Important information about your health benefits – Washington

For: Quality Point of Service® (QPOS®) and Managed 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 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 benefits.

Where to find information about your specific plan
Your plan documents list all the details for your plan. Such as, what's covered, what's not covered and the specific amounts you will pay for services. Plan document names vary. They may include a Booklet-certificate, Group Agreement and Group Insurance Certificate, Group 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.

Specific details of the Aetna plan offered by your employer are also provided in pre-enrollment materials. This document is available to any member of the general public upon request and on our public website at **www.aetna.com**.

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

www.aetna.com

Getting help

Contact us

Member Services can help with your questions. To contact Member Services, call the toll-free number on your ID card. 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 on.

Member Services can help you:

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

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

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

Language hotline – **1-888-982-3862** *(140 languages are available. You must 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)*

You can request the following information to help you understand your plan

Washington law requires us to provide certain information to you, upon request. You can find some of this information within this document. Otherwise, if you are a member, contact Member Services at the toll-free number on your ID card. All others, contact your benefits administrator.

You may request the following information about your plan:

- A listing of covered benefits, including:
  - Prescription drug benefits, if any
  - A copy of the current formulary, if any is used
  - Definitions of terms such as generic versus brand name
  - Policies on the coverage of drugs, such as how they become approved or taken off the formulary
  - How consumers may be involved in decisions about benefits
- A list of exclusions, reductions and limitations to covered benefits, and an explanation of how we determine what to cover
- A statement of how we protect your privacy
- A statement of what you pay in premiums and out of pocket when you receive covered services
- A summary explanation of how to file a complaint or to appeal a denial of a claim
- A statement about the availability of a point-of-service option, if any, and how the option operates
- A convenient means to get a list of our participating primary care and specialty care providers, including disclosure of network arrangements that restrict access to providers within the plan's network

Also, upon request, we will provide written information about any health benefits plan we offer including the following written information:

- Any documents, instruments, or other information referred to in the medical coverage agreement
- A full description of the procedures you must follow for consulting a health care provider other your primary care provider (for example, whether you need to get a referral) and whether your primary care provider, our medical director or anyone else must authorize the referral
- Procedures, if any, that you must first follow to get prior authorization (or precertification) for health care services

- A written description of how we pay health care providers, including, but not limited to, capitation provisions, fee-for-service provisions and health care delivery efficiency provisions, between Aetna and a provider or network
- Descriptions and justifications for provider compensation programs, including any incentives or penalties that are intended to encourage providers to withhold services or minimize or avoid referrals to specialists
- An annual accounting of all payments we have made that have been counted against any payment limitations, visit limitations or other overall limitations on your coverage under the plan
- Our accreditation status with one or more national managed care accreditation organizations, and whether we track our health care effectiveness performance using the health employer data information set (HEDIS), whether we publicly report our HEDIS data and how interested persons can access the HEDIS data

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 you generally pay less out of pocket when you visit doctors, hospitals, labs and other health care providers who are in our network.

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

- Log on 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.
- Or, call us at the toll-free number on your Aetna ID card. If you don't have your card, you can call us at **1-888-87-AETNA (1-888-872-3862).**

For up-to-date information about how to find inpatient and outpatient services, partial hospitalization and other behavioral health care services, please follow the instructions above. If you do not have Internet access and would like a printed list of providers, please contact Member Services at the toll-free number on your Aetna ID card to ask for a copy.

Our online directory is more than just a list of doctor's names and addresses. It also includes information about where the physician attended medical school, board certification status, language spoken, gender and more. You can even get driving directions to the office. If you don't have Internet access, you can call Member Services to ask about this information.

Provider credentialing
Doctors and other health care providers who want to be part of the Aetna network must meet our high standards before we will accept them. For example, prospective PCPs must comply with more than two dozen criteria before they are certified and accepted.

These criteria include:

- License and malpractice insurance
- Hospital privileges
- Provision of continuous, comprehensive care
- Emergency coverage
- Office appearance, cleanliness and equipment
- Organization of medical records
- Participation in continuing medical education programs

These providers are evaluated regularly for continued compliance with our criteria. This process includes a review of provider performance, office environment, patient charts, member surveys and member complaints. Results are submitted to a peer committee composed of physicians before participation is continued. Hospitals and ancillary providers are also reviewed for quality and appropriateness of care.

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 fixed amount (for example, $15) you pay for a covered health care service. You usually pay this when you receive the service. The amount can vary by the type of service. For example, the copay for your primary doctor's office visit may be different than a specialist's office visit.
- Coinsurance – Your share of the costs of a covered service. Coinsurance is calculated as 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 – Some plans include a deductible. The amount you owe for health care services before your health plan begins to pay. For example, if your deductible is $1,000, your plan won't pay anything until you have paid $1,000 for any covered health care services that are subject to the deductible. The deductible may not apply to all services. Other deductibles may apply at the same time:
  - Inpatient Hospital Deductible – This deductible applies when you are a patient in a hospital.
  - Emergency Room Deductible – 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.

The Inpatient Hospital and Emergency Room Deductibles are separate from your general deductible. For example, your plan may have an overall $1,000 deductible and also has a $250 Emergency Room Deductible. This means that 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.

Your costs when you don't get a referral or you go outside the network
With the Managed Choice plan you may choose a doctor who participates in our network, with or without a PCP referral. You may choose to visit an out-of-network doctor. We cover the cost of care based on your choices.

"Nonreferred/nonpreferred" benefits – You must get a PCP referral to in-network doctors to receive the highest level of benefits for specialty care. (See the "Referrals" section for more about this.) If you don't get a referral, your benefit will be paid at the "nonreferred" or "nonpreferred" level. This is the same level of benefits as if you went to an out-of-network doctor.

"Out of network" – This means you went outside the network for your health care. These benefits will be paid at the "nonreferred/nonpreferred" benefit level. But you may also pay more than your normal share of the cost. "Out of network" means that we do not have a contract for discounted rates 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 higher — sometimes much higher — than what your Aetna plan "recognizes" or "allows." Your doctor may bill you for the dollar amount that Aetna doesn't "recognize." You must also pay any copayments, coinsurance and deductibles under your plan. No dollar amount above the "recognized charge" counts toward your deductible or out-of-pocket limits.

This means that you are fully responsible for paying everything above the amount that Aetna allows for a service or procedure.

How we pay doctors in our network
We pay doctors who participate in the Aetna network on a discounted fee-for-service basis. That amount may be less than the doctor's normal charge. Your coinsurance amount, however, will be based on the discounted rate.

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, Aetna pays for your health 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. See "Emergency and urgent care and care after office hours" for more.

Going to your PCP just makes sense!

- You'll get the highest level of benefits at negotiated discounted rates.
- 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.

Choose a primary care physician (PCP)

With a Managed Choice plan, you are covered at different levels depending on whether you visit your chosen primary care provider (PCP), or if you go directly to any licensed physician without seeing your PCP first.

Your PCP can coordinate all your health care. If it's an emergency, you don't have to call your PCP first. 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.

If you visit any licensed physician without going to your PCP first, your out-of-pocket costs are generally higher.

A female member may choose an Ob/Gyn as her 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. They will issue referrals to other doctors (if your plan requires referrals) and they will get all required approvals and comply with any preapproved treatment plans. See the sections about referrals and precertification for more about those requirements.

Tell us who you chose to be your PCP
You may choose a different PCP from the Aetna network for each member of your family. Enter the name of the PCP you have chosen on your enrollment form. Or, call Member Services after you enroll to tell us your selection. The name of your PCP will appear on your Aetna ID card. You may change your selected PCP at any time. If you change your PCP, you will receive a new ID card.

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

To receive the highest level of benefits under the plan, you will need to get a referral from your PCP before you can see a network specialist.

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, the plan will pay for the service at the lower benefits level.
- Your specialist might recommend treatment or tests that were not on the original referral. In that case, you may need to get another referral from your PCP for those services.
- Women can go to an Ob/Gyn without a referral. See **"PCP and referral rules for Ob/Gyns"** below.
- Referrals are valid for one year as long as you are still a member of the plan. Your first visit must be within 90 days of the referral issue date.
- You can get a special referral to go outside the network if a network specialist is not available for your health care needs. With a special referral, your covered expenses will be paid at the highest benefits level.

Referrals within physician groups
Some PCPs are part of a larger group of doctors. These PCPs will usually refer you to another doctor within that same group. If this group cannot meet your medical needs, you can ask us for a coverage exception to go outside this group. You may also need to precertify these services. And you may need permission from the physician group as well.

PCP and referral rules for Ob/Gyns

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

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

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." Precertification is usually limited to more serious care like surgery or being admitted to a hospital or skilled nursing facility. When you get care from a doctor in the Aetna network, your doctor takes care of precertification. 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 the precertification. If you don't, you will have to pay for all or a larger share of the cost of the service. Even with precertification, if you receive services from an out-of-network provider, you will usually pay more.

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

Precertification is not required for emergency services.

What we look for when reviewing a precertification request
First, we check to see that you are still a member. And we make sure the service is considered medically necessary for your condition. We also check that the service and place requested to perform the service is cost effective. If we know of a treatment or place of service that is just as effective but costs less, we may talk to you or your doctor about it. We also look to see if you qualify for one of our case management programs. If so, one of our nurses may call to tell you about it and help you understand your upcoming procedure.

Precertification does not, however, verify if you have reached any plan dollar limits or visit maximums for the service requested. That means precertification is not a guarantee that the service will be covered.

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 a delay would not risk your health, call your doctor or PCP.
- Tell your doctor or PCP as soon as possible afterward. A friend or family member may call on your behalf.
- Emergency care services do not require precertification.

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.

Follow-up care with your 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 take out stitches, remove a cast or take another set of X-rays to see if you've healed. To be sure you get the highest benefit level, you will need a referral for follow-up care that is not performed by your PCP. You may also need to precertify the services if you go outside the network.

After-hours care — available 24/7
Call your doctor anytime if you have medical questions or concerns. Your doctor should have an answering service if you call after the office closes. You can also go to an urgent care center, which may have limited hours. To find a center near you, log on to **www.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 them. You'll not only pay your normal share of the cost, 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, you usually will pay more. Check your plan documents to see how much you will pay. If your plan has an "open formulary," that means you can use those drugs, but you'll pay the highest copay under the plan. If your plan has a "closed formulary," those drugs are not covered.

Drug Manufacturer Rebates
Drug manufacturers may give us rebates when our members buy certain drugs. While those rebates mostly apply to drugs on the Preferred Drug List, they may also apply to drugs not on the Preferred Drug List. But, in any case, in plans where you pay a percent of the cost, your share of the cost is based on the price of the drug before any rebate is received by Aetna.

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.

How we determine what you pay
Our pharmacy benefit manager (PBM) subcontractor negotiates discounts with independent pharmacies, chain pharmacies and mail vendors who accept negotiated reimbursement rates for dispensing and ingredient costs. The reimbursement formula can be based on average wholesale price (AWP) less a negotiated discount, plus a dispensing fee. The negotiated rate continues to apply until it is changed contractually. If your plan requires you to pay a percent coinsurance amount, that percent is based on the negotiated amount between Aetna and our PBM subcontractor, which may or may not be the same as the negotiated amount paid to the participating provider by the PBM subcontractor. Your coinsurance amount is not based on a participating provider's billed charges.

Mail-order and specialty-drug services are from Aetna-owned pharmacies
Aetna Rx Home Delivery® and Aetna Specialty Pharmacy® are pharmacies that Aetna owns. These pharmacies are for-profit entities.

You might not have to stick to the list
If it is medically necessary for you to use a drug that's not on your plan's preferred drug list, you or your doctor (or pharmacist in the case of antibiotics and pain medicines) can ask us to make an exception. 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 "prerequisite" 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 or your doctor (or pharmacist in the case of antibiotics and pain medicines) can ask for a medical exception.

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 or your doctor may have to get our approval to use one of these new drugs.

Get a copy of the preferred drug list
The Aetna Preferred Drug Guide is posted to our website at **www.aetna.com/formulary/.** If you don't use the Internet, you can ask for a printed copy. Just call Member Services at 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.

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

Prescription drug definitions

- Brand-Name Prescription Drug(s) – A prescription drug that is protected by trademark registration.
- Medication Formulary – Also called the Aetna "preferred drug list," the formulary is a listing of prescription drugs that have been evaluated and selected by Aetna clinical pharmacists for their therapeutic equivalency and efficacy. This listing includes both brand-name drugs and generic drugs and is subject to periodic review and modification by Aetna.
- Generic Prescription Drug(s) – A prescription drug that is not protected by trademark registration, but is produced and sold under the chemical formulation name.
- Prescription Drugs – Any of the following:
  - A drug, biological, or compounded prescription which, by federal law, may be dispensed only by prescription and that is required to be labeled "Caution: Federal law prohibits dispensing without prescription"
  - Injectable insulin
  - Disposable needles and syringes that are purchased to administer insulin
  - Disposable diabetic supplies
- Precertification Program – For certain outpatient prescription drugs, your prescribing doctor must contact us to request and obtain coverage for such drugs. Our list of drugs requiring precertification is subject to change. You can get an updated copy of the list of drugs requiring precertification by calling Member Services at the number on your Aetna ID card.
- Step Therapy Program – A form of precertification where certain prescription drugs will be excluded from coverage, unless a first-line therapy drug(s) is used first. Our list of step-therapy drugs is subject to change. You can get an updated copy of the list of drugs subject to step therapy by calling Member Services at the number on your Aetna ID card.

What's not covered under the prescription drug benefit
Does this plan limit or exclude certain drugs my health care provider may prescribe, or encourage substitutions for some drugs?

All prescription drug plans contain limitations and exclusions on the type of drugs that are covered. Depending on the plan design, the following are examples

of some of the types of limitations that may apply. In general, coverage is not provided for charges related to the following:

- A device of any type unless specifically included as a prescription drug. For example, prescription contraceptive devices are covered as prescription drugs.
- Any drug entirely consumed at the time and place it is prescribed
- Less than a 30-day supply or 90-unit doses of any drug dispensed by a mail-order pharmacy
- More than a 30-day supply or 90-unit doses per prescription or refill. However, this limitation does not apply to a supply of up to 90 days per prescription or refill for drugs that are provided by a mail-order pharmacy.
- The administration or injection of any drug
- Any refill of a drug if it is more than the number of refills specified by the prescriber. Before recognizing charges, we may require a new prescription or evidence as to need:
  - If the prescriber has not specified the number of refills
  - If the frequency or number of prescriptions or refills appears excessive under accepted medical practice standards
- Any refill of a drug dispensed more than one year after the latest prescription for it or as permitted by the law of the jurisdiction in which the drug is dispensed
- Any drug provided by or while the person is an inpatient in any health care facility; or for any drug provided on an outpatient basis in any health care facility to the extent benefits are paid for it under any other part of this plan or under any other medical or prescription drug expense benefit plan carried or sponsored by your employer
- Immunization agents
- Biological sera and blood products
- Vitamins
- Nutritional supplements
- Any fertility drugs
- A prescription drug dispensed by a mail-order pharmacy that is not a preferred pharmacy

Precertification program

Your pharmacy benefits plan may include our precertification program. Precertification helps encourage the appropriate and cost-effective use of certain drugs. It is your responsibility to arrange for your health care provider to call the number shown on your ID card to request certification. This call must be made as soon as reasonably possible before the drug is to be dispensed. Copies of laboratory and/or medical records may be requested. If such information is requested, it must be provided in order to certify the necessity of the drug. Refer to the Precertification List in the Aetna Medication Formulary Guide to determine which prescription drugs require precertification. The precertification list is subject to periodic review and modification by Aetna. The precertification program is based on current medical findings, manufacturer labeling, FDA guidelines and cost information. For these purposes, cost information includes any rebate arrangements between Aetna and manufacturers for the benefit of Aetna. The drugs requiring precertification are subject to change. Visit our website at **www.aetna.com** for the current precertification list. Please refer to your Prescription Drug Rider to see if precertification applies to your plan.

To be covered, drugs that require precertification must be authorized by Aetna before they are dispensed. Coverage will not be authorized if you pay your pharmacist for a prescription and then request precertification for the drug. If your physician or pharmacist did not receive advance approval, and you pay the full cost of the medication, you will not be reimbursed for the cost of the drug.

Step-therapy program:

This program is a different form of precertification. Under the step-therapy program, certain drugs are not covered unless you have tried one or more "prerequisite therapy" medication(s) first. However, if it is medically necessary for you to use a step-therapy medication as initial therapy without trying a "prerequisite therapy" drug, your doctor can contact us to request coverage of the step-therapy medication as a medical exception.

Changes to the approved drug list

When can my plan change the approved drug list (formulary)? If a change occurs, will I have to pay more to use a drug I had been using?

Since we are regularly evaluating both new and existing therapies, our formulary is subject to change. We encourage the use of generic drugs when appropriate. The Food and Drug Administration (FDA) has deemed that generic drugs are therapeutically equivalent to brand-name drugs. Generic drugs must contain the same active ingredients in the same amounts as their brand-name counterparts. Also, the same FDA quality and safety standards apply to generic drugs and brand-name drugs.

Furthermore, generic drugs may help lower your health care expenses. Under some Aetna prescription drug benefit plans, members pay a lower copayment if they choose generic drugs over brand-name medications. Until the (APTC) reviews a new brand-name FDA-approved drug and Aetna makes a formulary determination, it will not be listed on the formulary.

Under closed formulary plans, such drugs will require your health care provider to obtain a medical exception. For open formulary plans, the new drug will be covered at the highest copay.

During the calendar year, deletions to the formulary may occur either by a drug being removed from the marketplace by a federal directive or if an FDA-approved generic formulation of a brand-name formulary drug becomes commercially available. When a new generic drug becomes commercially available, we may remove the brand-name formulary drug from the formulary and place the generic drug on the formulary instead. For most prescription plan options, this change would mean that you would receive the generic drug at a lower copay than you previously paid for the brand-name drug. Under some plan options, you would be required to pay a higher copay to continue using the brand-name drug, and/or your provider might have to obtain a medical exception for coverage for your continued use of the brand-name drug.

Requesting coverage for excluded drugs
What should I do if I want a change from limitations, exclusions, substitutions or cost increases for a drug specified in this plan?

If you have a pharmacy benefit plan with a closed formulary and it is medically necessary for you to use a drug that is on the Drug Formulary Exclusion List, your provider (or pharmacist in the case of antibiotics and analgesics) may contact the Pharmacy Management Precertification Unit via fax at **1-800-408-2386** or by calling the unit at **1-800-414-2386** to request coverage of a drug on the Drug Formulary Exclusions List as a medical exception. If your pharmacy benefit plan includes the precertification or step-therapy program and it is medically necessary for you to use a drug on the precertification or step-therapy lists, your provider should contact Aetna to request a medical exception. We will respond to complete exception requests within 24 hours of receipt. In urgent or emergent situations providers may request same business day response. Coverage granted as a result of a medical exception will be based on an individual case-by-case medical necessity determination and coverage will not apply or extend to other members.

Clinical Policy Bulletins (CPB) detail general criteria used in determining medical exceptions for many drugs. CPBs are available on our website, **www.aetna.com.** You may also contact Member Services at the number on your ID card to request the CPB for a specific drug, if one is available.

If we deny your provider's precertification request or medical exception request, you or your provider acting on your behalf may file an appeal (oral or written) according to the Appeal Procedures outlined in your plan documents.

You may contact Member Services at the toll-free number shown on your ID card to file an appeal. See "What to do if you disagree with us" in this disclosure brochure, or the "Appeal Procedures" in your Booklet-Certificate for more information about the appeal process.

Out-of-pocket costs for prescription drugs
How much do I have to pay to get a prescription filled?

Your out-of-pocket costs for prescription drugs, referred to throughout this section as "copayments" will vary depending on the type of plan your employer offers. Copayments may be a specific dollar amount or a percentage of the cost of the prescription drug (coinsurance). Copayment information for the plan(s) offered by your employer is included in your pre-enrollment information.

Where to buy prescription drugs
Do I have to use certain pharmacies to pay the least out of my own pocket under this health plan? How many days' supply of most medications can I get without paying another copay or other repeating charge?

- Participating retail pharmacies: With any Aetna prescription drug plan, you can fill your prescriptions easily at over 64,000* participating pharmacies nationally, including the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. Participating pharmacies in the state of Washington are listed in the pharmacy directory. You can also search our DocFind® directory at **www.aetna.com**.

  The maximum supply available from a participating retail pharmacy per copay is a 30-day supply. The maximum supply available per copayment from a participating mail-order pharmacy is a 90-day supply. Your prescription will indicate the number of refills your doctor has authorized. Any refill in excess of the amount indicated on the prescription will not be covered. If you need a supply greater than the maximum due to travel, your doctor may contact us to request an exception to the supply limitations. Additional copayments may apply to approved exceptions. Supply exception requests will be considered on an individual-case basis. Before filling prescriptions, we may require a new prescription or evidence of need if a prescription or refill appears excessive under accepted medical practice standards.

  Prescription orders filled before the effective date or after the termination date of your eligibility will not be covered. Replacement for lost or stolen prescriptions will not be covered. Always present your Aetna ID card at a participating pharmacy. This will help ensure that you will only be required to pay the appropriate amount under your benefits plan. Please keep in mind that if

* Aetna Enterprise Provider Database as of March 1, 2011

you get your prescription filled at a participating pharmacy and don't present your ID card, but rather pay for the prescription and submit a claim for reimbursement, you may not be reimbursed the full amount you paid. For instance, we will deduct from your reimbursement your copay amount, and depending on your plan design, we may reimburse you at the pharmacy's contracted rate, which may be less than the amount you paid out-of-pocket, or we may deny your claim altogether.

- Nonparticipating retail pharmacies: You may also fill your prescriptions at nonparticipating pharmacies. Bring your prescription and your Aetna ID card to a nonparticipating pharmacy and pay the full cost of the drug. You may then submit a claim form for reimbursement. However, because you did not use a participating pharmacy, under most benefit plans you will not be reimbursed the full cost of the drug. To receive the reimbursement, you need to submit a claim form and the prescription receipt.

  In an emergency or urgent care situation, you can fill your prescription at a nonparticipating pharmacy. The prescription drug charge for an emergency condition may be reimbursed at the preferred level of coverage. In this case, you will need to pay the pharmacy directly and submit a claim to Aetna for reimbursement under the terms of your plan. You may contact Member Services to order prescription drug claim forms or to submit emergency claims from a nonparticipating pharmacy.
- Mail-order prescriptions: Your prescription drug benefit may include mail-order delivery. You can order up to a 90-day supply of covered medications (if authorized by your physician) from a participating mail-order pharmacy. Medications most appropriate for mail order are those you take continuously, such as for the treatment of a chronic condition like arthritis, diabetes or heart disease. When it is time for a refill, you may call the mail-order pharmacy and place your request. For more information, please refer to your benefit plan documents or call the Member Services number on your ID card.

Other prescription drug services:
What other prescription drug services does my health plan cover?

Our prospective, concurrent, and retrospective drug utilization review (DUR) programs help promote safe and appropriate dispensing.

We provide:

- Support for disease management: We have programs to help physicians identify and risk stratify plan members who have a chronic disease such as asthma, congestive heart failure, diabetes or lower back pain.
- Aetna therapeutic interchange program (ATIP): The ATIP program is an educational program designed to help control the rising costs of prescription drugs and overall medical benefit expenses. Members are not required to switch prescription drugs as a result of this educational program.
- Support for case management: Our managed pharmacy program integrates with and complements the Aetna medical plan in support of case management for members who have long term or catastrophic illnesses.

The following information and services are available on our website at **www.aetna.com** or by calling Member Services at the number on your Aetna ID card:

- List of pharmacies that participate in the Aetna network:
- Formulary, precertification and step-therapy information: Users can inquire about a specific drug using the formulary search engine this site provides.
- Claim forms: Once you are a member, you can register for and link to your secure member website to print claim forms.

Your right to safe and effective pharmacy services
State and federal laws establish standards to assure safe and effective pharmacy services, and to guarantee your right to know what drugs are covered under this plan and what coverage limitations are in your contract. If you would like more information about the drug coverage policies under this plan, or if you have a question or concern about your pharmacy benefit, please contact us at **1-800-323-9930** or call the number on your ID card. If you would like to know more about your rights under the law, or if you think anything you received from this plan may not conform to the terms of your contract, you may contact the Washington State Office of Insurance Commissioner at **1-800-562-6900**. If you have a concern about the pharmacists or pharmacies serving you, please call the State Department of Health at **360-236-4825**.

Behavioral health and substance abuse benefits

Here's how to get behavioral health services

- Emergency services – call 911.
- Call the toll-free Behavioral Health number on your Aetna ID card.
- If no other number is listed, call Member Services.

- If you're using your employer's or school's EAP program, the EAP professional can help you find a behavioral health specialist.

If you are using your out-of-network benefits, you are responsible for getting precertification when required. You can access most outpatient therapy services without precertification. However, you should first consult Member Services to confirm that any such outpatient therapy services do not require precertification.

Read about behavioral health provider safety
We want you to feel good about using the Aetna network for behavioral 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.

Behavioral 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

For more information on either of these prevention programs and how to enroll in the programs, ask Member Services for the phone number of your local Care Management Center.

Breast reconstruction benefits

Notice regarding Women's Health and Cancer Rights Act
Under this health plan, as required by the 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:

(1) all stages of reconstruction of the breast on which a mastectomy has been performed;

(2) surgery and reconstruction of the other breast to produce a symmetrical appearance;

(3) prostheses; and

(4) treatment of physical complications of all stages of mastectomy, including lymph edemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be provided in accordance with the plan design, limitations, copays, deductibles, and referral requirements, if any, as outlined in your plan documents.

If you have any questions about our coverage of mastectomies and reconstructive surgery, please contact the Member Services number on your ID card.

For more information, you can visit this U.S. Department of Health and Human Services website, **www.cms.hhs.gov/HealthInsReformforConsume/06_TheWomen'sHealthandCancerRightsAct.asp** and the U.S. Department of Labor at: **www.dol.gov/ebsa/consumer_info_health.html.**

Transplants and other complex conditions

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

What's not covered

Aetna plans do not cover all health care expenses. Each plan has limitations and exclusions. You can find a complete list of these exclusions and limitations in the Booklet-Certificate.

In general, this plan does not cover charges for or related to:

- Services and supplies that we determine are not necessary for the diagnosis, care or treatment of the disease or injury involved. This applies even if they are prescribed, recommended, or approved by the attending doctor.
- Care, treatment, services or supplies that are not prescribed, recommended or approved by the person's attending doctor.
- Experimental or investigational services or supplies. This exclusion does not apply to services or supplies (other than drugs) received in connection with a disease if we determine that: the disease can be expected to cause death within one year, in the absence of effective treatment; and the care or treatment is effective for that disease or shows promise of being effective for that disease as demonstrated by scientific data. In making this determination we will take into account the results of a review by a panel of independent medical professionals that includes professionals who treat the type of disease involved. Also, this exclusion does not apply to drugs that: have been granted treatment investigational new drug (IND) or Group C/treatment IND status; or are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer

Institute; if Aetna determines that available scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease.

- Services, treatment, education testing or training related to learning disabilities or developmental delays.
- Care furnished mainly to provide a surrounding free from exposure that can worsen the person's disease or injury.
- The following types of treatment: primal therapy; rolfing; psychodrama; megavitamin therapy; bioenergetic therapy; vision perception training; or carbon dioxide therapy.
- Treatment of covered health care providers who specialize in the mental health care field and who receive treatment as a part of their training in that field.
- Services of a resident physician or intern rendered in that capacity.
- Service and supplies that are provided only because there is health coverage.
- Charges that a covered person is not legally obligated to pay.
- To the extent allowed by law, services and supplies:
  - Furnished by, paid for or required for injuries or illnesses found by the Secretary of Veterans Affairs to have been incurred in or aggravated during the performance of uniformed service.
  - Furnished, paid for or for which benefits are provided or required under any law of a government. (This exclusion will not apply to "no fault" auto insurance if it: is required by law; is provided on other than a group basis; and is included in the definition of Other Plan in the section entitled Effect of Benefits Under Other Plans Not Including Medicare of the Booklet-certificate. In addition, this exclusion will not apply to: a plan established by government for its own employees or their dependents; or Medicaid.)
- Eye surgery mainly to correct refractive errors.
- Education, special education or job training whether or not given in a facility that also provides medical or psychiatric treatment.
- Those for plastic surgery, reconstructive surgery (except in connection with a mastectomy), cosmetic surgery or other services and supplies that improve, alter, or enhance appearance, whether or not for psychological or emotional reasons; except to the extent needed to: Improve the function of a part of the body that is not a tooth or structure that supports the teeth; and is malformed as a result of a congenital abnormality; including harelip, webbed fingers, or toes; or as a direct result of disease; or surgery performed to treat a disease or injury.
- Therapy, supplies, or counseling for sexual dysfunctions or inadequacies.
- Sex change surgery or to any treatment of gender identity disorders.
- Artificial insemination, in vitro fertilization, or embryo transfer procedures.
- Marriage, family, child, career, social adjustment, pastoral or financial counseling.
- Speech therapy. This exclusion does not apply to charges for speech therapy that is expected to restore speech to a person who has lost existing speech function (the ability to express thoughts, speak words and form sentences) as the result of a disease or injury.
- Charges that are not "reasonable charges", as determined by Aetna.
- Voluntary sterilization procedure or the reversal of a sterilization procedure.

See also "What's not covered under prescription drug benefits" on page 11 for more exclusions and limitations that may apply to your plan.

Knowing what is covered

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

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

We check if it's "medically necessary"

Medical necessity is more than being ordered by a doctor. "Medically necessary" means your doctor ordered a product or service for an important medical reason. It might be to help prevent a disease or condition. Or to check if you have one. 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. It also has to be known to help the particular symptom.
- Cannot be for the member's or the doctor's convenience
- Cannot cost more than another service or product that is just as effective

Only medical professionals can deny coverage if the reason is medical necessity. We do not give financial incentives or otherwise to Aetna employees for denying coverage.

Sometimes the review of medical necessity is handled by a physicians' group. Those groups might use different resources than we do.

If we deny coverage, we'll send you and your doctor a letter. The letter will explain how to appeal the denial. You have the same right to appeal if a physician's group denied coverage for medical necessity. You can call Member Services to ask for a free copy of the criteria we use to make coverage decisions. Or visit **www.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

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

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

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

We publish our decisions in our Clinical Policy Bulletins.

We post our findings on www.aetna.com

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

CPBs tell if we view a product or service as medically necessary. They also help us decide whether to approve a coverage request. But your plan may not cover everything that 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** 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 particular product or service.

We can help when more serious care is suitable

In certain cases, we review a request for coverage to be sure the service or supply is consistent with established 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 verify that it is necessary for you to still be in the hospital. We look at the level and quality of care you are getting.

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 get back home.

Third, after you are home, we may review your case. 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:

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

Where such use is appropriate, our Utilization Review/Patient Management staff uses nationally recognized guidelines and resources, such as The Milliman Care Guidelines® to guide these processes. When provider groups, such as independent practice associations, are responsible for these steps, they may use other criteria that 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 appropriate 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 that your issue be sent to the appropriate department.

If you don't agree with a denied claim, you can file an appeal.
Sometimes we receive claims for services that may not be covered by your health benefits plan. It can be confusing — even to your providers. Our job is to make coverage decisions based on your specific benefits plan. If a claim is denied, we'll send you a letter to let you know. If you don't agree, you can file an appeal.

To file an appeal, follow the directions in the letter 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. Our appeals decisions will be based on your plan provisions and any state and federal laws or regulations that apply to your plan. You can learn more about the appeal procedures for your plan from your plan documents.

- An appeal is defined as a verbal or written request by a member or a member's authorized representative, requesting a change in the Initial Determination decision.
- An "adverse determination" is defined as a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. This also includes rescissions of coverage and declination of coverage for individual plans only.

Appeal Review

- An appeal must be submitted to us within 180 days of the date we provided notice of denial. The Aetna address is on your ID card.
- An acknowledgment letter will be sent to you within 5 business days of our receipt of the appeal.
- You will be sent a response within 14 calendar days of our receipt of the appeal. The response will be based on the information provided with or after the appeal.
- If more time is needed to resolve the appeal, we will provide a written notice indicating that more time is needed, explaining why such time is needed and setting a new date for a response. The additional time will not be extended beyond 30 days.
- In any urgent or emergency situation, you or your health care provider may call Member Services to initiate an Expedited Appeal. The Member Services telephone number is on your ID card. A verbal response to the appeal will be given to the health care provider within 72 hours after we receive all necessary information. Written notice of the decision will be sent within two (2) business days of our verbal response. If you are dissatisfied with our response, you may request and External Review.

Get a review from someone outside Aetna
In some cases, you, your doctor or hospital representative can ask for an outside review if you're not satisfied after going through our internal appeals process.

A request for an External Review must be submitted within 180 calendar days from the date you receive your final determination letter. The final determination letter will explain how to submit a request for an External Review.

Members have the right to appeal any (eligibility, services not covered) decision to an independent medical review. The right to independent medical review is not restricted to denials based on medical necessity or experimental and investigative products or services.

For more information on the External Review Program you may call Member Services at the toll-free number shown on your ID card.

If you are not satisfied with the outcome of your appeal, you have 180 days after the appeal process is concluded to request an independent review.

An Independent Review Organization (IRO) will assign the case to a physician reviewer with appropriate expertise in the area in question. Once we receive all necessary information, The IRO will generally make a decision within 30 calendar days of the request. Expedited reviews are available when your health care provider certifies that a delay in service would jeopardize your health. Once the review is complete, the plan will abide by the decision of the external reviewer. Aetna will pay any charges by the IRO.

For details about your plan's appeal process, the availability of an external review process or for an external review request form, call the Member Services toll-free number listed on your ID card or visit our website **www.aetna.com.** You may also call your state insurance or health department or consult their website for more information about state-mandated external review procedures.

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-health-insurance/member-guidelines/member-rights.html to view the list.** You can also call Member Services at the number on your ID card to ask for a printed copy.

Making medical decisions before your procedure

An "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 – name the person you want to make medical decisions for you.
- Living will – spells out the type and extent of care you want to receive.
- Do-not-resuscitate order – states 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. September 2010. Available at **http://familydoctor.org/online/famdocen/home/pat-advocacy/endoflife/003.html**. Accessed December 6, 2010.*

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/individuals-families-health-insurance/member-guidelines/health-care-quality.html.** You can also call Member Services to ask for a printed copy. See "Contact Us" on page 1.

We protect your privacy

We consider your personal information to be private. Our policies help us protect your privacy. By "personal information," we mean information about your physical condition, the health care you receive and what your health care costs. Personal information does not include what is available to the public. For example, anyone can find out what your health plan covers or how it works. It also does not include summarized reports that do not identify you.

Below is a summary of our privacy policy. For a copy of our actual policy, go to **www.aetna.com.** You'll find the "Privacy Notices" link at the bottom of the page. You can also write to:

Aetna Legal Support Services Department
151 Farmington Avenue, W121
Hartford, CT 06156

Summary of the Aetna privacy policy
We have policies and procedures in place to protect your personal information from unlawful use and disclosure. We may share your information to help with your care or treatment and administer our health plans and programs. We use your information internally, share it with our affiliates, and we 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
- Third-party administrators
- Vendors
- Consultants
- Government authorities and their respective agents

These parties must also keep your information private. Doctors in the Aetna network must allow you to see your medical records within a reasonable time after you ask for them.

Some of the ways we use your personal information include:

- Paying claims
- Making decisions about what to cover
- Coordinating payments with other insurers
- Preventive health, early detection, and disease and case management

We consider these activities key for the operation of our health plans. We usually will not ask if it's okay to share your information unless the law requires us to. We will ask your permission to disclose personal information if it is for marketing purposes. Our policies include how to handle requests for your information if you are unable to give consent.

Anyone can get health care

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

We must comply with these laws:

- Title VI of the Civil Rights Act of 1964
- Age Discrimination Act of 1975
- Americans with Disabilities Act
- Laws that apply to those who receive federal funds
- 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).

When you have a new dependent
Getting married? Having a baby? A new dependent changes everything. And you can change your mind. If you chose not to enroll during the normal open enrollment period, you can enroll within 31 days after a life event. That includes marriage, birth, adoption or placement for adoption. Talk to your benefits administrator for more information, to request special enrollment or for more information.

Getting proof that you had previous coverage
Sometimes when you apply for health coverage, the insurer may ask for proof that you were covered before. This helps determine if you are eligible for their 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.

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 this directory.

Providers, in all settings, achieve recognition by submitting data that demonstrates they are providing quality care. The program constantly assesses key measures that were carefully defined and tested for their relationship to improved care; therefore, NCQA provider recognition is subject to change. Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice.

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