Quality health plans & benefits
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Intelligent solutions

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Important Disclosure Information – Massachusetts

Aetna Health Maintenance Organization (HMO)

www.aetna.com

01.28.325.1-MA B (7/15)

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 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 rules.

Where to find information about your specific plan

This disclosure notice is provided in accordance with the laws of the Commonwealth of Massachusetts. This disclosure notice is only a summary of certain provisions of the plan. Your "plan documents" list all the details for the plan you choose. 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 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.

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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 benefits plans are provided by Aetna Health Inc.

Get plan information online and by phone

If you're already enrolled in an Aetna health plan

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

1. **Log in to your secure Aetna Navigator® member website**

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

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

   Then you can log in any time to:

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

2. **Use your mobile device to access a streamlined version of Aetna Navigator**

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

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

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

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

   As an Aetna member, you can use the Aetna Voice Advantage self-service options to:

   - Verify who's covered under your plan
   - Find out what's covered under your plan
   - Get an address to mail your claim and check a claim status
   - Find other ways to contact Aetna
   - Order a replacement Aetna ID card
   - Be transferred to behavioral health services (if included in your plan)

   You can also speak with a representative to:

   - Understand how your plan works or what you will pay
   - Get information about how to file a claim
   - Get a referral
   - Find 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

Not yet a member?

For help understanding how a particular medical plan works, you should review your Summary of Benefits and Coverage document or contact your employer or benefits administrator.

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

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

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

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

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

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

Existing members: Visit **www.aetna.com** and log in. From your secure member website home page, select "Find a Doctor" from the top menu bar and start your search.

Considering enrollment: Visit **www.aetna.com** and scroll down to "Find a doctor, dentist, facility or vision provider" from the home page. You'll need to select the plan you're interested in from the drop-down box.

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

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

Get a FREE printed directory
To get a free printed list of doctors and hospitals, call the toll-free number on your Aetna ID card. If you're not yet a member, call **1-888-982-3862**.

Physician profiling
If you need physician profiling information, contact the Massachusetts Board of Registration in Medicine for physicians licensed to practice in Massachusetts.

Costs and rules for using your plan

What you pay

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

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

  Other copays may apply at the same time:

  - **Inpatient Hospital Copay** – This copay applies when you are a patient in a hospital.
  - **Emergency Room Copay** – This is the amount you pay when you go to the emergency room. If you are admitted to the hospital within 24 hours, you won't have to pay it.
- **Coinsurance** – Your share of the costs for a covered service. This is usually a percentage (for example, 20 percent) of the allowed amount for the service. For example, if the health plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20 percent would be $20. The health plan pays the rest of the allowed amount.
- **Deductible** – The amount you owe for health care services before your health plan begins to pay. For example, if your deductible is $1,000, you have to pay the first $1,000 for covered services before the plan begins to pay. You may not have to pay the deductible for some services.

Your costs when you go outside the network

HMOs 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. 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.

Choose a primary care physician (PCP)

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

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

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

Tell us who you chose to be your PCP
Each member of the family may choose a different PCP from the Aetna network. 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.

You may change your PCP at any time
Just call Member Services at the toll-free number on your ID card. You can also add or change your PCP on your secure member website. Log in at **www.aetna.com**. The link for changing a PCP is under the "Care & Treatment" tab. The change will become effective upon our receipt and approval of the request.

Switching to a new doctor
Remember, with an HMO plan, you must use network doctors. Member Services can tell you if your current doctor is in the network. If not, they can help you find one who is. They can also help if your current doctor leaves the Aetna network. Just call the toll-free number on your Aetna ID card.

Do you have a serious health condition that requires ongoing care and treatment with a doctor, like chemotherapy or dialysis? You may qualify for a special program that gives you extra time to find a network doctor. It's also for women who are more than 12 weeks pregnant (second trimester). In this case, you may be able to stay with your non-network doctor for the rest of your pregnancy, delivery and postpartum care as it relates to delivery.

- **If your doctor leaves the Aetna network,** we will notify you at least 30 days before the effective date. You can apply to keep seeing him or her for up to 30 days more.
- **If you're new to Aetna and your doctor isn't in the Aetna network,** you can apply to keep seeing your doctor for up to 30 days after the plan's effective date. Note: You cannot apply if your employer offered you a choice of other health plans and your doctor is in the network of that plan.

To be approved, your current doctor cannot be dismissed from our network for quality or fraud reasons. Your doctor must agree to accept our policies and procedures, and must meet our quality standards. He or she must accept our payment without charging the member more. We may ask for medical information related to your care when considering your case.

If approved, we do not have to pay for services that would not have been covered if your doctor stayed in the network.

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

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

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

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

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

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

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

Get a standing referral for your specialist
Covered benefits include outpatient and inpatient services. If you need ongoing care from a specialist, you may get a standing referral to that specialist. If your PCP, the Aetna Medical Director and an appropriate specialist agree that a standing referral is needed, your PCP will make the referral to the specialist. This standing referral must be for a treatment plan approved by the Aetna Medical Director, who will discuss it with you, your PCP and the specialist.

Coverage is provided for pediatric specialty care, including mental health care, by persons with recognized expertise in specialty pediatrics to members requiring such services.

Precertification: Getting approvals for services

Sometimes we will pay for care only if we have given an approval before you get it. We call that "precertification." You usually only need precertification for more serious care like surgery or being admitted to a hospital. Your plan documents list all the services that require this approval. Your PCP or network specialist will get this approval for you.

You do not have to get precertification for emergency services.

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

Our review process after precertification (Utilization Review/Patient Management)
We have developed a patient management program to help you access appropriate health care and maximize coverage for those health care services. In certain situations, we review your case to be sure the service or supply meets established guidelines and is a covered benefit under your plan. We call this a "utilization review."

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

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 you could die or risk your health. For a pregnant woman, that includes her unborn child.

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

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

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

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

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

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

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

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

Drug companies may give us rebates when our members buy certain drugs
We may share those rebates with your employer. Rebates usually apply to drugs on the preferred drug guide. They may also apply to drugs not in the guide. In plans where you pay a percentage 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 percentage of the cost instead of a flat dollar amount, you may pay more for a drug in the preferred drug guide than for a drug not in the guide.

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

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

You may have to try one drug before you can try another
"Step-therapy" means you may have to try one or more less expensive or more common drugs before a drug on the step-therapy list will be covered. 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 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 guide
You can find the Aetna Preferred Drug Guide on our website at **www.aetna.com/formulary/**. You can call the toll-free number on your Aetna ID card to ask for a printed copy. We are constantly adding new drugs to the guide. Look online or call Member Services for the latest updates.

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

Mental health and addiction benefits

Massachusetts Mental Health Parity Laws and the Federal Mental Health Parity and Addiction Equity Act (MHPAEA)
Under both Massachusetts laws and federal laws, benefits for mental health and substance use disorder services must be comparable to benefits for medical/surgical services. Your copays, coinsurance and deductibles must be at the same level. And our review and authorization of mental health or substance use disorder services must be handled the same way.

If we deny or reduce authorization of a service, we will send you a letter explaining why. We will also send you or your doctor a copy of the criteria used to make this decision, at your request.

You may complain to the state if our plans do not cover mental health the same as physical health

You can complain by phone, but you will also need to follow up in writing. Here's how to submit a complaint to the Massachusetts Division of Insurance (DOI):

- Call **1-877-563-4467** or **617-521-7794** to start the process.
- Use the state's official complaint form. To get a copy of the form:
  - Call: **1-877-563-4467** or **617-521-7794**
  - Visit: **www.mass.gov/ocabr/docs/doi/consumer/css-complaint-form.pdf**
- Or write to:

  Office of Consumer Affairs and Business Regulation
  Division of Insurance
  1000 Washington Street, Suite 810
  Boston, MA 02118-6200

Be sure to include:

- Your name and address
- The nature of your complaint
- Your signature so the DOI can get everything they need to complete their review

The DOI will make every effort to resolve your complaint in a timely fashion.

Filing a written complaint with the DOI is not the same as filing a grievance under your plan. You must also file a grievance with us in order to have a denial or reduction in coverage of a service reviewed. This may be necessary to protect your right to continued coverage of treatment while you wait for a grievance decision. Follow the grievance procedures outlined in the "Inquiry, grievance and external review" section.

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

- Call 911 if it's an emergency.
- Call the toll-free Behavioral Health number on your Aetna ID card.
- Call Member Services if no other number is listed.
- Employee Assistance Program (EAP) professionals can also help you find a mental health specialist.

You must use therapists and other mental health professionals who are in the Aetna network

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

- Call 911 if it's an emergency.
- Call the 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 "Quality and Cost Information" link. No Internet? Call Member Services instead. Use the toll-free number on your Aetna ID card to ask for a printed copy.

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

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

Call Member Services to learn more about these programs.

Transplants and other complex conditions

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

Important benefits for women

Women's Health and Cancer Rights Act of 1998

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

Please contact Member Services for more information, or visit the U.S. Department of Health and Human Services website, **www.cms.gov/HealthInsReformforConsume/Downloads/WHCRA_Helpful_Tips_2010_06_14.pdf**, and the U.S. Department of Labor website, **www.dol.gov/ebsa/consumer_info_health.html**.

No coverage based on U.S. sanctions

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

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. It might also be to treat an injury or illness.

The product or service:

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

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

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

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.

We study the latest medical technology

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

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

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

We publish our decisions in our Clinical Policy Bulletins.

We post our findings on www.aetna.com

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

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

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

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

Inquiry, grievance and external review

Please tell us if you are not satisfied with a decision we have made or with our operations. The following information outlines our formal process for responding to inquiries, grievances and external appeals.

Need help with the process?

Call Member Services at the toll-free telephone number on your ID card for help in resolving a grievance.

You may also contact the Office of Patient Protection at:

- Phone: **1-800-436-7757**
- Fax: **617-624-5046**
- Online: **www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/patient-protection/**

Definitions

Adverse Benefit Determination
This can mean any of the following:

- We denied a claim.
- We decided not to provide a benefit that was presented for precertification.
- We reduced or modified a benefit that was previously precertified.
- We terminated coverage back to the original plan effective date (rescission).

An adverse benefit determination may be based on:

- Your eligibility for coverage
- Plan limitations or exclusions of coverage
- The results of any utilization review activities
- A decision that the service or supply is experimental or investigational
- A decision that the service or supply is not medically necessary

Inquiry: An **inquiry** is any communication that has not been the subject of an **adverse benefit determination**.

Grievance: This is an oral or written complaint from you or your authorized representative about the scope of coverage, denial of a service, rescission of coverage, quality of care or administrative operations.

Final adverse benefit determination (denial): This is an adverse benefit determination that has been upheld after exhausting the grievance process.

External review: If you're not satisfied after following the formal grievance process for a qualified adverse benefit determination, you may request a review by someone outside Aetna.

Internal inquiry process

We will address your inquiry as quickly as possible, and provide a call back within 24 hours. If we cannot resolve your inquiry within three days, you may submit the issue as a grievance. See the "Inquiry, grievance and external review" section for how your grievance will be addressed.

We maintain a record of each inquiry and our response for at least two years. These records are subject to inspection by the Commissioner of Insurance and the Office of Patient Protection.

We will respond in writing to your grievance within 30 days beginning:

- On the day immediately after the three-business-day time period for processing inquiries if we have not addressed the inquiry within that period of time; or
- On the day you or your authorized representative notifies us that you are not satisfied with our response to your inquiry.

You or a person you designate (an authorized representative) may file a formal grievance with us
Your authorized representative must include your written consent to act on your behalf.

All of your rights extend to your authorized representative. An authorized representative may be a guardian, conservator, holder of a power of attorney, health care agent designated by law or a family member. It can also be a person authorized by law if you are unable to designate a representative.

If your authorized representative is a health care provider, you must specify a named individual who will act on behalf of the authorized representative and a telephone number for that individual.

Internal grievance process

You have 180 calendar days from the date of the adverse determination notice to submit your grievance. You may do so in person, or by phone, fax, mail or e-mail. If you submit an oral grievance, we will transcribe it into writing and mail you a copy within 48 hours.

We will send you (or your authorized representative) a written acknowledgement that we received your grievance within 15 days, unless we already delivered a written transcription of an oral grievance.

This acknowledgement will describe our process for considering the grievance and the date you will receive our decision.

You may be allowed to provide evidence or testimony during the grievance process in accordance with the guidelines established by the federal Department of Health and Human Services.

There is only one level of review for an internal grievance, regardless of whether we contract with a utilization review organization or other entity.

You may ask us, in writing, to waive the internal grievance process
If approved, you would be allowed to seek immediate external review of an adverse benefit determination. You or your authorized representative must submit your request in writing within 48 hours of receiving our notice of adverse benefit determination. If we waive the internal grievance process, we will notify you or your authorized representative in writing within 48 hours of receiving the written request. You will need to provide a copy of this written waiver to the Office of Patient Protection along with the timely request for external review.

We'll tell you if we rely on new information to make our decision
If we consider, generate or rely upon new evidence or a new rationale for our decision to deny coverage, which was not provided with the adverse benefit determination, we will share this information with you free of charge. We must send it to you as soon as possible and sufficiently in advance of, and no fewer than seven days before the date on which we are required to provide the notice of final adverse benefit determination.

This notice will help give you or your authorized representative a reasonable opportunity to respond to the new information before that final adverse benefit determination.

Timeframes for responding to a grievance

Issue	Our response time from receipt of grievance
Urgent care claim – A "rush" request for medical care or treatment if a delay could: • Seriously jeopardize your life or health or your ability to regain maximum function • Subject you to severe pain that cannot be adequately managed without the requested care or treatment	Within 48 hours for DME and ongoing treatment decisions Within 72 hours for other urgent care claims Review provided by Aetna personnel not involved in making the adverse benefit determination
Preservice claim – A request for approval of the benefit before you receive medical care	Within 30 calendar days Review provided by Aetna personnel not involved in making the adverse benefit determination
Concurrent care claim extension – A request to extend a course of treatment that we previously preauthorized	Treated like an urgent care claim or a preservice claim depending on the circumstances
Post-service claim – Any claim for a benefit that is not a preservice claim	Within 30 calendar days Review provided by Aetna personnel not involved in making the adverse benefit determination
Other grievances – Involving issues not related to claim denials, such as complaints about operations or contractual provisions of the plan	Within 30 calendar days

If we fail to handle your grievance within the required time frames, the grievance will be deemed resolved in your favor.

Get a "rush" review for your internal grievance
If you are admitted to a hospital, we will send a written resolution of an internal review and give you the opportunity to request continuation of services before you are discharged. We call this an "expedited" internal review. These reviews are for immediate and urgently needed service(s) only.

"Immediate and urgently needed service(s)" means, in the opinion of the health care professional responsible for the treatment or proposed treatment:

- The requested service(s) or durable medical equipment is medically necessary.
- A denial of coverage for the requested service(s) or durable medical equipment would create a substantial risk of serious harm to the insured.
- The risk of serious harm is so immediate that you cannot wait for the outcome of the normal internal grievance process to receive the requested service(s) or durable medical equipment.

As a hospital patient, you can have an Aetna network participating doctor or a representative from the hospital act as your representative without having to provide written authorization.

We will provide a written resolution of an expedited internal review as soon as possible and no later than 72 hours after we receive the request.

We can provide an automatic reversal of the denial if the treating doctor certifies the treatment or proposed treatment is considered "immediate and urgently needed service(s)" as described above. For durable medical equipment, if the certifying doctor exercises the option of automatic reversal earlier than 48 hours, the doctor must further certify the specific, immediate and severe harm that will result to the patient without action within the 48-hour time period.

If the expedited internal review process results in a final adverse benefit determination for continuing inpatient care, our written resolution will inform you or your authorized representative that you can request an expedited external review. If the review involves the termination of ongoing services, the notice will also explain that you may request continuation of services.

You may file a request for an expedited external review at the same time as a request for expedited internal review of the grievance.

Grievance process for members with a terminal illness
If you or a covered family member has a terminal illness, we will resolve the grievance within five business days. If the grievance is for urgently needed services, we will resolve it within 72 hours.

If the expedited review process affirms the denial of coverage to a member with a terminal illness, we will provide the following within five business days of the decision:

- A statement setting forth the specific medical and scientific reasons for denying coverage
- A description of alternative treatment, services or supplies covered by Aetna, if any
- The procedure for the member to request a conference

You may request a conference with the reviewer
We will schedule the conference within 10 days of receiving the request. At the conference, you and a representative of Aetna who has authority to determine the disposition of the grievance will review the information presented for the grievance. You can designate someone to attend on your behalf. Or, if the member is a minor or incompetent, the parent, guardian or conservator of the member may attend.

The conference shall be held within five business days if, after consulting with the our medical director or designee, and based on standard medical practice, the treating doctor determines the effectiveness of either the proposed treatment, services or supplies or any alternative treatment, services or supplies the plan covers, would be materially reduced if not provided at the earliest possible date.

If we fail to meet the time limits
A grievance on which we have not acted properly within the time limits required by applicable Massachusetts laws will be deemed resolved in your favor.

Coverage for treatment pending resolution of internal grievance

- If we receive a grievance concerning the termination of ongoing coverage for treatment, the disputed coverage or treatment will remain in effect at our expense through completion of the internal grievance process, regardless of the original internal grievance decision, provided the grievance is filed on a timely basis, based on the course of treatment.
- We will automatically reverse a denial, pending the outcome of the internal grievance process, within 48 hours of receiving certification from your doctor stating these factors are present:
  - The service at issue in the grievance is medically necessary.
  - Denial of coverage for these services would create a substantial risk of serious harm to the patient.
  - The risk of that harm is so immediate that the provision of such services should not await the outcome of the normal grievance process.

We will send you a letter when we make our decision

The letter will explain the basis of the decision and identify the specific information we considered when making the decision. If our decision results in an adverse benefit determination, the letter will also provide clinical justification for the denial, consistent with generally accepted principals of professional medical practice that, at a minimum, will:

- Include information about the claim including, if applicable, the date(s) of service, the health care provider(s), the claim amount, and any diagnosis, treatment, and denial code(s) and their corresponding meaning(s).
- Identify the specific information on which the complaint or denial was based.
- Discuss the patient's presenting symptoms or condition, diagnosis and treatment interventions.
- Explain in a reasonable level of detail why we found that the medical evidence does not support a finding of medical necessity.
- Reference and include a copy of any clinical practice guidelines and medically necessity criteria used in making the decision, or if none were used, a statement that no medical necessity criteria were used in making the determination.
- Specify alternative treatment options that the plan covers, and any network doctors who can provide that option, and who is geographically accessible, speaks the same language and accepts new patients.
- Provide a summary of the reviewer's professional qualifications, and a certification that the reviewer meets the qualifications specified by Massachusetts' law.
- Explain any available procedure for reconsideration of our decision and the procedures for requesting an external review and expedited external review.

We must include with every written final adverse benefit determination the following:

- A copy of the form prescribed by the Office of Patient Protection for requesting external review, as well as instructions for locating the form on the Office of Patient Protection's website
- The toll-free numbers and other contact information for:
  - The Massachusetts Consumer Assistance Program
  - The Office of Patient Protection
- A clear list of additional documents and information you can request, including your entire claim file, and other documents and information Massachusetts or federal law requires us to provide. We will include instructions for you to get these documents and our toll-free telephone number for help you resolve grievances.

You may be able to request reconsideration of our denial

We may offer you the opportunity for reconsideration of our final adverse benefit determination where relevant medical information:

- Was received too late to review within the 30-business-day limit; or
- Was not received but is expected to become available within a reasonable time period after the written resolution; or
- Was due to other good cause.

Record retention

We will retain the records of all grievances for a period of at least seven years.

Fees and costs

We are not responsible to pay counsel fees or any other fees or costs you incur for pursuing a grievance.

External review procedures

If you are not satisfied after exhausting at least one level of the formal grievance processes, you may request in writing an outside review with the Office of Patient Protection. You must request this outside review within four months of receiving our determination. You don't have to have a final adverse benefit determination when you simultaneously request an expedited internal review and expedited external review or where we have waived an internal review.

You or your authorized representative may file a request for external review for services of any monetary value. There is no minimum financial threshold for filing a request for external review.

For the purposes of this provision, an adverse benefit determination (denial) is based on a review of information provided by Aetna to deny, reduce, modify or terminate an admission, continued inpatient stay or the availability of any other health care services for failure to meet the requirements for coverage based on medical necessity, appropriateness of health care setting and level of care, or effectiveness.

If we fail to meet time limits required by applicable Massachusetts laws, the grievance will be deemed resolved in your favor.

A review will be made on your standard external review and will be completed within 45 calendar days of receipt.

You or your authorized representative, if any, may request to have your request for review processed as an expedited external review. You may be eligible to file an expedited external review at the same time you file an expedited internal grievance. The external review agency will issue its final disposition within 72 hours of receiving the referral from the Office of Patient Protection.

You can request a "rush" external review
This is called an "expedited" external review. You do not have to exhaust the internal grievance process before filing an expedited external review. You can also file an expedited external review at the same time as an expedited internal review.

The Office of Patient Protection will qualify the request as eligible for an expedited external review when your treating doctor certifies that a delay in the service(s) would pose a serious and immediate threat to your health.

The external review agency will issue a decision within 72 hours of receiving the request.

Your cost for an external review is $25
You will never have to pay more than $75 in fees for external review requests in a plan year, regardless of the number of external requests submitted. If the Office of Patient Protection reverses the denial, it will refund your $25 fee.

The Office of Patient Protection will waive the fee if your total household income does not exceed 300 percent of the federal poverty level or if it determines the payment of the fee would result in an extreme financial hardship for you.

We will pay the remaining costs for an external review. Upon completion of the external review, the Office of Patient Protection will bill us the amount established in a contract between the department and the assigned external review agency minus the $25 fee when this fee is your responsibility. When you are not required to pay the fee, we will pay the full cost of the review including the $25 fee.

You must give consent to release your medical information
You or your authorized representative must sign the request to allow us to release your medical information and records relevant to the subject matter of the external review to any external review agency assigned to your request. We'll also give you access to the medical information and records.

Send the following documents to the Office of Patient Protection
- The form prescribed by the Office of Patient Protection, signed to authorize the release of your medical information. The form is included with our final adverse benefit determination letter.
- A copy of the final adverse benefit determination letter
- The $25 fee unless it is not required or has been waived

You can request to continue services until an external review is decided
If the external review involves the termination of ongoing services, you can apply to the external review panel to continue coverage for the terminated service while the review is pending. You must make this request before the end of the second business day after receiving the final adverse benefit determination.

State your request for continued care on the external review request form issued by the Office of Patient Protection. The external review agency will order continued care if it determines absence of the continued care will be harmful to your health.

We will cover the continued care regardless of the final external review determination. If you received continued coverage during the internal review process, then we will provide coverage during the external review so there is no gap in coverage.

You will receive a written notice of the final external review decision
The external review agency will determine whether the service that is the subject of the review is medically necessary and is a covered benefit. The notice will include:

- The specific medical and scientific reasons for the decision
- An analysis of the medical evidence and how the evidence supports the reviewer's finding
- The medical necessity standard as defined by Massachusetts law, and an explanation of why the requested treatment or service was found or was not found to be medically necessary
- A list of any medical literature or references the reviewer used to make the decision
- A statement that the decision is final and binding, but you may have other legal rights under state or federal law
- A statement that we will provide translation and interpretation assistance if you need it

Each external review agency will retain records of all external review requests, decisions and notices for three years from the date of the final disposition. The agency will make these records available to the Office of Patient Protection upon request.

The binding decision does not preclude us from making payment on the claim or otherwise providing benefits at any time, including after a final external review decision that denies the claim or otherwise fails to require such payment or benefits.

If the external review agency overturns our decision in whole or in part, we will send you a written notice within five business days from the date we received the written decision from the external review agency. The notice will:

- Acknowledge the decision of the review agency.
- Tell you about any additional procedures for getting the requested coverage of services.
- Tell you when we will make the payment or authorize the services.
- Give you the name and phone number of an Aetna employee who can help you with final resolution of the appeal.

The official external review request form is included with your previous denial letter
You can also call the Office of Patient Protection at **1-800-436-7757** to ask for a form, or fax your request to **617-624-5046**, or download the form at **www.mass.gov/anf/docs/hpc/opp/hpc-opp-external-review-form-4-20-2013.pdf**.

You can get a member satisfaction report and other information
The Office of Patient Protection, under the direction of the Health Policy Commission, administers and enforces certain Massachusetts Managed Care requirements. You can ask the Office of Patient Protection to send you the following information for the previous calendar year:

- A list of sources of independently published information assessing insured satisfaction and evaluating the quality of health care services offered by Aetna
- The percentage of doctors who voluntarily and involuntarily terminated participation contracts with us and the three most common reasons for doing so
- The percentage of premium revenue we spent on health care
- A report detailing:
  - The total number of filed grievances, the type of medical or behavioral health treatment at issue where applicable, the number of grievances that were approved internally, the number of grievances that were denied internally and grievances that were withdrawn before resolution
  - The number of grievances, the type of medical or behavioral health treatment at issue and the outcomes of those appeals; or if this information is also being reported to the Commissioner of Insurance on or before July 1, a statement to that effect
  - The percentage of insured who filed internal appeals with us
  - The total number of internal appeal that were reconsidered, the number of reconsidered appeals that were approved internally, the number of reconsidered appeals that were denied internally, and the number of reconsidered appeals that were withdrawn before resolution
  - The total number external reviews pursued after exhausting the internal grievance process and the resolution of all such reviews

If the information is available, the report will identify insured demographic information, such as race, gender and age.

Dispute resolution

Any controversy, dispute or claim between Aetna and one or more interested parties arising out of or relating to the Group Agreement, whether stated in tort, contract, statute, claim for benefits, bad faith, professional liability or otherwise ("claim"), shall be settled by confidential binding arbitration administered by the American Arbitration Association ("AAA") before a sole arbitrator. Judgment on the award rendered by the arbitrator may be entered by any court having jurisdiction thereof.

If the AAA declines to administer the case and the parties do not agree on an alternative administrator, a sole neutral arbitrator shall be appointed upon petition to a court having jurisdiction. Aetna and interested parties hereby give up their rights to have claims decided in a court before a jury.

Any claim alleging wrongful acts or omissions of participating or nonparticipating providers will not include Aetna. A member must exhaust all complaint, grievance and independent external review procedures before the beginning of arbitration hereunder. No person may recover any damages arising out of or related to the failure to approve or provide any benefit or coverage beyond payment of or coverage for the benefit or coverage where (i) we have made available independent external review and (ii) we have followed the reviewer's decision. Punitive damages may not be recovered as part of a claim under any circumstances. No interested party may participate in a representative capacity or as a member of any class in any proceeding arising out of or related to the Group Agreement. This agreement to arbitrate shall be specifically enforced even if a party to the arbitration is also a party to another proceeding with a third party arising out of the same matter.

Termination of coverage and disenrollment rates

Termination of coverage
Your coverage may be cancelled or its renewal refused if:

- Your employer or plan sponsor does not pay the plan's premium
- You fraudulently misrepresent being eligible for the plan
- You physically or verbally abuse your doctor or other Aetna members in a way that is unrelated to your physical or mental condition
- You move outside the Aetna service area
- Your group contract is not renewed or is cancelled
- You do not meet the eligibility requirements of the contract

Disenrollment rates
- Aetna Health Inc. voluntary disenrollment rate for Massachusetts insured is 0.00%. Voluntary disenrollment means an insured has terminated coverage with Aetna for nonpayment of premium.
- Aetna Health Inc. involuntary disenrollment rate for Massachusetts insured is 0.00%. Involuntary disenrollment means we have terminated the insured's coverage for reasons stated above under "Termination of coverage."

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

Making medical decisions before your procedure

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

There are three types of advance directives:

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

You can create an advance directive in several ways:

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

Source: American Academy of Family Physicians. Advance Directives and Do Not Resuscitate Orders. January 2012. Available at **http://familydoctor.org/familydoctor/en/healthcare-management/end-of-life-issues/advance-directives-and-do-not-resuscitate-orders.html**. Accessed January 12, 2015.

Quality management programs make sure your doctor provides quality care for you and your family

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

We protect your privacy

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

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

Summary of the Aetna Privacy Policy

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

- Your doctors, dentists, pharmacies, hospitals and other caregivers
- Other insurers
- Vendors
- Government departments
- Third-party administrators (TPAs) (this includes plan sponsors and/or employers)

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

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

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

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

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

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

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).

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.

The Office of Patient Protection

The Office of Patient Protection includes the Office of the Managed Care Ombudsman and is within the Massachusetts Health Policy Commission. Each year we provide the following information to the Office of Patient Protection and make it available to you:

- Sample evidence of coverage and amendments
- Physician directory
- This disclosure brochure
- A list of sources of independently published information assessing insured satisfaction and evaluating the quality of health care services offered by the plan
- Reports relating to voluntary and involuntary physician termination
- The percentage of premiums we use toward health care services
- Member grievance reports

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 list of health plans and their NCQA status can be found on the NCQA website located at **http://reportcard.ncqa.org**.

To refine your search, we suggest you search these areas:

1. **Health Insurance Plans** – for HMO and PPO health plans and
2. **Physicians and Physician Practices** – for physicians recognized by NCQA in the areas of Physician Practice Connections, Physician Practice Connections-Patient Centered Medical Home, Patient Centered Medical Home, Heart/Stroke, Diabetes, and Patient Center Specialty Practice. Providers, in all settings, achieve recognition by submitting data that demonstrate 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.

See "Other Reports on Health Care Quality" in the dropdown menu for Managed Behavioral Healthcare Organizations – for behavioral health accreditation and Credentials Verifications Organizations – for credentialing certification.

If you need this material translated into another language, please call Member Services at 1-888-982-3862.
Si usted necesita este material en otro lenguaje, por favor llame a Servicios al Miembro al 1-888-982-3862.

www.aetna.com

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