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Important information about your health benefits

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Aetna Open Access® HMO
Aetna Choice® POS
Aetna Open Access® Managed Choice®
Health Network Only
Health Network Option

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Understanding your plan of benefits

Aetna* health benefits 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.

Warning: If you or your family members are covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and hospitals, and it may be impossible to comply with both plans at the same time. Before you enroll in this plan, read all of the rules very carefully and compare them with the rules of any other plan that covers you or your family.

Have a Student Plan?

If you have a Student Accident and Sickness plan, please visit **www.aetnastudenthealth.com** for questions or call Aetna Student Health at the toll-free number on your ID card for more information. For appeals, please forward your request to Chickering Claims Administrators, Inc., P.O. Box 15717, Boston, MA 02215-0014. Fully insured student health insurance plans are underwritten by Aetna Life Insurance Company (ALIC) and administered by Chickering Claims Administrators, Inc. (CCA). Self-insured plans are funded by the applicable school, with claims administration services provided by Chickering Claims Administrators, Inc. Aetna Student Health is the brand name for products and services provided by ALIC and CCA.

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 does not. For example, not all plans have deductibles or prescription drug benefits. Information about those topics will only apply if the plan includes those rules.

Table of Contents

Understanding your plan of benefits....2
Getting help....3
Contact Member Services with questions....3
Search our network for doctors, hospitals and other health care providers....3
Help for those who speak another language and for the hearing impaired....3
Costs and rules for using your plan....4
What you pay....4
Provider networks improve care while lowering costs....4
Your costs when you go outside the network....4
Precertification: Getting approvals for services....5
Filing claims in Oklahoma....6
Information about specific benefits....6
Emergency and urgent care and care after office hours....6
Prescription drug benefit....6
Mental health and addiction benefits....7
Transplants and other complex conditions....7
Breast reconstruction benefits....7
Knowing what is covered....8
We check if it's "medically necessary"....8
We study the latest medical technology....8
We post our findings on www.aetna.com....9
We can help when more serious care is suitable....9
What to do if you disagree with us....9
Complaints, appeals and external review....9
Member rights & responsibilities....10
Know your rights as a member....10
Making medical decisions before your procedure....10
Learn about our quality management programs....10
We protect your privacy....10
Anyone can get health care....10
How we use information about your race, ethnicity and the language you speak....10
Your rights to enroll later if you decide not to enroll now....11
Consumer Choice Option – Georgia....11
Nondiscrimination for genetic testing....11
Hawaii informed consent....11
More information is available....11

* Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies. Health benefits and health insurance plans are offered, underwritten and/or administered by Aetna Health Inc., Aetna Health Insurance Company and/or Aetna Life Insurance Company.

State-specific information throughout this booklet does not apply to all plans. To be sure, review your plan documents, ask your benefits administrator, or call Aetna Member Services. Some states may also have differences that are not reflected in this document.

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, Certificate of Coverage, Group Agreement, Group Insurance Certificate, Group 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.

Getting help

Contact Member Services with questions

Call the toll-free number on your ID card. Or, call **1-800-US-Aetna (1-800-872-3862)** Monday through Friday, 7 a.m. to 7 p.m. ET. You can also send Member Services an e-mail. Just go to your secure Aetna Navigator® member website at **www.aetna.com**. Click on "Contact Us" after you log in.

Member Services can help you:

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

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

It's important to know which doctors are in our network. That's because some health plans only let you visit doctors, hospitals and other health care providers if they are in our network. Some plans allow you to go outside the network. But, you pay less when you visit doctors in the network.

Here's how you can find out if your health care provider is in our network.

- Log in to your secure Aetna Navigator® member website at **www.aetna.com**. Follow the path to find a doctor and enter your doctor's name in the search field.
- Call us at the toll-free number on your Aetna ID card, or call us at **1-888-87-AETNA (1-888-872-3862)**.

For up-to-date information about how to find health care services, please follow the instructions above. If you would like a printed list of doctors, contact Member Services at the toll-free number on your Aetna ID card.

Our online directory 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
- Gender

You can even get driving directions to the office. If you don't have Internet access, call Member Services to ask about this information.

If you live in **Georgia**, you can call toll-free at **1-800-223-6857** to confirm that the preferred provider in question is in the network and/or accepting new patients.

Hawaii Insurance Division – You may contact the Hawaii Insurance Division and the Office of Consumer Complaints at **1-808-586-2790**.

Michigan members may contact the Michigan Office of Financial and Insurance Services at **517-373-0220** to:

- Verify participating providers' license
- Access information on formal complaints and disciplinary actions filed or taken against a health care provider in the immediate preceding three years.

For more information on your health plan, call Member Services at **1-800-208-8755** or refer to your plan documents.

A provider's right to join the network – Kentucky

Any health care provider who meets our enrollment criteria and who is willing to meet the terms and conditions for participation has a right to become a participating provider in our network.

Customary waiting times – Kentucky

Routine	Within 7 days
Preventive Care	Within 8 weeks
Symptomatic, Non Urgent	Within 3 days
Urgent Complaint	Same day/within 24 hours
Emergency	Immediately or referred to ER

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

Do you need help in another language? Member Services can connect you to a special line where you can talk to someone in your own language. You can also get help with a complaint or appeal.

Language hotline – **1-888-982-3862** *(140 languages are available, ask for an interpreter.)*

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

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

¿Necesita ayuda en otro idioma? Los representantes de Servicios al Miembro le pueden conectar a una línea especial donde puede hablar con alguien en su propio idioma. También puede obtener asistencia de un intérprete para presentar una queja o apelación.

Línea directa – **1-888-982-3862** *(Tenemos 140 idiomas disponibles. Debe pedir un intérprete.)*

TDD **1-800-628-3323** *(sólo para personas con impedimentos auditivos)*

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, $15) 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.	
Coinsurance	Your share of the costs for a covered service. This is usually a percent (for example, 20%) 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% 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 for some services.	
Other deductibles may apply at the same time:		
Inpatient Hospital Deductible	Applies when you are a patient in a hospital	**Note:** These are separate from your general deductible. For example, your plan may have a $1,000 general deductible and a $250 Emergency Room Deductible. This means you pay the first $1,000 before the plan pays anything. Once the plan starts to pay, if you go to the emergency room you will pay the first $250 of that bill.
Emergency Room Deductible	The amount you pay when you go to the emergency room, waived if you are admitted to the hospital within 24 hours	

Some doctors are not in the Aetna network even if they work in a network hospital

Louisiana notice: *"Health care services may be provided to you at a network health care facility by facility-based physicians who are not in your health plan. You may be responsible for payment of all or part of the fees for those* ***out-of-network services****, in addition to applicable amounts due for copayments, coinsurance, deductibles, and noncovered services.*

Specific information about in-network and out-of-network facility-based physicians can be found at the website address of your health plan or by calling the customer service telephone number of your health plan"

Provider networks improve care while lowering costs
Members who receive care from providers from value-based arrangements are participating in a network designed to improve care while lowering costs. These networks may be set up in different ways, but all include primary care doctors and specialists. They also typically include at least one hospital.

Like most plans, we usually pay doctors and hospitals on a fee-for-service basis. This means your doctor or hospital still gets paid for each visit. However, the value-based network's mission is to better coordinate patient care to improve efficiency, quality and patient satisfaction.

We agree with the network on certain goals,* such as:

- Clinical performance goals – completing enough screenings for cancer, diabetes and cholesterol
- Cost-efficiency goals – reducing avoidable ER visits, short-term hospital stays, repetitive tests and the overall cost of care

We pay these value-based networks more when they meet certain goals. The amount of these payments depends on how well the network meets their goals. The network may also have to make payments to us if they fail to meet their goals.

In most of our arrangements we will reward the network financially for both efficient care and higher quality of care. This helps encourage savings that are tied to value and better health outcomes for our members.

Doctors and hospitals that are members of a value-based (accountable care) network may have their own financial arrangements through the network itself. Ask your doctor for details.

Choose a doctor the fast and easy way with DocFind®. Simply log on to your secure Aetna Navigator® website at **www.aetna.com** and select "Find a Doctor, Pharmacy or Facility." After entering your search criteria, look for the ACO logo Ⓐ. If you need a printed directory instead, call the Member Services phone number on your member ID card.

*The specific goals will vary from network to network.

Costs and rules for using your plan

Your costs when you go outside the network

Network-only plans
Open Access HMO and Health Network Only plans are network-only plans. That means the plan covers health care services only when provided by a doctor who participates in the Aetna 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.

Plans that cover out-of-network services
With Open Choice, Health Network Option, Open Access Managed Choice and Aetna Choice POS plan, you may choose a doctor in our network. You may choose to visit an out-of-network doctor. We cover the cost of care based on if the provider, such as a doctor or hospital, is "in network" or "out of network." We want to help you understand how much we will pay for your out-of-network care. At the same

time, we want to make it clear how much more you will need to pay for this care. The following are examples for when you see a doctor:

"In network" means we have a contract with that doctor. Doctors agree to how much they will charge you for covered services. That amount is often less than what they would charge you if they were not in our network. Most of the time, it costs you less to use doctors in our network. Doctors also agree to not bill you for any amount over their contract rate. All you have to pay is your coinsurance or copayments, along with any deductible. Your network doctor will handle any precertification required by your plan.

"Out of network" means we do not have a contract with that doctor. We don't know exactly what an out-of-network doctor will charge you. If you choose a doctor who is out of network, your Aetna health plan may pay some of that doctor's bill. Most of the time, you will pay a lot more money out of your own pocket if you choose to use an out-of-network doctor.

Your out-of-network doctor or hospital sets the rate to charge you. It may be much higher than what your Aetna plan "recognizes" or "allows." Your doctor may bill you for the dollar amount that your plan doesn't "recognize." You must also pay any copayments, coinsurance and deductibles that apply. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket limits.

This means you are fully responsible for paying everything above the amount we allow for a service or procedure.

How we pay doctors who are not in our network
When you choose to see an out-of-network doctor, hospital or other health care provider, we pay for your care using a "prevailing" or "reasonable" charge obtained from an industry database; a rate based on what Medicare would pay for that service; or a local market fee set by Aetna. Your plan will state which method is used.

This way of paying out-of-network doctors and hospitals applies when you choose to get care out of network. See "Emergency and urgent care and care after office hours" for more.

Going in network just makes sense.
- We have negotiated discounted rates for you.
- In-network doctors and hospitals won't bill you for costs above our rates for covered services.
- You are in great hands with access to quality care from our national network.

To learn more about how we pay out-of-network benefits visit **www.aetna.com**. Type "how Aetna pays" in the search box.

You never need referrals with open access plans

As an Aetna Open Access or PPO plan member, you never need a referral from your regular doctor to see a specialist. You also do not need to select a primary care provider (PCP), but we encourage you to do so to help you navigate the health care system. Regardless, some states require us to tell you about certain open access benefits. Be assured that all of your benefits are "open access," including the following:

Florida
- **Chiropractor and Podiatrist** – You have direct access to a participating primary care chiropractic and podiatric provider of your choice and do not need a referral from your PCP to access these benefits covered under your health benefits plan.
- **Dermatologist** – You have direct access to a participating primary care dermatologist provider of your choice and do not need a referral from your PCP to access these benefits covered under your health benefits plan.

Georgia
- **Ob/Gyn** – Female members have direct access to the participating primary Ob/Gyn provider of their choice and do not need a referral from their PCP for a routine well-woman exam, including a Pap smear when appropriate and an unlimited number of visits for gynecologic problems and follow-up care.
- **Dermatologist** – You have direct access to the participating dermatologist provider of your choice and do not need a referral from your primary care physician(s) to access dermatologic benefits covered under your health plan.

Kentucky
Participating primary chiropractic providers – If you live in Kentucky, you have direct access to the participating primary chiropractic provider of your choice. You do not need a referral from your PCP to access chiropractic benefits covered under your benefits plan.

North Carolina
Ob/Gyn – Any female member 13 years or older may visit any participating gynecologist for a routine well- woman exam, including a Pap smear when appropriate and an unlimited number of visits for gynecologic problems and follow-up care.

Tennessee
Routine Vision Care – You are covered for routine vision exams from participating providers without a referral from your PCP. Copayments may apply. For routine eye exams, you can visit a participating optometrist or ophthalmologist without a referral, once every 12 months. A contact lens fitting exam is not covered.

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. When you get care from a doctor in the Aetna network, your doctor gets precertification from us. But if you get your care outside our network, you must call us for precertification when that's required.

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. Even with precertification, you will usually pay more when you use out-of-network doctors,

Call the number shown on your Aetna ID card to begin the process. You must get the precertification before you receive the care.

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. 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 case 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.

Filing claims in Oklahoma

Aetna participating doctors and other health care providers will file claims for you. However, you may need to file a claim for covered out-of-network services. You can download and print a claim form at **www.aetna.com/individuals-families-health-insurance/document-library/find-document-form.html**. You can also call Member Services at the number on your ID card to ask for a form. The claim form includes complete instructions including what documentation to send with it.

We determine how and whether a claim is paid based on the terms and conditions of the health coverage plan and our internal coverage policies. See "Knowing what is covered" on page 8 to learn more about coverage policies.

Information about specific benefits

Emergency and urgent care and care after office hours

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

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

- Call 911 or go to the nearest emergency room. 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.

In **Kentucky**, the definition for Emergency Medical Condition is, *"A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson would reasonably have cause to believe constitutes a condition that the absence of immediate medical attention could reasonably be expected to result in: placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part; or with respect to a pregnant woman who is having contractions, a situation in which there is inadequate time to effect a safe transfer to another hospital before delivery; or a situation in which transfer may pose a threat to the health or safety of the woman or the unborn child."*

How we cover out-of-network emergency care

You are covered for emergency and urgently needed care. You have this coverage while you are traveling or if you are near your home. That includes students who are away at school. When you need care right away, go to any doctor, walk-in clinic, urgent care center or emergency room.

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.

Your plan pays out-of-network benefits when you choose to get care out of network. When you have no choice (for example: emergency room visit after a car accident), we will pay the bill as if you got care in network. You pay your plan's copayments, coinsurance, and deductibles for your in-network level of benefits. Under federal health care reform (Affordable Care Act), the government will allow some plans an exception to this rule. Contact Aetna if your provider asks you to pay more. We will help you determine if you need to pay that bill.

After-hours care – available 24/7

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.

Prescription drug benefit

Check your plan documents to see if your plan includes prescription drug benefits.

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 list shows which prescription drugs are covered on a preferred basis. It also explains how we choose medications to be on the list.

When you get a drug that is not on the preferred drug list, 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.

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.

Drug company rebates
Drug companies may give us rebates when our members buy certain drugs. We may share those rebates with your employer. Rebates usually apply to drugs on the preferred drug list. They may also apply to drugs not on the list. 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 on the preferred drug list than for a drug not on the list.

Mail-order and specialty-drug services from Aetna-owned pharmacies
Mail-order 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 list
Sometimes your doctor might recommend a drug that's not on the preferred drug list. If it is medically necessary for you to use that drug, you, someone helping you or your doctor can ask us to make an exception. Your pharmacist can also ask for an exception for antibiotics and pain medicines. Check your plan documents for details.

You may have to try one drug before you can try another
Step therapy means you have to try one or more drugs before a "step-therapy" drug will be covered. The preferred drug list includes step-therapy drugs. Your doctor might want you to skip one of these drugs for medical reasons. If so, you, someone helping you or your doctor can ask for a medical exception. Your pharmacist can also ask for an exception for antibiotics and pain medicines.

Some drugs are not covered at all
Prescription drug plans do not cover drugs that don't need a prescription. Your plan documents might also list specific drugs that are not covered. You cannot get a medical exception for these drugs.

New drugs may not be covered
Your plan may not cover drugs that we haven't reviewed yet. You, someone helping you or your doctor may have to get our approval to use one of these new drugs.

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

Mental health and addiction benefits

You must use therapists and other mental health professionals who are in the Aetna network. Here's how to get 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.
- Employee Assistance Program (EAP) professionals can also help you find a mental health specialist.

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

Mental health programs to help prevent depression
Aetna Behavioral Health offers two prevention programs for our members:

- Beginning Right® Depression Program: Perinatal Depression Education, Screening and Treatment Referral and
- SASDA: Identification and Referral of Substance Abuse Screening for Adolescents with Depression and/or Anxiety Prevention

Call Member Services for more information on either of these prevention programs. Ask for the phone number of your local Care Management Center.

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

Notice regarding Women's Health and Cancer Rights Act of 1998

Coverage will be provided to a person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy for:

- All stages of reconstruction of the breast on which a mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of all stages of mastectomy, including lymph edemas

We will talk to you and your doctor about these rules when we provide the coverage. We will also follow your plan design. For example, the following may apply to your breast reconstruction benefits as outlined in your plan design:

- Limitations
- Copays
- Deductibles
- Referral requirements

If you have any questions about this coverage, please contact the Member Services number on your ID card.

Also, you can visit the following websites for more information:

U.S. Department of Health and Human Services – **http://cciio.cms.gov/programs/protections/WHCRA/whcra_factsheet.html**

U.S. Department of Labor – **www.dol.gov/ebsa/consumer_info_health.html**

Oklahoma Breast Cancer Patient Protection Act
The Oklahoma Breast Cancer Patient Protection Act requires plans to provide the following benefits:

- For members who receive benefits for a medically necessary mastectomy the plan must also cover at least 48 hours of inpatient care after the mastectomy, unless the member and attending doctor determine that a shorter hospital stay is appropriate.
- For members who receive a lymph node dissection, the plan must cover at least 24 hours of inpatient care after the lymph node dissection, unless the member and attending doctor determine that a shorter hospital stay is appropriate.
- For members who receive benefits for a medically necessary partial or total mastectomy, the plan must cover reconstructive breast surgery performed as a result of the mastectomy, except as prohibited by federal laws or regulations pertaining to Medicaid. When the reconstructive surgery is performed on a diseased breast, the plan will cover all stages of reconstructive surgery performed on a nondiseased breast to establish symmetry with the diseased breast. Adjustments made to the nondiseased breast must occur within 24 months of reconstruction of the diseased breast.

Other state-mandated benefits
West Virginia legislation mandates that group insurance policies and contracts that provide coverage for prescription drugs must include a rider providing coverage for contraceptive drugs and devices that are approved by the FDA or generics approved as substitutes by the FDA. However, "religious employers," as defined in the law, may elect not to include this coverage under their policy or contract. If a religious employer elects not to provide coverage for contraceptives, each member/enrollee covered under the contract is eligible to obtain a contraceptive rider directly from Aetna. Please refer to your plan administrator for specifics regarding your benefits.

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.

Knowing what is covered

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. Or it might be to treat an injury or illness.

The product or service:

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

Only medical professionals can 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.

Iowa
"Coverage decision" means a final adverse decision based on medical necessity. This definition does not include a denial of coverage for a service or treatment specifically listed in plan or evidence of coverage documents as excluded from coverage, or a denial of coverage for a service or treatment that has already been received and for which the enrollee has no financial liability.

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 Health Care Research and Quality.
- Ask experts.
- Check how often and how successfully it has been used.

We publish our decisions in our Clinical Policy Bulletins.

We post our findings on www.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.

We can help when more serious care is recommended

We may review a request for coverage to be sure the service is in line with recognized guidelines. Then we follow up. We call this "utilization management review."

It's a three step process:

First, we begin this process if your hospital stay lasts longer than what was approved. We make sure it is necessary for you to be in the hospital. We look at the level and quality of care you are getting. (In **South Dakota**, "concurrent review" is defined as a utilization review conducted during a patient's hospital stay or course of treatment in a facility or other inpatient or outpatient health care setting.)

Second, we begin planning your discharge. This process can begin at any time. We look to see if you may benefit from any of our programs. We might have a nurse case manager follow your progress. Or we might recommend that you try a wellness program after you're home.

Third, we may review your case after your discharge. We may look over your medical records and claims from your doctors and the hospital. We look to see that you got appropriate care. We also look for waste or unnecessary costs.

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

- 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 claims. Physician's groups, such as independent practice associations, may use other resources they deem appropriate.

What to do if you disagree with us

Complaints, appeals and external review

Please tell us if you are not satisfied with a response you received from us or with how we do business.

Call Member Services to file a verbal complaint or to ask for the address to mail a written complaint. The phone number is on your Aetna ID card. You can also e-mail Member Services through the secure member website.

If you're not satisfied after talking to a Member Services representative, you can ask us to send your issue to the appropriate department.

If you don't agree with a denied claim, you can file an appeal. To file an appeal, follow the directions in the letter or explanation of benefits statement that explains that your claim was denied. The letter also tells you what we need from you and how soon we will respond.

Get a review from someone outside Aetna

If the denial is based on a medical judgment, you may be able to get an outside review if you're not satisfied with your appeal. Follow the instructions on our response to your appeal. Call Member Services to ask for an External Review Form. You can also visit **www.aetna.com**. Enter "external review" into the search bar.

You can get an outside review for most claims. If the reason for your denial is that you are no longer eligible for the plan, you may not be able to get an outside review.

Some states have a separate external review process. These state processes can vary from state to state. You may even need to pay a filing fee as part of the state mandated program.

If your state does not have a separate external review process, then you would follow the federal external review process. Most claims are allowed to go to external review. An exception would be if you are denied because you're no longer eligible for the plan.

An Independent Review Organization (IRO) will assign your case to an outside expert. The expert will be a doctor or other professional who specializes in that area or type of appeal. You should have a decision within 45 calendar days of the request.

The outside reviewer's decision is final and binding; we will follow the outside reviewer's decision. We will also pay the cost of the review.

A "rush" review may be possible

If your doctor thinks you cannot wait 45 days, ask for an "expedited review." That means we will make our decision as soon as possible.

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. This includes our Member Rights and Responsibilities.

Some of your rights are below. We also publish a list of rights and responsibilities on our website. Visit **www.aetna.com**. Click on "Rights & Resources" on the home page to view the list. You can also call Member Services at the number on your ID card to ask for a printed copy.

Making medical decisions before your procedure

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

There are three types of advanced 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 advanced directive in several ways:

- Ask your doctor for an advanced directive form.
- Pick up a form at state or local offices on aging, bar associations, legal service programs or your local health department.
- Work with a lawyer to write an advanced directive.
- Create an advanced directive using computer software designed for this purpose.

Source: American Academy of Family Physicians. Advanced 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 April 2, 2013.

Learn about our 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. See "Contact Us" on page 3.

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 about your physical or mental health
- Information about the health care you receive
- Information about what your health care costs

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
- Those who pay for your health care services. That can include health care provider organizations and employers who fund their own health plans or who share the costs
- Other insurers
- Vendors
- Government authorities
- Third party administrators

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 health plans. If allowed by law, we usually will not ask if it's okay to use your information. However, we will ask for your permission to use your information for marketing purposes. We have policies in place if you are unable to give us permission to use your information. We are required to give you access to your information. You may also request corrections to your personal information. We must fulfill your requests within a reasonable amount of time.

If you'd like a copy of our privacy policy, call the toll-free number on your ID card or visit us at **www.aetna.com**.

Anyone can get health care

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

We must comply with these laws:

- Title VI of the Civil Rights Act of 1964
- Age Discrimination Act of 1975
- Americans with Disabilities Act
- Laws that apply to those who receive federal funds
- 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 or if your employer stops contributing to the cost. This includes enrolling your spouse or children and other dependents. If that happens, you must apply within 31 days after your coverage ends (or after the employer stops contributing to the other coverage).

Getting proof that you had previous coverage

We may ask for proof that you had previous coverage when you apply. Other insurers may do the same. This helps determine if you are eligible for the plan. Your plan sponsor may have contracted with us to issue a certificate. Ask us for a Certificate of Prior Health Coverage anytime you want to check the status of your coverage. If you lost your coverage, you have 24 months to make this request. Just call Member Services at the toll-free number on your ID card.

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 31 days after a life event if you chose not to enroll during the normal open enrollment period. Life events include:

- Marriage
- Birth
- Adoption
- Placement for adoption

Talk to your benefits administrator for more information or to request special enrollment.

Consumer Choice Option – Georgia

The Consumer Choice Option is available for Georgia residents enrolled in certain Aetna managed care plans. Under this option, with certain restrictions required by law and an additional monthly premium cost, members of certain Aetna managed care plans may nominate an out-of-network health care provider to provide covered services, for themselves and their covered family members. The out-of-network provider you nominate must agree to accept the Aetna compensation, to adhere to the plan's quality assurance requirements, and to meet all other reasonable criteria required by the plan of its in-network participating providers

It is possible the provider you nominate will not agree to participate. If the out-of-network provider you nominate agrees to participate, your benefits and any applicable copayments will be the same as for in-network providers. It will be available for an increased premium in addition to the premium you would otherwise pay. Your increased premium responsibility will vary depending on whether you have a single plan or family coverage, and on the type of insurance, riders, and coverage. Call **1-800-433-6917** for exact pricing and other information. Please have your Aetna member ID card available when you call.

Nondiscrimination for genetic testing

Aetna will not in any way use the results of genetic testing to discriminate against applicants or enrollees.

Hawaii Informed Consent

You have the right to be fully informed before making any decision about any treatment, benefit, or nontreatment. Your provider will:

- Discuss all treatment options, including the option of no treatment at all
- Ensure that persons with disabilities have an effective means of communication with the provider and other members of the managed care plan
- Discuss all risks, benefits, and consequences of treatment and nontreatment Your provider will also discuss with you and your immediate family both living wills and durable powers of attorney in relation to medical treatment.

More information is available

Georgia
A summary of any agreement or contract between Aetna and any health care provider will be made available upon request by calling the Member Services telephone number listed on your ID card. The summary will not include financial agreements as to actual rates, reimbursements, charges, or fees negotiated by Aetna and the provider. The summary will include a category or type of compensation paid by Aetna to each class of health care provider under contract with Aetna.

Illinois
Illinois law requires health plans to provide the following information each year to enrollees and to prospective enrollees upon request:

- A complete list of participating health care providers in the health care plan's service area
- A description of the following terms of coverage:
  1. The service area
  2. The covered benefits and services with all exclusions, exceptions and limitations
  3. The precertification and other utilization review procedures and requirements
  4. A description of the process for the selection of a PCP, any limitation on access to specialists, and the plan's standing referral policy
  5. The emergency coverage and benefits, including any restrictions on emergency care services
  6. The out-of-area coverage and benefits, if any
  7. The enrollee's financial responsibility for copayments, deductibles, premiums, and any other out-of-pocket expenses
  8. The provisions for continuity of treatment in the event a health care provider's participation terminates during the course of an enrollee's treatment by the provider
  9. The appeals process, forms, and time frames for health care services appeals, complaints, and external independent reviews, administrative complaints, and utilization review complaints, including a phone number to call to receive more information from the health care plan concerning the appeals process

10. A statement of all basic health care services and all specific benefits and services to be provided to enrollees by a state law or administrative rule

- A description of the financial relationship between the health plan and any health care provider, including, if requested, the percentage of copayments, deductibles, and total premiums spent on health care related expenses and the percentage of copayments, deductibles and total premiums spent on other expenses, including administrative expenses.

Kansas

Kansas law permits you to have the following information upon request: (1) a complete description of the health care services, items and other benefits to which you are entitled in the particular health plan which is covering or being offered to you; (2) a description of any limitations, exceptions or exclusions to coverage in the health benefit plan, including prior authorization policies, restricted drug formularies or other provisions that restrict your access to covered services or items; (3) a listing of the plan's participating providers, their business addresses and telephone numbers, their availability, and any limitation on your choice of provider; (4) notification in advance of any changes in the health benefit plan that either reduces the coverage or increases the cost to you; and (5) a description of the grievance and appeal procedures available under the health benefit plan and your rights regarding termination, disenrollment, nonrenewal or cancellation of coverage. If you are a member, contact Member Services by calling the toll-free number on your ID card to ask for more information. If you are not yet an Aetna member, contact your plan administrator.

Kentucky

Kentucky law requires Aetna to provide, upon enrollment and upon request, the following information: (1) a current participating provider directory with information on access to primary care providers and available providers; (2) general information on the type of financial incentives between contracted participating providers including any incentives and bonuses; and (3) our standard customary waiting times for appointments for urgent and routine care. Additionally, upon request, we will make available information about the provider network, including hospital affiliations and whether a particular network provider is board certified and whether a provider is currently accepting new patients. Members may contact Member Services at the toll-free number on their ID card for more information; all others contact your benefits administrator.

North Carolina

Procedures and medically based criteria for determining whether a specified procedure, test or treatment is experimental, are available upon request.

Rhode Island

Prospective and existing members can access the Consumer Disclosure Guide to Health Plans and the Consumer Right to Know about Health Plans documents at **www.aetna.com/products/member_disclosure.html**, or by calling **1-888-982-3862** to request a paper copy.

Aetna is committed to Accreditation by the National Committee for Quality Assurance (NCQA) as a means of demonstrating a commitment to continuous quality improvement and meeting customer expectations. A complete listing of health plans and their NCQA status can be found on the NCQA website located at **reportcard.ncqa.org**.

To refine your search, we suggest you search these areas: Managed Behavioral Healthcare Organizations – for behavioral health accreditation; Credentials Verification Organizations – for credentialing certification; Health Insurance Plans – for HMO and PPO health plans; Physician and Physician Practices – for physicians recognized by NCQA in the areas of heart/stroke care, diabetes care, back pain and medical home. Providers who have been duly recognized by the NCQA Recognition Programs are annotated in the provider listings section of the Aetna provider directory.

Providers, in all settings, achieve recognition by submitting data that demonstrates they are providing quality care. The program constantly assesses key measures that were carefully defined and tested for their relationship to improved care; therefore, NCQA provider recognition is subject to change.

Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice.

Aetna does not provide care or guarantee access to health services. For up-to-date information, please visit our DocFind® directory at **www.aetna.com** or, if applicable, visit the NCQA's new top-level recognition listing at **recognition.ncqa.org**.

If you need this material translated into another language, please call Member Services at 1-800-323-9930.
Si usted necesita este material en otro lenguaje, por favor llame a Servicios al Miembro al 1-800-323-9930.

www.aetna.com

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