
- There are public exchanges or "online marketplaces" where you can compare/buy plans.
- Five factors can affect marketplace plan prices: location, age, family size, tobacco use and plan category. Health status and gender don't affect pricing.
- Young adults up to age 26 can stay on their parent's plan.

Learn more about health care reform.

Visit www.aetna.com/health-reform-connection/index.html.




How does the New Jersey Savings Plus EPO network work?

Affordable options

Aetna's individual health benefits plans use the New Jersey Savings Plus EPO network. These plans offer health care benefits that help fit your needs and budget. They give you access to an affordable network of providers in your community.

How to find New Jersey Savings Plus providers

It's important to know which doctors and hospitals are part of this network before you choose your health plan.

- Go to www.aetnaindividualdocfind.com.
- Select New Jersey from the drop-down menu.
- Choose the New Jersey Savings Plus EPO plan under the 2017 plan choices.
- Enter the type of provider you're looking for and your ZIP code.
- Look for doctors and hospitals with the Savings Plus . They're part of the Savings Plus network.

Know which doctors and hospitals are in your network

These plans only cover certain doctors and hospitals in New Jersey. If you see a provider in another state, or a provider that isn't part of the network, we won't cover those services unless it's an emergency.

Sometimes, you don't need to receive care at a hospital. X-ray, lab and ambulatory surgery centers in your area may be able to provide the right care for you, at the right cost for your health care budget.

Emergency care

If you have an emergency, you can go to the nearest hospital or call 911. You'll be covered as if you stayed in the New Jersey Savings Plus EPO network.



Use our online tools

Once you're an Aetna member, you'll have access to our online tools. You can get estimates and cost ranges for many health care services. When you know costs, you can make the most out of your benefits. And maybe save a little, too.

Just log in to your secure member website at **www.aetna.com** to:

- See what you'll pay for doctor and hospital services, based on your actual plan. You can compare estimates for up to 10 doctors or hospitals at a time.*
- Look up costs for drugs before you fill a prescription. And find out what you can save by using our home delivery service.

*Estimated costs aren't available in all markets. Your actual costs may differ for a number of reasons. This may include if you receive different services from the doctor or facility at the time of your visit. Or additional claims or member payments are processed before the actual claim for the estimated service is processed. Estimated costs aren't available for hospitals or other inpatient facilities.

Your plan options

Plans are grouped in three types: Bronze, Silver and Gold. The plan type lets you know how much you pay for premiums and out-of-pocket costs. Generally, the more you pay for your premium, the less you pay for your doctor visits and other care.

Plan type	Monthly premium	Costs you pay out of pocket
Bronze	\$	\$\$\$
Silver	\$\$	\$\$
Gold	\$\$\$	\$

Note: Not all plan types are available in every state. Check the plans on the following pages for what's available in your state. If you are under 30 years old or have a very low income, you might be able to buy what's called a "catastrophic plan." These are not available in all states.

Aetna Health Plan options in New Jersey

These plans include pediatric dental (PD).

	NJ Aetna Bronze 3000 Savings Plus EPO PD	NJ Aetna Silver 2500 Savings Plus EPO PD
Member benefits	In network you pay	In network you pay
Deductible (ded) individual/family¹ (applies to out-of-pocket maximum)	\$3,000/\$6,000	\$2,500/\$5,000
Member coinsurance	50%	20%
Out-of-pocket maximum individual/family¹ (maximum you will pay for all covered services)	\$7,150/\$14,300	\$5,500/\$11,000
Primary care visit	50% after ded	\$50 copay; ded waived
Specialist visit	50% after ded	20% after ded
Hospital stay	\$300 copay per day to a maximum of \$1,500 per admission after ded	20% after ded
Outpatient surgery (ambulatory surgical center/hospital)	50% after ded	20% after ded
Emergency room	\$100 copay plus 50% after ded	\$100 copay plus 20% after ded
Urgent care	\$100 copay plus 50% after ded	\$100 copay plus 20% after ded
Preventive care/screening/immunization (age and frequency visit limits apply)	Covered in full; ded waived	Covered in full; ded waived
Annual routine gyn exam (annual pap/mammogram)	Covered in full; ded waived	Covered in full; ded waived
Diagnostic lab	\$30 copay after ded	20% after ded
Diagnostic X-ray	50% after ded	20% after ded
Imaging (CT/PET scans, MRIs)	50% after ded	20% after ded
Vision		
Pediatric eye exam (1 visit per year)	Covered in full; ded waived	Covered in full; ded waived
Pediatric glasses/contacts (coverage is limited to 1 set of frames and 1 set of contact lenses or eyeglass lenses per calendar year)	Covered in full; ded waived	Covered in full; ded waived
Pediatric dental		
Dental checkup/preventive dental care (2 visits per year)	Covered in full; ded waived	Covered in full; ded waived
Basic dental care	30% after ded	30% after ded
Major dental care	50% after ded	50% after ded
Orthodontia (medically necessary only)	50% after ded	50% after ded
Pharmacy		
Pharmacy deductible	Integrated with medical ded	\$0 per member
Preferred generic drugs	50% up to \$25 after ded	\$13 copay
Preferred brand drugs	50% up to \$100 after ded	50% up to \$100
Nonpreferred drugs	Brand: 50% up to \$150 after ded	Brand: 50% up to \$150
Specialty drugs	50% up to \$25 after ded	\$13 copay

¹ The family deductible and/or out-of-pocket limit can be met by a combination of family members. Each covered family member only needs to satisfy his or her individual deductible and/or out-of-pocket limit.

Aetna individual health benefits and health insurance plans are offered and/or underwritten by Aetna Health Inc. and/or Aetna Life Insurance Company (Aetna). Each insurer has sole financial responsibility for its own products.

NJ Aetna Gold 1000 Savings Plus EPO PD

In network you pay
\$1,000/\$2,000
30%
\$2,400/\$4,800
30% after ded
30% after ded
30% after ded
30% after ded
\$100 copay plus 30% after ded
\$100 copay plus 30% after ded
Covered in full; ded waived
Covered in full; ded waived
30% after ded
30% after ded
30% after ded
Covered in full; ded waived
Covered in full; ded waived
Covered in full; ded waived
30% after ded
50% after ded
50% after ded
Integrated with medical ded
\$10 copay after ded
50% up to \$100 after ded
Brand: 50% up to \$150 after ded
\$10 copay after ded

This plan comparison guide shows in-network benefits only.

Out-of-network benefits are not available for NJ EPO plans, except in an emergency.

To learn more details about specific plans, including whether a plan includes out-of-network benefits, see the Summary of Benefits and Coverage at <https://www.aetna.com/sbcsearch/home>. Then,

- Choose Aetna under “Select a Carrier”
- Click the “General Search” tab
- Fill out the required fields (choose “Individual and Family” Group Size)
- Click “Submit”
- Select a plan (or plans) and click “Download”
- Open the SBC you selected

This information is a partial description of the benefits and in no way details all of the benefits, limitations, or exclusions of the plan. Please refer to the individual policy, schedule of benefits, and applicable riders to determine exact terms, conditions and scope of coverage, including all exclusions and limitations and defined terms.

This is an exclusive provider organization (EPO) plan. You must choose a primary care physician (PCP) in New Jersey. If you need to see a specialist, you’ll need a referral from your PCP. Your plan only covers providers in New Jersey. If you don’t get a referral, or if you see a provider in another state, those services won’t be covered.

This material is for information only. A summary of exclusions is listed in the Aetna Health Plan brochure. For a full list of benefits coverage and exclusions refer to the plan documents. 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.

Things to think about when choosing your 2017 health plan*:

How your health care needs may be changing. Maybe you're planning to add to your family. Or maybe you had major surgery this year and expect next year to be less eventful. Planning ahead can help you find the right balance between your monthly payment and what you'll pay out of pocket.

The total cost for your plan. When comparing your plan options, make sure you're looking at more than just the monthly payment (also called premium). Take a close look at the plan benefits too. Look for terms like "copay" and "deductible." These will tell you what you could pay for your care when you go to the doctor, pick up a prescription, or have a hospital stay.

Who is in your plan's network. Networks can be different depending on the plan you pick. Even plans offered by the same insurance company could have different networks with different hospitals and doctors. Check that all your doctors are in your plan's network before choosing a plan.

*For 2017, your insurance company may automatically enroll you in the same or a similar plan. You can change your plan during Open Enrollment.

Rating areas*

New Jersey

This list shows where Aetna individual health plans are available in your state. Just look for your county below. 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 **1-844-829-8875**.

Area 1

Atlantic
Bergen
Burlington
Camden
Cape May
Cumberland
Essex

Gloucester
Hudson
Hunterdon
Mercer
Middlesex
Monmouth
Morris

Ocean
Passaic
Salem
Somerset
Sussex
Union
Warren



*Networks may not be available in all ZIP codes and are subject to change.

Eligibility and requirements

What you need to know

To qualify for an Aetna individual health plan, you must:

- Be a resident of the state in which you're applying and a state in which we offer coverage
- Not be entitled to or enrolled in Medicare

We offer dependent coverage up to age 26, with some state exceptions. In Florida, we offer dependent coverage up to age 30, with certain eligibility requirements. In New Jersey, we offer dependent coverage up to age 31, with certain eligibility requirements.

10-day right to review*

Don't cancel your current insurance until we let you know we've accepted you for coverage. We'll review your enrollment form or application to determine if you meet eligibility requirements. You'll get a letter if we close your application or enrollment form. You'll get an Aetna individual health plan contract and ID card by mail if we approve your application or enrollment form.

If you're not satisfied after reviewing your contract, simply return it to us within 10 days. We'll refund any monthly payment you 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.

*For New Jersey, it's a 30-day right to review.

**The Easy Pay program is administered by MFS Funding Services, Inc. MFS is not affiliated with Aetna, and Aetna is not responsible for the actions of MFS.

Convenient monthly payments

Easy Pay** from Aetna is a fast, easy way to pay your monthly payment. Each month on the due date, funds are automatically withdrawn from your checking account. Easy Pay saves you money by eliminating the cost of checks, envelopes and postage. Plus, you don't have to worry about your monthly payment being late or getting lost in the mail. It's available to anyone who is currently enrolled or has been accepted into an Aetna individual health insurance plan. As long as you have a checking account and are a customer in good standing, you can participate in this billing plan.

Your coverage

Your coverage stays in effect as long as you pay the required monthly payment on time, and as long as you are eligible for the plan. Your coverage ends if you:

- Don't pay your monthly bill
- Move to another state
- Get duplicate coverage

Levels of coverage and enrollment

These plans are subject to the final rating factors applicable in your state. Once we confirm your eligibility, you may be enrolled in your selected plan at:

- The lowest rate available (known as the standard premium charge)
- A higher monthly payment due to age, where you live and if you use tobacco, if applicable in your state



Limitations and exclusions

Medical

These medical plans don't cover all health care expenses and include limitations and exclusions. Please 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, essential health benefits or the plan design.

- All medical and hospital services not specifically covered in, or that are limited or excluded by, your plan documents, including costs of services before coverage begins and after coverage ends
- Cosmetic surgery
- Custodial care
- Dental care and dental X-rays for individuals ages 19 and older
- Donor egg retrieval
- Experimental and investigational procedures (except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial)
- Eyeglass frames, nonprescription lenses and nonprescription contact lenses that are for individuals ages 19 and older or are for cosmetic purposes
- Hearing aids
- Home births
- Immunizations for travel or work
- Implantable drugs and certain injectable drugs, including injectable infertility drugs
- Infertility services including artificial insemination and advanced reproductive technologies such as IVF, ZIFT, GIFT, ICSI and other related services, unless specifically listed as covered in your plan documents
- Non-emergency care when traveling outside the U.S.
- Nonmedically necessary services or supplies
- Office visits to an ophthalmologist, optometrist or optician related to the fitting of prescription contact lenses
- Orthotics
- Over-the-counter medications and supplies
- Radial keratotomy or related procedures
- Reversal of sterilization

- Services for the treatment of sexual dysfunction or inadequacies including therapy, supplies or counseling
- Special or private duty nursing
- Weight-control services including surgical procedures, medical treatments, weight-control/loss programs, dietary regimens and supplements, appetite suppressants and other medications, and food or food supplements; exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including morbid obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions

Pediatric dental*

These medical plans don't cover all pediatric dental care expenses and include limitations and exclusions. Please refer to your plan documents to see which services we cover. The following is a partial list of services and supplies that we generally don't cover. **However, your plan documents may have exceptions to this list. We base these documents on state laws, essential health benefits or the plan design.**

- All pediatric dental services not specifically covered in, or that are limited or excluded by, your plan documents, including costs of services before coverage begins and after coverage ends
- Instructions for diet, plaque control and oral hygiene
- Dental services or supplies that you may primarily use to change, improve or enhance appearance
- Dental implants
- Experimental or investigational drugs, devices, treatments or procedures
- Services not necessary for the diagnosis, care or treatment of a condition
- Orthodontic treatment that isn't medically necessary for a severe or handicapping condition
- Replacement of lost or stolen appliances
- Services and supplies provided where there is no evidence of pathology, dysfunction or disease

*Not all plans sold on exchanges include coverage for pediatric dental care. Please refer to your plan documents to confirm coverage.

Important information about your health benefits — New Jersey

Aetna Elect Choice® plans

Understanding your plan of benefits

Aetna health insurance plans cover most types of health care from a doctor or hospital, but they do not cover everything. The plan covers recommended preventive care and care that you need for medical reasons. It does not cover services you may just want to have, like plastic surgery. It also does not cover treatment that is not yet widely accepted. You should also be aware that some services may have limits. For example, a plan may allow only one eye exam per year.

Not all of the information in this booklet applies to your specific plan

Most of the information in this booklet applies to all plans, but some information may not apply. For example, not all plans have deductibles. Information about those topics will only apply if the plan includes those rules.

Where to find information about your specific plan

Your “plan documents” list all the details for the plan you choose. This includes what’s covered, what’s not covered and what you will pay for services. Plan document names vary. They may include a Schedule of Benefits, Insurance Policy and/or any riders and updates that come with them.

If you can’t find your plan documents, call Member Services to ask for a copy. Use the toll-free number on your Aetna ID card.

Get plan information online and by phone

If you’re already enrolled in an Aetna health plan

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

1. Log in to your secure member website

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

Have your Aetna ID card handy. Then visit www.aetna.com and click “Log In/Register.” Follow the prompts to complete the one-time registration.

Then you can log in any time to:

- Verify who’s covered and what’s covered
- Access your “plan documents”
- Track claims or view past copies of Explanation of Benefits statements
- Use the online provider search tool to find network care
- Use our cost-of-care tools so you can know before you go
- Learn more about and access any wellness programs that come with your plan

2. Use your mobile device to access a streamlined version of your secure member website

Go to your Play Store (Android) or App Store (iPhone) and search for Aetna Mobile. You can also text **APPS** to **23862** to download.

Here’s just some of what you can do from Aetna Mobile:

- Find a doctor or facility
- View alerts and messages
- View your claims, coverage and benefits
- View your ID card information
- Use the Member Payment Estimator
- Contact us by phone or email

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

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

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

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

Aetna individual health insurance plans are underwritten by Aetna Life Insurance Company and/or by Aetna Health Inc. (Aetna). Each insurer has sole financial responsibility for its own products

3. Call Member Services at the toll-free number on your Aetna ID card

As an Aetna member you can use the voice response self-service options:

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

You can also speak with a representative to:

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

Not yet a member?

For help understanding how a particular medical plan works, you should review your Summary of Benefits and Coverage document. You can also call us with questions.

- If you are purchasing your health plan through an agent or directly from Aetna, you can call **1-866-565-1236**. A representative will transfer you to the appropriate sales department.
- If you are purchasing your health plan through the public exchange (**www.healthcare.gov**), you can call **1-855-586-6960**.

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

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

- **Existing members:** Visit **www.aetna.com** and log in. From your secure member website home page, select "Find a Doctor, Dentist or Facility" and start your search.
- **Considering enrollment:** Visit **www.aetna.com** and select "Find a Doctor" from the top menu bar. You'll need to select the plan you're interested in from the drop-down box.

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

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

Get a FREE printed directory

To get a free printed list of doctors and hospitals, call the toll-free number on your Aetna ID card. If you're not yet a member, call **1-866-565-1236**. (If you purchased your plan at **www.healthcare.gov**, call us at **1-855-586-6960** instead.)

Physician board certification

79.46* percent of our participating physicians are board certified. If you would like to know if a specific physician is board certified, or is currently accepting new patients, please call the Member Services number listed on your ID card.

Appointment waiting times

Our standard for customary waiting times for PCP appointments for urgent care is to be seen the same day or within 24 hours. Routine Care (non-urgent) is divided into three categories as: Preventive care is the expectation to be seen within eight weeks; Symptomatic care is to be seen within three days; and Routine care is to be seen within seven days. See "Get plan information online and by phone" for more information on your health plan. You should also refer to your plan documents.

*As of January 1, 2016.

Costs and rules for using your plan

What you pay

You will share in the cost of your health care. These are called “out-of-pocket” costs. Your plan documents show the amounts that apply to your specific plan. Those costs may include:

Copay — A set amount (for example, \$25) you pay for covered health care service. You usually pay this when you get the service. The amount can vary by the type of service. For example, you may pay a different amount to see a specialist than you would pay to see your family doctor.

Other copays may apply at the same time:

- **Inpatient Hospital Copay** — This copay applies when you are a patient in a hospital.
- **Emergency Room Copay** — This is the amount you pay when you go to the emergency room. If you are admitted to the hospital within 24 hours, you won't have to pay it.

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

Deductible — The amount you owe for health care services before your health plan begins to pay. For example, if your deductible is \$1,000, you have to pay the first \$1,000 for covered services before the plan begins to pay. You may not have to pay a deductible for some services.

How we pay your doctors

We pay doctors who are in our network on a discounted fee-for-service basis. This is the amount used when determining your percent share if your plan includes “coinsurance.” Any charge for a service or supply furnished by a participating provider in excess of such provider's negotiated charge for that service or supply will not be a covered expense under the group contract. In no event will you or your eligible dependents be expected to pay any such excess charge. It will be the responsibility of Aetna and the participating provider to resolve the amount deemed to be excess.

Your costs when you go outside the network

Elect Choice is a network-only plan. That means the plan covers health care services only when provided by a doctor who participates in the plan's network. If you receive services from an out-of-network doctor or other health care provider, you will have to pay all of the costs for the services. See “Emergency care” for more.

How your plan covers out-of-network services at a network hospital

Not all doctors and other health care providers are in the network, even if they work within a network hospital. Even when you are admitted to an in-network hospital, if an out-of-network doctor provides care during your confinement, the cost of that doctor's care may not be covered. This applies to lab work, imaging and other services provided during your stay. See “Emergency care” for more information about when you have no choice in who provides your care. Call Member Services at the toll-free number on your Aetna ID card with questions or to help you determine if you need to pay a bill.

How your plan covers prescription drug benefits

Aetna Pharmacy Management negotiates discounts from independent pharmacies, chain pharmacies, and home delivery vendors that participate in the Aetna network. The reimbursement formula is based on Average Wholesale Price (AWP) less a negotiated discount, plus a dispensing fee. (There is no dispensing fee for home delivery vendors.) The dispensing fee is a contractual fee negotiated between Aetna Pharmacy Management and the network pharmacy.

Call Member Services with your questions about how we pay your doctors

The number is on your Aetna ID card. You should also feel free to talk about it with your doctor.

Choose a primary care physician

You can choose any primary care physician (PCP) who participates in the Aetna network and who is accepting new patients. If you do not pick a PCP when required, your benefits may be limited or we may select a PCP for you. Even if not required, it is still a good idea to choose a PCP. That's because a PCP can get to know your health care needs and help you better manage your health care.

A PCP is the doctor you go to when you need health care. If it's an emergency, you don't have to call your PCP first. This one doctor can coordinate all your care. Your PCP will perform physical exams, order tests and screenings and help you when you're sick. Your PCP will also refer you to a specialist when needed.

A female member may choose an Ob/Gyn as her PCP if the Ob/Gyn elects to be a PCP. You may also choose a pediatrician for your child(ren)'s PCP. Your Ob/Gyn acting as your PCP will provide the same services and follow the same guidelines as any other PCP. He or she will issue referrals to other doctors (if your plan requires referrals). He or she will also get approvals you may need and comply with any treatment plans you are on. See the sections about referrals and precertification for more information.

Tell us who you choose to be your PCP

Each member of the family may choose a different PCP from the Aetna network. Provide the chosen doctor's Primary Medical Office ID Number when you enroll. You can get the number from the online search tool. Or, call Member Services after you enroll to tell us your selection. You may change your selected PCP at any time.

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

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

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

Remember these points about referrals:

- You do not need a referral for emergency care.
- If you do not get a referral when required, you may have to pay the bill yourself.
- Your specialist might recommend treatment or tests that were not on the original referral. In that case, you may need to get another referral from your PCP for those services.
- Women can go to an Ob/Gyn without a referral. See "PCP and referral rules for Ob/Gyns" for more.
- Referrals are valid for one year as long as you are still a member of the plan. Your first visit must be within 90 days of the referral issue date.

- In network-only plans, you can get a special referral if a network specialist is not available. You are required to get approval from us when you get a referral to an out-of-network specialist.

Your doctor must tell you if he or she has a financial interest when making a referral

Doctors, chiropractors and podiatrists are allowed to refer you to other health care providers where they have a financial interest. New Jersey law requires them to tell you when they do. You can contact your doctor to learn more about this. Call the New Jersey Division of Consumer Affairs at **1-973-504-6200** or **1-800-242-5846** if you believe your doctor is not giving you this information.

PCP and referral rules for obstetricians and gynecologists (Ob/Gyn)

A female member can choose an Ob/Gyn as her PCP. Women can also go to any Ob/Gyn who participates in the Aetna network without a referral or prior authorization. Visits can be for:

- Checkups, including breast exam
- Mammogram
- Pap smear
- Obstetric or gynecologic problems

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

Precertification: Getting approvals for services

Sometimes we will pay for care only if we have given an approval before you get it. We call that “precertification.” You usually only need precertification for more serious care like surgery or being admitted to a hospital. Your PCP or network specialist will get this approval for you.

Your plan documents list all the services that require you to get precertification. If you don’t, you will have to pay for all or a larger share of the cost for the service.

You do not have to get precertification for emergency services.

What we look for when reviewing a request

First, we check to see that you are still a member. And we make sure the service is considered medically necessary for your condition. We also make sure the service and place requested to perform the service are cost effective. Our decisions are based entirely on appropriateness of care and service and the existence of coverage, using nationally recognized guidelines and resources. We may suggest a different treatment or place of service that is just as effective but costs less. We also look to see if you qualify for one of our care management programs. If so, one of our nurses may contact you.

Precertification does not verify if you have reached any plan dollar limits or visit maximums for the service requested. So, even if you get approval, the service may not be covered.

Our review process after precertification (Utilization Review/Patient Management)

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

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

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

Paying primary care providers for quality

Some PCPs are paid more when their offices score high for performance. The scores are based on these factors:

- Member satisfaction
- Percent of members who visit the office every year
- Medical record reviews
- The burden of illness of the members that have selected the PCP
- How well they manage chronic illnesses like asthma, diabetes and congestive heart failure
- Whether they accept new patients
- Whether they submit claims and referrals electronically

We encourage you to ask all your doctors how they are paid for their services.

You can learn more about how we pay PCPs and other network doctors. Just call or write to Member Services. The phone number and address are on your Aetna ID card. You can also write to: Aetna, 9 Entin Road, Parsippany, NJ 07054.

Information about specific benefits

Coverage for children

You may include children who do not live with you on the plan. The child does not have to live in the same service area as you. But, the child must follow the same plan rules that you must follow. For example, this is a network-only plan. Your child must use doctors and hospitals for the network service area where he or she lives.

Dependent coverage to age 31

The federal age limit for children is 26 years. In New Jersey, you may include children on your plan up to age 31. You and your child must meet all other eligibility requirements. Review your plan documents to learn more. You can also call Member Services at the number on your Aetna ID card.

If you have a chronic condition or an upcoming hospital stay, you may qualify for one of our care management programs. An Aetna nurse can be the extra support you need. After you enroll, just call the number on your ID card to learn more.

Emergency care

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

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

- Call **911** or go to the nearest emergency room. If you have time, call your doctor or PCP.
- Tell your doctor or PCP as soon as possible afterward. A friend or family member may call on your behalf.
- You do not have to get approval for emergency services.

You are covered for emergency care

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

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

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

Follow-up care for plans that require a PCP

If you use a PCP to coordinate your health care, your PCP should also coordinate all follow-up care after your emergency. For example, you'll need a doctor to remove stitches or a cast or take another set of X-rays to see if you've healed. Your PCP should coordinate all follow-up care. You will need a referral for follow-up care that is not performed by your PCP. You may also need to get approval if you go outside the network.

Urgent care

Call your doctor when you have medical questions or concerns. Your doctor should have an answering service if you call after the office closes. You can also go to an urgent care center, which may have limited hours. To find a center near you, log in to www.aetna.com and search our list of doctors and other health care providers. Check your plan documents to see how much you must pay for urgent care services.

No coverage based on U.S. Sanctions

If U.S. trade sanctions consider you a blocked person, the plan cannot provide benefits or coverage to you. If you travel to a country sanctioned by the United States, the plan in most cases cannot provide benefits or coverage to you. Also, if your health care provider is a blocked person or is in a sanctioned country, we cannot pay for services from that provider. For example, if you receive care while traveling in another country and the health care provider is a blocked person or is in a sanctioned country, the plan cannot pay for those services. For more information on U.S. Trade sanctions, visit www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

Prescription drug benefit

Some plans encourage generic drugs over brand-name drugs

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

We may also encourage you to use certain drugs

Some plans encourage you to buy certain prescription drugs over others. The plan may even pay a larger share for those drugs. We list those drugs in the Aetna Preferred Drug Guide (also known as a "drug formulary"). This guide shows which prescription drugs are covered on a preferred basis. It also explains how we choose medications to be in the guide.

When you get a drug that is not on the preferred drug guide, your share of the cost will usually be more. Check your plan documents to see how much you will pay. You can use those drugs if your plan has an "open formulary," but you'll pay the highest copay under the plan. If your plan has a "closed formulary," those drugs are not covered.

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

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

Home delivery and specialty-drug services from Aetna owned pharmacies

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

You might not have to stick to the preferred drug guide

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

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

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

Get a copy of the preferred drug guide

You can find the Aetna Preferred Drug Guide on our website at www.aetna.com/formulary/. You can call the toll-free number on your Aetna ID card to ask for a printed copy. We are constantly adding new drugs to the guide. Look online or call Member Services for the latest updates.

Have questions? Get answers.

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

Mental health and addiction benefits

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

- Call **911** if it's an emergency.
- Call the toll-free Behavioral Health number on your Aetna ID card.
- Call Member Services if no other number is listed.
- If you're using your school's employee assistance program (EAP), call your EAP professional for help finding a mental health specialist.

Get information about using network therapists

We want you to feel good about using the Aetna network for mental health services. Visit www.aetna.com/docfind and click the "Quality and Cost Information" link. No Internet? Call Member Services instead. Use the toll-free number on your Aetna ID card to ask for a printed copy.

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

- **Beginning Right® Depression Program:** Perinatal and Postpartum Depression Education, Screening and Treatment Referral and
- **SASADA Program:** Substance Abuse Screening for Adolescents with Depression and/or Anxiety

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

Transplants and other complex conditions

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

Breast reconstruction benefits

Women's Health and Cancer Rights Act of 1998

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

Please contact Member Services for more information. For more information, you can visit the U.S. Department of Health and Human Services website, www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/whcra_factsheet.html, and the U.S. Department of Labor website, www.dol.gov/ebsa/consumer_info_health.html.

How we determine what's covered

Avoid unexpected bills. Check your plan documents to see what's covered before you get health care. Can't find your plan documents? Call Member Services to ask a specific question or have a copy mailed to you.

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

We check if it's "medically necessary"

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

The product or service:

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

Only medical professionals can decide if a treatment or service is not medically necessary. We do not reward Aetna employees for denying coverage. Sometimes a physician's group will determine medical necessity. Those groups might use different resources than we do.

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

We study the latest medical technology

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

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

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

We publish our decisions in our Clinical Policy Bulletins.

We post our findings on www.aetna.com

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

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

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

You and your doctor can read our CPBs on our website at www.aetna.com. You can find them under "Individuals & Families." No Internet? Call Member Services at the toll-free number on your ID card. Ask for a copy of a CPB for any product or service.

Claim procedures

With Elect Choice plans, it is very rare that you would have to file a claim. That's because network doctors file claims for you. If you ever do need to file a claim, you can get the form online. Just log in to your secure member website at www.aetna.com. You can also call Member Services at the number on your ID card to ask for a form. The claim form includes complete instructions, like what documentation to send with it.

You'll need the itemized bill with your Aetna ID number clearly marked on it. Send everything to the address shown on your Aetna ID card. We pay claims according to the Claim Payment Procedure section of your plan documents.

We will make a decision on your claim. For urgent care claims and preservice claims, we will notify you by mail of our decision, whether paid or not. For other types of claims, we may only notify you if we make an "adverse determination."

Adverse benefit determinations are decisions that result in denial, reduction, or termination of a benefit or the amount paid for it. It also means a decision not to provide a benefit or service. Adverse benefit determinations can be made for one or more of the following reasons:

- The service or supply is not medically necessary, is an experimental or investigational procedure, or is for dental or cosmetic purposes.
- The service or supply is not covered by the plan. A service or supply is not covered if it is not included in the list of covered benefits.
- You have reached a coverage limit.
- You or your dependents are not eligible to be covered by the plan.

We will notify you in writing according to the time frames shown below. Under certain circumstances, we may extend these time frames. For a precertification request while a covered person is receiving inpatient hospital services or emergency care, we will communicate a denial or limitation imposed on the requested service to the hospital or physician within a time frame appropriate to the medical exigencies of the case but no later than 24 hours after the time the request was made.

The notice will explain how you can appeal the adverse benefit determination. Please see the Complaints and Appeals section for more information about appeals.

The chart below summarizes some information about how different types of claims are handled.

Time frames for notifying you that we denied a claim

Type of claim	Response time from receipt of claim
Urgent Care Claim A claim for medical care or treatment where a delay could seriously jeopardize your life or health, your ability to regain maximum function; or subject you to severe pain that cannot be adequately managed without the requested care or treatment.	As soon as possible but not later than 72 hours.
Preservice Claim A claim for a benefit that requires approval of the benefit before getting medical care.	Within 15 calendar days.
Concurrent Care Claim Extension A request to extend a course of treatment that we previously approved.	If an urgent care claim, as soon as possible but not later than 24 hours. Otherwise, within 15 calendar days.
Concurrent Care Claim Reduction or Termination Decision to reduce or terminate a course of treatment that we already approved. We will not deny coverage based on medical necessity for previously approved services unless the approval was based on material misrepresentation or fraudulent information submitted by the covered person or provider.	With enough advance notice to allow the member to appeal.
Postservice Claim A claim for a benefit that is not a preservice claim.	Within 30 calendar days.

What to do if you disagree with us

Complaints, appeals and external review

We have procedures you can follow if you are not satisfied with a decision we have made or with our operations. The procedure depends on the type of issue or problem you have.

- **Appeal** — An appeal is a formal request that we reconsider an adverse benefit determination.
- **Complaint** — A complaint is an expression of dissatisfaction about quality of care or our operation.

This chart summarizes how we handle appeals for different types of claims:

Time frame for responding to an adverse benefit determination appeal

Type of claim	Response time from receipt of appeal	
	Utilization review appeals	Non-utilization review appeals
Urgent Care Claim A claim for medical care or treatment where a delay could seriously jeopardize your life or health or your ability to regain maximum function or subject you to severe pain that cannot be adequately managed without the requested care or treatment.	Within 72 hours Our review will be provided by Aetna Appeals Committee whose members were not involved in making the adverse benefit determination.	N/A
Preservice Claim A claim for a benefit that requires approval before getting medical care.	Within 10 calendar days Our review will be provided by Aetna Appeals Committee whose members were not involved in making the adverse benefit determination.	Within 30 calendar days Our review will be provided by someone who was not involved in making the adverse benefit determination.
Concurrent Care Claim Extension A request to extend or a decision to reduce a previously approved course of treatment.	Treated like an urgent care claim or a preservice claim depending on the circumstances.	Treated like an urgent care claim or a preservice claim depending on the circumstances.
Postservice Claim Any claim for a benefit that is not a preservice claim.	Within 10 calendar days Our review will be provided by Aetna Appeals Committee whose members were not involved in making the adverse benefit determination.	Within 60 business days Our review will be provided by someone who was not involved in making the adverse benefit determination.

A. Complaints

If you are dissatisfied with the administrative services you receive from us or you want to complain about a network doctor, call or write to Member Services within 30 calendar days of the incident. Please include a detailed description of the matter and copies of any records or documents that you think are relevant to the matter. We will review the information and provide you with a written response within 30 calendar days of the receipt of the complaint, unless we need more information and you cannot get it within this time frame. The response will explain what you need to do to seek an additional review.

B. Appeals of adverse benefit determinations

We will send written notice of an adverse benefit determination. The notice will include the reason for the decision and it will explain what steps to take if you wish to appeal. The notice will also identify your rights to receive additional information that may be relevant to an appeal. Requests for an appeal must be made in writing within 180 calendar days from the date of the notice. However, level-one appeals may also be requested orally.

You or your doctor acting on your behalf and with your consent may appeal if you are not satisfied with an adverse benefit determination.

We provide for two levels of appeal. You must complete both levels of review before pursuing an appeal to an independent utilization review organization (IURO) or bringing a lawsuit against us, unless serious or significant harm has occurred or will imminently occur to you. If you decide to appeal to the second level, the request must be made in writing within 60 calendar days from the date of our notice from the level-one appeal. That notice will explain your right to make a level-two appeal. We will acknowledge the appeal in writing within 10 business days of receipt of a level-two appeal.

- The level-one appeal review will be conducted by a doctor who was not the original reviewer nor a subordinate of the original reviewer who rendered the initial adverse benefit determination.
- For a level-two appeal, we will conduct a same or similar specialty review for appeals involving clinical issues. The consulting practitioner or professional will be someone who was not involved in the original determination.

We maintain a formal appeal process (level two) if you or your doctor acting on your behalf and with your consent are not satisfied with the results of a level-one appeal. You'll have the opportunity to pursue your appeal before a panel of physicians and/or other health care professionals that we select. The professional will not have been involved in any of the previous decisions. You and/or your authorized representative may attend the level-two appeal hearing and question the Aetna representatives and present your case.

C. Exhaustion of process

You are not required to exhaust internal appeals before complaining to the Department of Banking and Insurance. The Department of Banking and Insurance's ability to investigate a complaint will also not be limited by any exhaustion.

In the event that we fail to comply with any of the deadlines to complete the level-one or level-two appeal, or if we, for any reason, expressly waive our rights to an internal review of any appeal, then you and/or your doctor may go directly to the external appeals process as follows.

D. External appeal process

If you or your doctor acting on your behalf and with your consent are not satisfied with the result of the level-one and level-two appeal process above, you may pursue your appeal to an independent utilization review organization (IURO) as outlined below.

Except as explained in section C, your right to an external appeal under this section is contingent on your full compliance with both stages of our level-one and level-two appeal processes.

1. Within four months from receipt of the written determination of the level-two appeal panel, you or your doctor acting on your behalf and with your consent must file a written request with the Department of Banking and Insurance. You can download a copy of the "Application for the Independent Health Care Appeals Program" from www.state.nj.us/dobi/index.html. Or you can call Member Services to have us mail a request form to you. You will also have to sign a general release for all medical records pertinent to the appeal. Mail your request to:

Office of Managed Care
Consumer Protection Services
Department of Banking and Insurance
Care Attn: IHCAP
PO Box 329
Trenton, NJ 08625-0329
Courier: 20 West State Street
2. You will have to pay a \$25 filing fee, payable by check or money order to the Department of Banking and Insurance. The filing fee will be waived if you submit evidence of participation in one of the following: Pharmaceutical Assistance to the Aged and Disabled, Medicaid, NJ FamilyCare, General Assistance, SSI, or New Jersey Unemployment Assistance.
3. Upon receipt of the appeal, the executed release and the appropriate fee, the Department of Banking and Insurance will immediately assign the appeal to an IURO.

4. Upon receipt of the request for appeal from the Department of Banking and Insurance, the IURO will conduct a preliminary review of the appeal and accept it for processing if it determines that:
 - You are or were a member of Aetna
 - The service that is the subject of the complaint or appeal reasonably appears to be a covered benefit under the Insurance Policy
 - You have fully complied with both the level-one and level-two appeal processes
 - You have provided all information required by the IURO and the Department of Banking and Insurance to make the preliminary determination. That information includes the appeal form, a copy of any information provided by us regarding our decision to deny, reduce, or terminate the covered benefit, and a fully executed release to obtain any necessary medical records from us and any other relevant health care provider.
5. Once the IURO completes the preliminary review, it will immediately notify you and/or your doctor in writing as to whether the appeal has been accepted for processing and the reasons if it was not accepted.
6. If the IURO accepts the appeal for processing, it will conduct a full review to decide if you were deprived of medically necessary covered benefits as a result of our decision. The IURO will have taken into consideration:
 - All pertinent medical records, consulting physician reports, and other documents submitted by the parties
 - Any applicable, generally accepted practice guidelines developed by the federal government and national or professional medical societies, boards and associations
 - Any applicable clinical protocols and/or practice guidelines that we have developed
7. The full review referenced above will initially be conducted by a registered, professional nurse or physician licensed to practice in New Jersey. When necessary, the IURO will refer all cases for review to a consultant physician in the same specialty or area of practice who would generally manage the type of treatment that is the subject of the appeal. All final recommendations of the IURO will be approved by the medical director of the IURO.
8. The IURO will complete its review and issue its recommended decision as soon as possible in accordance with the medical exigencies of the case. Except as provided for in this subsection, that will not exceed 30 business days from receipt of all documentation necessary to complete the review. The IURO may, however, extend its review for a reasonable period of time as may be necessary due to circumstances beyond its control. In such an event, the IURO will send written notice to you, to the Department of Banking and Insurance, and to Aetna before concluding its preliminary review. The notice will indicate the status of the review and the specific reasons for the delay.
9. If the IURO determines that you were deprived of medically necessary covered benefits, it will recommend to you, Aetna, and the New Jersey Department of Health and Senior Services the appropriate covered health care services you should receive.
10. Once the review is complete, we will abide by the decision of the IURO.
11. The filing fee will be refunded to you (or health care provider) if the IURO reverses our final internal adverse benefit determination.
12. We pay the cost of the IURO's preliminary review and full review, regardless of the outcome.

E. Fees and Costs

Except as set forth in section D.11 and D.12 above for an external appeal, nothing herein shall be construed to require us to pay counsel fees or any other fees or costs that you incur in pursuing a complaint or appeal.

F. Record Retention

We shall retain the records of all complaints and appeals for a period of at least seven years.

G. Addresses and Phone Numbers

For New Jersey Department of Banking and Insurance:

Office of Managed Care Consumer Protection Services
PO Box 329
Trenton, NJ 08625-0329

1-609-292-5316
1-888-393-1062

For Aetna Life Insurance Company:

Aetna Complaints and Appeals
151 Farmington Avenue
Hartford, CT 06156

You may also call the toll-free number on your Aetna member ID card.

Member rights & responsibilities

Know your rights as a member

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

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

You have the right to:

- Available and accessible services when medically necessary, including availability of care 24 hours a day, 7 days a week for urgent or emergency conditions. For urgent or emergency conditions, call **911** or go to the nearest emergency facility
- Be treated with courtesy and consideration, and with respect for your dignity and need for privacy
- Be provided with information about our policies and procedures for products, services, health care providers, appeals and other information about us and the care you receive from your doctors
- Choose a primary care physician within the limits of the covered benefits and availability and included as a participating health care professional in the plan network
- A choice of specialists among participating network doctors when you receive an authorized referral, subject to the doctor's availability to accept new patients
- Request and receive a list of participating doctors in the Aetna network, including addresses, telephone numbers and languages spoken
- Get help and referral to doctors with experience in treating patients with chronic disabilities
- Receive from your doctors, in terms you understand, an explanation of your complete medical condition, recommended treatment, risk(s) of the treatment, expected results and reasonable medical alternatives whether they are covered benefits or not. If you are not capable of understanding the information, your doctor must explain it to your next of kin or guardian and document it in your medical record
- Pay your copayments, coinsurance and/or deductible as outlined in your plan, without any additional bill from in-network doctors for amounts above the plan's "recognized" charge
- Formulate and have advance directives implemented

- All the rights afforded by law or regulation as a patient in a licensed health care facility, including the right to refuse medication and treatment after possible consequences of this decision have been explained in language you understand
- Prompt notification of termination or changes in benefits, services or provider network
- File a complaint or appeal with Aetna or the Department of Banking and Insurance (20 West State Street, 9th Floor, PO Box 329, Trenton, NJ 08625-0329, Main phone: **1-609-292-5316**, Fax: **1-609-292-5865**) and to receive an answer to those complaints within a reasonable period of time

Independent consumer satisfaction surveys

You can get the results of an independent consumer satisfaction survey and an analysis of quality outcomes of health care services of managed care plans in the State of New Jersey. For a copy of the guide, call **1-888-393-1062**, or write the New Jersey Department of Banking and Insurance, PO Box 325, Trenton, NJ 08625-0325. You can view or download a copy of the Performance Report at no charge from the Department's website at: www.state.nj.us/dobi/index.html.

New Jersey QUITNET and New Jersey QUITLINE

Tobacco products pose a serious health threat in New Jersey and cost the health insurance industry millions of dollars each year. The New Jersey Department of Health and Senior Services has two free services that can help you kick the tobacco habit.

- **New Jersey Quitline** — Call **1-866-NJ-STOPS** or **1-866-657-8677** for individualized telephone-based counseling and referral programs
- **New Jersey Quitnet** — Visit www.njquitline.org for personalized support and referrals online

Making medical decisions before your procedure¹

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

There are three types of advance directives:

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

You can create an advance directive in several ways:

- Ask your doctor for an advance directive form.
- Write your wishes down by yourself.
- Pick up a form at state or local offices on aging, 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.

Learn about our Care Management and Quality Management Programs

We make sure your doctor provides quality care for you and your family. To learn more about these programs, go to our website at www.aetna.com. Enter “commitment to quality” in the search bar. You can also call Member Services to ask for a printed copy. The phone number is on your Aetna member ID card.

We protect your privacy

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

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

Summary of the Aetna Privacy Policy

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

- Your doctors, dentists, pharmacies, hospitals and other caregivers
- Other insurers
- Vendors
- Government departments
- Third-party administrators (TPAs)

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

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

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

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

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

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

¹American Academy of Family Physicians. Advance Directives and Do Not Resuscitate Orders. January 2012. Available at <http://familydoctor.org/familydoctor/en/healthcare-management/end-of-life-issues/advance-directives-and-do-not-resuscitate-orders.html>. Accessed June 10, 2016.

Anyone can get health care

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

We must comply with these laws:

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

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

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

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

When you lose your other coverage

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

When you have a new dependent

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

- Marriage
- Birth
- Adoption
- Placement for adoption

Talk to your broker (if you have one) or call us at **1-866-565-1236** for more information or to request special enrollment.

Aetna does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan, including enrollment and benefit determinations.

We are committed to Health Plan Accreditation by the National Committee for Quality Assurance (NCQA) as a means of demonstrating a commitment to continuous quality improvement and meeting customer expectations. You can find a complete list of health plans and their NCQA status on the NCQA website located at www.ncqa.org. Click on the "Report Cards" tab to search on "Health Plans."

To refine your search for other health care providers, click on "Clinicians" or "Other Healthcare Organizations." The link for "Clinicians" includes doctors recognized by NCQA in the areas of heart/stroke care, diabetes care, patient centered medical home and patient centered specialty practice. The recognition programs are built on evidence-based, nationally recognized clinical standards of care; therefore, NCQA provider recognition is subject to change. You can access the official NCQA directory of recognized clinicians at <http://recognition.ncqa.org>. The link for "Other Healthcare Organizations" includes "Managed Behavioral Healthcare Organizations" for behavioral health accreditation and "Credentials Verifications Organizations" for credentialing certification.

If you need this material translated into another language, please call Member Services at 1-855-586-6960.

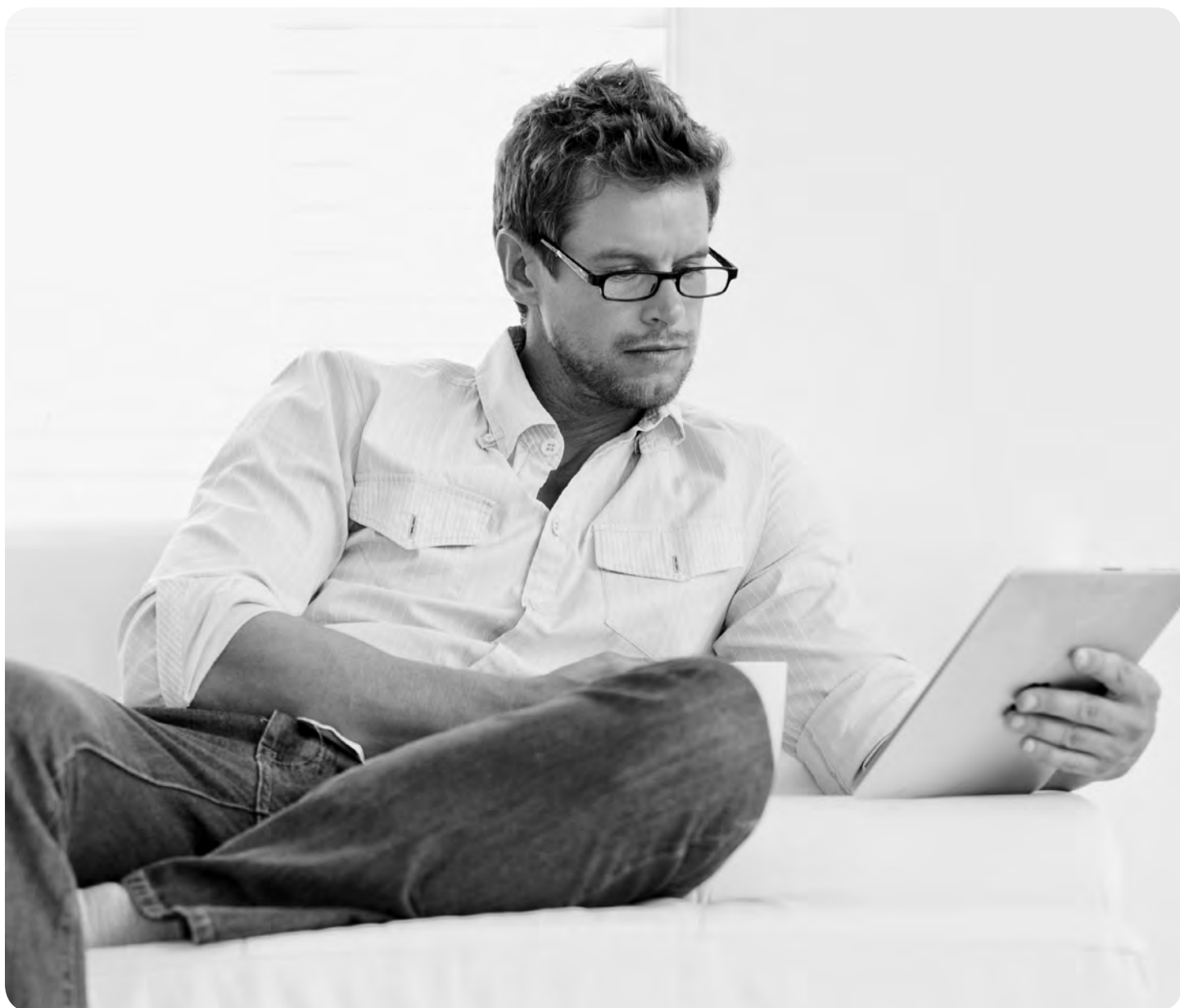
Si usted necesita este material en otro lenguaje, por favor llame a Servicios al Miembro al 1-855-586-6960.

Better manage your health and health care

Your secure member website

Your Aetna Navigator® website puts all of your plan information and cost-saving tools in one place. It's where you go to:

- **Find the right doctor** — and save money. Locate in-network doctors who accept your plan.
- **See what you owe.** Look up claims to see how much the plan paid and what you may have to pay.
- **Know your plan.** Check who is covered by your plan and what it covers.
- **Get valuable information.** See which doctors and hospitals have met extra standards for quality and efficiency.
- **Know costs before you go.** See cost estimates before you make an appointment for an office visit, test or procedure.
- **Get healthier.** Take a health assessment to learn about your health and how to lower your risks.
- **Check your health accounts.** Easily look up your health savings account or health fund balances.



This material is for information only. Plan features and availability may vary by location. 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. If you are in a plan that requires the selection of a primary care physician and your primary care physician is part of an integrated delivery system or physician group, your primary care physician will generally refer you to specialists or hospitals that are affiliated with the physician group or delivery system. 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 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. Aetna Rx Home Delivery refers to Aetna Rx Home Delivery, LLC, a subsidiary of Aetna Inc., which is a licensed pharmacy providing prescription services by mail. 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.

For more information about Aetna plans, refer to <http://www.aetna.com>

You can always visit us online
for more information:
www.aetnaindividual.com.

