Paying for care

An overview of terms

Claims

Claims are requests for your plan to pay for services you receive. We use these to check what your plan will cover and the amount we'll pay. You can find the status and amounts billed for your claim on your member website or the Aetna Health℠ app.

Explanation of Benefits (EOB) statements

An EOB shows a breakdown of how we process claims. It's not a bill and may not show the current balance you owe. And anytime something changes with your claim, you'll get a new statement.

Provider bills

Bills show the amount you actually owe for services. Your provider will give this to you. You can make payments for what you owe directly to them or through the "Pay Your Provider" link on each of your claims.

Coordination of benefits (COB)

Some members have health coverage under more than one plan. If so, we work with the other carriers to decide which plan pays first and which pays second, based on the rules in your plan documents. We call this process COB.

YOU PAY

Deductible

The deductible is the amount you pay for out-of-pocket costs for your covered health care before your plan begins to pay.

Each year, you pay 100% of your covered expenses until you meet your deductible amount. For most plans, eligible preventive care is covered at 100% with no deductible when you use network providers.

YOU + THE PLAN PAY

Cost sharing

Once you meet the deductible, you share the cost with the plan. This may be in the form of coinsurance and/or copayments (also called copays).

Coinsurance

This is a fixed percentage. For example, if your care is $100 and your coinsurance is 20%, you pay $20.

Copay

This is a fixed dollar amount. For example, you may pay $25 per doctor office visit.

Out-of-pocket maximum

The maximum you pay each year for covered expenses. Once you hit your maximum, the plan pays 100% of covered expenses for the rest of the year.

In-network care

Who pays for what

Highlights

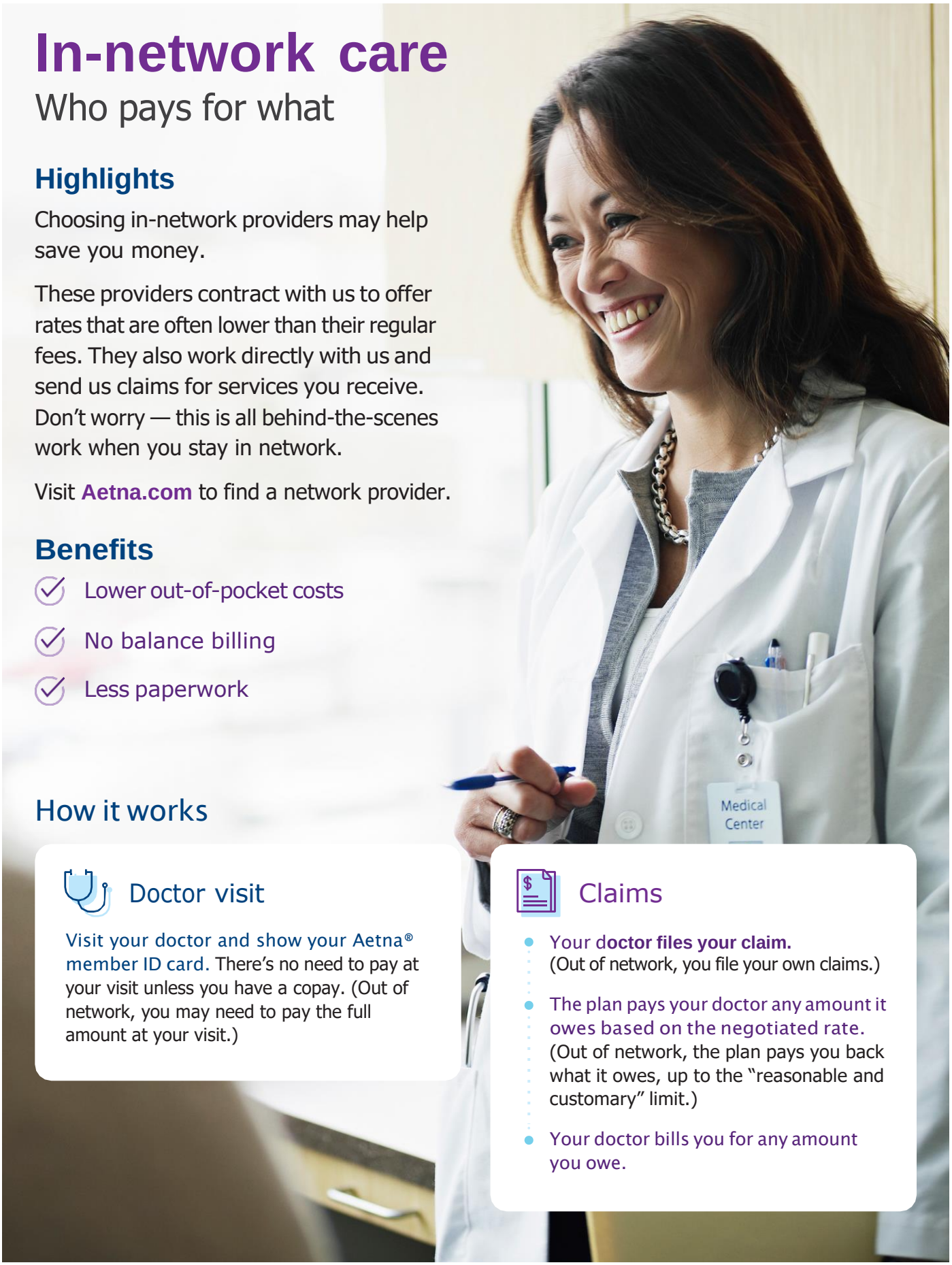
Choosing in-network providers may help save you money.

These providers contract with us to offer rates that are often lower than their regular fees. They also work directly with us and send us claims for services you receive. Don't worry — this is all behind-the-scenes work when you stay in network.

Visit **Aetna.com** to find a network provider.

Benefits

- Lower out-of-pocket costs
- No balance billing
- Less paperwork



How it works

Doctor visit

Visit your doctor and show your Aetna® member ID card. There's no need to pay at your visit unless you have a copay. (Out of network, you may need to pay the full amount at your visit.)

Claims

- Your d**octor files your claim.** (Out of network, you file your own claims.)
- The plan pays your doctor any amount it owes based on the negotiated rate. (Out of network, the plan pays you back what it owes, up to the "reasonable and customary" limit.)
- Your doctor bills you for any amount you owe.

In network vs. out of network

In network

This network option may **cost you less.**

Highlights

Choosing in-network providers may help save you money.

These providers contract with us to offer rates that are often lower than their regular fees. They also work directly with us and send us claims for services you receive. Don't worry — this is all behind-the-scenes work when you stay in network.

Visit Aetna.com to find a network provider.

How it works

The provider files your claim and the plan pays them the amount it owes based on the negotiated rate. You pay the remaining costs.

Benefits

- Lower out-of-pocket costs
- No balance billing
- Less paperwork

Out of network

This network option may **cost you more.**

Highlights

Your plan may allow you to visit an out-of-network provider. To find out details, check your Summary of Benefits and Coverage document.

How it works

Out-of-network doctors and hospitals don't contract with us. So that means:

- They normally charge more for their services
- You might have to pay the difference between what your plan pays for services and the amount they charge

Plus, they generally don't send us claims or get approval for coverage. So you may need to handle these details on your own.

Keep in mind

Covered

"Covered" doesn't mean free. A covered health care service is one that your plan recognizes. Your plan only pays for this service after you've met the deductible, coinsurance or copay.

Referral

A referral is like a permission slip from your primary care physician (PCP) to see a specialist or another provider. Many providers can easily send referrals electronically.

In-network providers

Network providers participate in our network and offer special, lower rates for our members. So remember that staying in network can help you save money.