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

aetna®

Important Disclosure Information – New York

Aetna Elect Choice® EPO

www.aetna.com

63.28.303.1-NY C (9/15)

General information

Your plan of benefits is underwritten or administered by Aetna Life Insurance Company 980 Jolly Road, U12N, Blue Bell, PA 19422.

Member Services and Aetna Navigator® secure member website

When you need help from an Aetna representative, call us during regular business hours at the number on your ID card or e-mail us at **www.aetna.com**. You may also access your plan information from your secure member website.

To access Aetna Navigator, click on "Log In/Register." Enter your user name and password and click the "Secure Log In" button. If you are not a member yet, click on the "Sign Up Now" button. To learn more before signing up, click on the "Take a Tour" link to the right of the "Sign Up Now" button.

Aetna Navigator allows you to:

- Check a claim payment
- Compare hospitals in your area or anywhere in the country
- Research medical costs and prescription prices
- Learn about healthy lifestyles
- Get health information from Harvard Medical School
- Look through our online encyclopedia for information about hundreds of health conditions

For online Member Services:

Click on "Contact us" after you log in. Our representatives can:

- Verify or change personal information about your coverage
- Answer benefits questions
- Help you look up network providers
- Find care outside your area
- Advise you on how to file a claim or check on a claim payment
- Advise you on how to file complaints and appeals
- Connect you to behavioral health services
- Find specific health information
- Provide information on our quality management program, which evaluates the ongoing quality of our services

Table of Contents

Aetna Health Plans for Individuals, Families and the Self-Employed are underwritten by Aetna Life Insurance Company and/or Aetna Health Inc. (together, "Aetna"). In some states, individuals may qualify as a business group of one and may be eligible for guaranteed issue, small group health plans.

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. 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. 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.

Plan of benefits

Covered services include most types of treatment provided by primary care physicians, specialists and hospitals. However, the Aetna Elect Choice EPO plan does exclude and/or include limits on coverage for some services. In addition, in order to be covered all services including the location (type of facility), duration and costs of services must be medically necessary as defined below and as determined by Aetna. The information that follows provides general information regarding the Aetna Elect Choice EPO plan. For a complete description of the benefits available to you, including procedures, exclusions and limitations, refer to your specific plan documents, which include the Aetna Elect Choice EPO plan policy and any applicable amendments to the plan.

General conditions for coverage

The service or supply must be covered by the plan. For a service or supply to be covered, it must be included as a covered expense in your policy and not be an excluded expense and not exceed the maximums and limitations outlined in your policy; and be obtained in accordance with all the terms, policies and procedures outlined in your Certificate of Coverage. The plan will pay for covered medical expenses up to the maximums shown in your policy. You are responsible for any expenses incurred over the maximum limits or any noncovered health care procedures, treatments or services as outlined in your policy.

Medically necessary

Medically necessary means that the service or supply is provided by a physician or other health care provider exercising prudent clinical judgment for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that provision of the service or supply is:

- Clinically appropriate in terms of type, frequency, extent, site and duration, and considered effective for your illness, injury or disease.
- Needed because your condition would be adversely affected if the services were not provided.
- Provided in accordance with generally accepted standards of medical practice.
- Not primarily for the convenience of you, your family or your provider.
- Not more costly than an alternative service or sequence of services. That is, they are at least as likely to produce equivalent therapeutic or diagnostic results.
- When setting or place is part of the review, services that can be safely provided to you in a lower cost setting will not be medically necessary if they are performed in a higher cost setting. For example, we will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis.

For these purposes, generally accepted standards of medical practice means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, or otherwise consistent with physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

Important note
Not every service, supply or prescription drug that fits the definition for medical necessity is covered by the plan.

Exclusions and limitations apply to certain medical services, supplies and expenses – see Exclusions. For example, some benefits are limited to a certain number of days, visits or a dollar maximum. Refer to the Schedule of Benefits for the plan limits and maximums.

Costs and rules for using your plan

What you pay

Besides paying your monthly premium, 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. This is calculated as 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:** Some plans include a deductible. This is 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 have a $250 emergency room deductible. This means you pay the first $1,000 before the plan pays anything. Once the plan starts to pay, if you go to the emergency room you will pay the first $250 of that bill.

Your costs when you go outside the network

Network-only plans
Elect Choice EPO plans are network-only plans. That means the plan covers health care services only when provided by a doctor who participates in the Aetna network. If you receive services from an out-of-network doctor or other health care provider, you will have to pay all of the costs for the services, unless precertified. See the "Precertification" and "Emergency and urgent care and care after hours" sections for more.

How to estimate cost of care
After you enroll, you'll have access to the Member Payment Estimator tool through your secure member website (see page 2). Estimated costs are not available in all markets. The tool gives you an estimate of what you would owe for a particular service based on your plan at that point in time. Actual costs may differ from the estimate if, for example, claims for other services are processed after you get your estimate but before the claim for this service is submitted. Or, if the doctor or facility performs a different service at the time of your visit.

Follow the steps below:

Step 1. Log in at **www.aetna.com**. If this is your first visit, click "Register Now."

Step 2. Under the "I want to . . ." menu you can "Ask Ann to help me compare costs" or use the tools right from the Care & Treatment menu.

Step 3. Use the Member Payment Estimator*
- Choose a covered family member.
- Pick the health care service you need.
- Search for a specific network doctor, hospital or outpatient facility. Or, the tool can show you a list of providers in your area.

*The tool factors in your plan details like deductible and coinsurance. The result: a real-time cost estimate based on your actual plan.

Primary care physician ("PCP") and referral rules

Role of PCPs

You are required to select a PCP who participates in the network. If you do not select one, we will assign you a PCP in your area, based on your Zip code. If you wish to choose a different PCP, you may do so at any time. To find a new doctor in your area, call Member Services at the toll-free number on your member ID card, or visit DocFind, our online provider directory, at **www.aetna.com**.

Through **www.aetna.com**, you can also register for our Aetna Navigator self-service website and select the "Change PCP" option. Before selecting a PCP, you should either call Member Services at the number on your ID card, or call the doctor's office directly to verify he or she is accepting new patients. A PCP may be a general practitioner, family physician, internist or a pediatrician. Each covered family member may select his or her own PCP. Your PCP will provide primary care as well as coordinate your overall care. You should consult your PCP when you are sick or injured to help determine the care that is needed.

Your PCP will issue referrals to participating specialists and facilities for certain services. For some services, your PCP is required to obtain prior authorization from Aetna. Except for those benefits described in the plan documents as direct access benefits, or in an emergency, you will need to obtain a referral authorization ("referral") from your PCP before seeking covered non-emergency specialty or hospital care. Participating providers will be responsible for obtaining any required preauthorization of services from Aetna.

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 in the Aetna NY Signature℠ network. You can access the tool from your secure Aetna Navigator website at **www.aetna.com**. If you're not yet enrolled, click "Find a doctor, dentist, facility or vision provider" from the home page instead.

Follow the path and enter your doctor's name in the search field. You can also call us at the toll-free number on your Aetna ID card for help or to ask for a free printed list of doctors. If you're not yet enrolled, call **1-866-565-1236**. If you use the printed list, call Member Services or the provider to make sure he or she is accepting new patients.

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

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

We cannot guarantee the availability or continued participation of a particular doctor. We or the doctor you chose may terminate the provider contract or limit the number of people accepted in a practice.

Before selecting any doctor, you should either call Member Services at the number on your ID card, or call the doctor's office directly to verify he or she is accepting new patients.

If the doctor you chose cannot accept additional patients, you can make another selection.

How to change your PCP or specialist

You may change your PCP or specialist at any time when you log in at **www.aetna.com**, or call the Member Services toll-free number on your identification card. The change will become effective upon our receipt and approval of the request.

How referrals work

Except for PCP, direct access and emergency or urgent care services, you must have a prior written or electronic referral from your PCP to receive coverage for all services and any necessary follow-up treatment. The referral will be good for 90 days as long as you remain covered under the plan.

- When you visit the provider or facility, bring the referral (or check in advance to verify they've received the electronic referral). Without it, benefits will not be covered.
- Certain services, such as inpatient stays, outpatient surgery and certain other medical procedures and tests, require both a PCP referral and precertification. Precertification verifies the recommended treatment is covered by Aetna. Your PCP or other network providers are responsible for obtaining precertification for you for in-network services.

Out-of-network referrals
If a covered service you need isn't available from a network provider or facility, or a participating provider is not geographically accessible, your PCP may refer you to an out-of-network provider. Your PCP or other network provider must get preapproval from Aetna and issue a special nonparticipating referral for services from out-of-network providers to be covered.

Standing referrals
If you have a condition that requires ongoing care from a specialist, you may request a standing referral from your PCP or Aetna to such a specialist.

Specialist as PCP

If you have a life-threatening condition or disease, or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, you may request a referral to a specialist with expertise in treating the life-threatening or degenerative and disabling disease or condition, who shall be responsible for and capable of providing and coordinating your primary and specialty care. This referral will be issued based on a treatment plan that is approved by Aetna, in consultation with the primary care provider if appropriate, the specialist, and you or your authorized representative. Please call Member Services at the toll-free number in your ID card, or call **1-866-565-1236**, in order to request these services.

Direct specialist care for life-threatening conditions
If you have a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, you may request access to a specialty care center, or a specialist responsible for providing or coordinating your medical care. To request these services, please call Member Services at the toll-free number on your ID card or call **1-866-565-1236**.

Direct access OB/GYN program
This program allows female members direct access to primary and preventive obstetric and gynecologic services, including annual examinations, care resulting from such examinations, and treatment of acute gynecologic conditions from a qualified participating provider of the member's choice or for any care related to pregnancy.

Transition of care

If a participating provider leaves the Aetna network, members who are under an ongoing course of treatment on the day the provider's agreement terminates may continue to receive treatment from the provider during a transitional period of up to ninety days. Female members who have entered the second trimester of pregnancy may continue to receive treatment from the provider for a transitional period that includes the provision of post-partum care directly related to the delivery.

A member whose health care provider is not a participating provider at the time of enrollment may request to continue an ongoing course of treatment with that provider for a period of up to 60 days from the effective date of enrollment if the member has a life-threatening disease or condition or a degenerative and disabling disease or condition. If the member has entered the second trimester of pregnancy at the effective date of enrollment, the transitional period shall include post-partum care directly related to the delivery.

For such a request for transitional coverage to be approved, the health care provider must agree to accept reimbursement from Aetna at established rates prior to the start of the transitional period as payment in full; adhere to our quality assurance requirements; provide us with necessary medical information related to this care; and adhere to our policies and procedures. The provider must agree to these conditions before the plan will approve transitional care.

In accordance with New York law, transitional care is not permitted if the provider leaves the network due to imminent harm to patient care, a determination of fraud or a final disciplinary action by a state licensing board (or other governmental agency) that impairs the health care professional's ability to practice.

Transplants and other complex conditions

Our National Medical Excellence Program® and other specialty programs help you access covered treatment for transplants and certain other complex medical conditions at participating facilities experienced in performing these services. Such services must be prescribed by a specialist. Depending on the terms of your plan of benefits, you may be limited to only those facilities participating in these programs when needing a transplant or other complex condition covered.

Emergency care

If you need emergency care, you are covered 24 hours a day, 7 days a week, anywhere in the world. An emergency medical condition means a medical or behavioral condition that manifests itself by symptoms of sufficient severity, including severe pain, which a prudent layperson possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, or in the case of a behavioral condition, placing the health of the person or others in serious jeopardy
- Serious impairment of such person's bodily functions
- Serious dysfunction of any bodily organ or part of such person
- Serious disfigurement of such person

Treatment for an emergency medical condition is not subject to prior approval. However, whether you are in or out of an Aetna service area, we simply ask that you follow the guidelines below when you believe you need emergency care.

- Call the local emergency hotline (ex. 911) or go to the nearest emergency facility. If a delay would not be detrimental to your health, call your PCP. Notify your PCP as soon as possible after receiving treatment.
- If you are admitted to an inpatient facility, you or a family member or friend on your behalf should notify your PCP or Aetna as soon as possible.
- Covered expenses for emergency medical conditions are payable in accordance with your plan. Please refer to your summary of benefits for the applicable copay, deductible and coinsurance amounts that apply.

Urgent care

Care for certain conditions, such as severe vomiting, earaches, sore throats or fever, is considered urgent care. Urgent care may be obtained from your PCP or an urgent care facility. However, if you are traveling outside your Aetna service area or if you are a student who is away at school, you are covered for any urgently needed care rendered by any licensed physician or facility.

Claims for emergency care

If, after reviewing information submitted to us by the provider who supplied care, the nature of the urgent or emergency problem does not qualify for coverage, it may be necessary to provide us with additional information. We will send you an emergency room notification report to complete, or a Member Services representative can take this information by telephone.

However, emergency care expenses that are not related to an emergency medical condition are excluded and are the member's financial responsibility.

Follow-up care after emergencies

All follow-up care should be coordinated by your PCP. Follow-up care with nonparticipating providers is only covered with a prior authorization from Aetna. Whether you were treated inside or outside your Aetna service area, you must obtain a referral before any follow-up care can be covered. Suture removal, cast removal, X-rays and clinic and emergency room revisits are some examples of follow-up care.

How Aetna compensates your doctor and other health care providers

All physicians are independent practicing physicians who are neither employed nor exclusively contracted with Aetna. Individual physicians and other providers are in the network by either directly contracting with Aetna and/or affiliating with a group or organization that contracts with us.

Participating providers in our network are compensated in various ways for the services covered under your plan:

- Per individual service or case (fee for service at contracted rates)
- Per hospital day (per diem contracted rates)
- Capitation (a prepaid amount per member, per month)
- Through integrated delivery systems (IDS), independent practice associations (IPA), physician hospital organizations (PHO), physician medical groups (PMG), behavioral health organizations and similar provider organizations or groups. Aetna pays these organizations, which in turn may reimburse the physician, provider organization or facility directly or indirectly for covered services. In such arrangements, the group or organization has a financial incentive to control the cost of care.

Technology review

We review new medical technologies, behavioral health procedures, pharmaceuticals and devices to determine which ones should be covered by our plans. And we even look at new uses for existing technologies to see if they have potential.

To review these innovations, we may:

- Study medical research and scientific evidence on the safety and effectiveness of medical technologies.
- Consider position statements and clinical practice guidelines from medical and government groups, including the federal Agency for Healthcare Research and Quality.
- Seek input from relevant specialists and experts in the technology.
- Determine whether the technologies are experimental or investigational. You can find out more on new tests and treatments in our clinical policy bulletins.

Prescription drugs

Your plan includes a preferred drug list (also known as a drug formulary). The preferred drug list includes a list of prescription drugs that, depending on your prescription drug benefits plan, are covered on a preferred basis. Many drugs, including many of those listed on the preferred drug list, are subject to rebate arrangements between Aetna and the manufacturer of the drugs. Such rebates are not reflected in and do not reduce the amount you pay to your pharmacy for a prescription drug.

In addition, in circumstances where your prescription plan utilizes copayments or coinsurance calculated on a percentage basis or a deductible, your costs may be higher for a preferred drug than they would be for a nonpreferred drug.

Closed formulary benefit plans may use a formulary exclusions list. Under these benefit plans, a drug on this list will be excluded from coverage unless a medical exception is obtained. In addition, the plans include our precertification and step-therapy programs. Under the step-therapy program, members must first try certain prerequisite medication(s) before a step-therapy drug will be covered.

The prescribing physician can submit a request for a medical exception to Aetna Pharmacy Management's Precertification Unit in writing, by phone or online. Information provided must include member identification, medical history and laboratory data necessary to review the request.

The request for medical exception will be reviewed along with the Aetna Pharmacy Clinical Policy Bulletin applicable to the medication. If the medical exception meets the criteria established in the clinical policy bulletin, we will notify the physician and member of the authorization. If an Aetna medical director determines the drug is not approved for coverage, an adverse determination letter will be sent to the member and provider. The notice will explain the reason for the denial of coverage and the appeal process.

For information regarding how medications are reviewed and selected for the preferred drug list, please refer to our website at **www.aetna.com** or the Aetna Preferred Drug (Formulary) Guide. Printed preferred drug guide information will be provided, upon request or if applicable, annually for current members and upon enrollment for new members. Additional information can be obtained by calling Member Services at the toll-free number listed on your ID card. The medications listed on the preferred drug list are subject to change in accordance with applicable state law.

If it is medically necessary for you to use drugs that are not on the formulary, your physician (or pharmacist in the case of antibiotics and analgesics) may contact us to request coverage as a medical exception. Check your plan documents for details.

In addition, certain drugs may require precertification or step-therapy before they will be covered under some prescription drug benefit plans. Step-therapy is a different form of precertification that requires a trial of one or more prerequisite therapy medications before a step-therapy medication will be covered. If it is medically necessary for you to use a medication subject to these requirements, your physician can request coverage of such drug as a medical exception.

You may determine which medications are included in the step-therapy program and require trial of prerequisite drugs through any of the following methods:

- Contact Member Services at the phone number on your ID card.
- Visit our public website at **www.aetna.com/formulary**.
- Use the Medication Search application on the website above.
- Access member-specific coverage information by logging in to your secure Aetna Navigator member website at **www.aetna.com**.

Nonprescription drugs and drugs in the Limitations and Exclusions section of the plan documents (received and/or available upon enrollment) are not covered, and medical exceptions are not available for them.

You should consult with your treating physician(s) regarding questions about specific medications. Refer to your plan documents or contact Member Services for information regarding terms, conditions and limitations of coverage. If you use the mail-order prescription program, Aetna Rx Home Delivery, LLC, or the Aetna Specialty Pharmacy® specialty drug program, you will be acquiring these prescriptions through an affiliate of Aetna. Our negotiated charge with Aetna Rx Home Delivery and Aetna Specialty Pharmacy may be higher than their cost of purchasing drugs and providing pharmacy services. For these purposes, Aetna Rx Home Delivery's and Aetna Specialty Pharmacy's cost of purchasing drugs takes into account discounts, credits and other amounts that they may receive from wholesalers, manufacturers, suppliers and distributors.

Updates to the drug formulary
You can obtain formulary information from the Internet at **www.aetna.com/formulary**, or by calling your Member Services toll-free number.

Behavioral health network

Behavioral health care services are managed by Aetna, who is responsible for making initial coverage determinations and coordinating referrals to the Aetna provider network. As with other coverage determinations, you may appeal adverse behavioral health care coverage determinations in accordance with the terms of your health plan.

You can determine the type of behavioral health coverage available under the terms of your plan by calling the Aetna Member Services number listed on your ID card. If you have an emergency, call 911 or your local emergency hotline, if available. For routine services, access covered behavioral health services available under your health plan by the following methods:

- Call the toll-free behavioral health number listed on your ID card or if no number is listed, call the Member Services number listed on your ID card for the appropriate information.
- For behavioral health provider referrals call the Member Services number on your ID card, or visit DocFind at **www.aetna.com/docfind** to find participating providers. When applicable, an employee assistance or student assistance professional may refer you to your designated behavioral health provider group.

You can access most outpatient therapy services without a referral or preauthorization. However, you should first consult with Member Services to confirm that any such outpatient therapy services do not require a referral or preauthorization.

Behavioral health provider safety data available

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

Behavioral health screening programs to help prevent depression

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

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

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

Breast reconstruction benefits

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 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**.

Clinical Policy Bulletins (CPBs)

CPBs describe our policy determinations of whether certain services or supplies are medically necessary or experimental or investigational, based upon a review of currently available clinical information. Clinical determinations in connection with individual coverage decisions are made on a case-by-case basis consistent with applicable policies.

Aetna CPBs do not constitute medical advice. Treating providers are solely responsible for medical advice and for your treatment. You should discuss any CPB related to your coverage or condition with your treating provider.

While our CPBs are developed to help administer plan benefits, they do not constitute a description of plan benefits. Each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits. You and your providers will need to consult the benefit plan to determine if there are any exclusions or other benefit limitations applicable to this service or supply.

CPBs are regularly updated and are therefore subject to change. Aetna CPBs are available online at **www.aetna.com**.

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**.

How to submit a claim

For most services, network doctors will file your claims for you. If you go outside the network, you may need to file claims yourself. Your health care professional may file a claim within 120 days from the date of service. You may also file a claim yourself.

We accept claims in paper, fax and electronically. If you need to file a claim with us, please call Member Services at the number on your Aetna ID Card. The representative will give you the mailing address, e-mail address or fax number to our claim office for your plan. You can also log in to your secure member website at **www.aetna.com** to download a claim form (which includes the mailing address) or to send the claim electronically.

1. Log in to your secure member website at **www.aetna.com**.
2. Click "Contact us" in upper right corner.
3. You can submit a claim form as an attachment.

Claim determinations

Our claim determination procedure applies to all claims that do not relate to a medical necessity or experimental or investigational determination. For example, our claim determination procedure applies to referrals and contractual benefit denials. If you disagree with our claim determination, you may submit a grievance.

For a description of the utilization review procedures and appeal process for medical necessity or experimental or investigational determinations, see utilization review.

A preservice claim is a request that a service or treatment be approved before it has been received. A postservice claim is a request for a service or treatment you have already received.

Preservice claim determinations
Preservice claims review is the review for approval of a claim before the service has taken place.

If we have all the information necessary to make a determination regarding a preservice claim (for example, a referral or a covered benefit determination), we will make a determination and provide notice to you (or your designee) within 15 days from receipt of the claim.

If we need additional information, we will request it within 15 days from receipt of the claim. You will have 45 calendar days to submit the information. If we receive the information within 45 days, we will make a determination and provide notice to you (or your designee) in writing, within 15 days of our receipt of the information. If all necessary information is not received by us within 45 days, we will make a determination within 15 calendar days of the end of the 45-day period.

Urgent preservice reviews
With respect to urgent preservice requests, if we have all information necessary to make a determination, we will make a determination and provide notice to you (or your designee) by telephone within 72 hours of receipt of the request. Written notice will follow within three calendar days of the decision. If we need additional information, we will request it within 24 hours. You will then have 48 hours to submit the information. We will make a determination and provide notice to you (or your designee) by telephone within 48 hours of the earlier of our receipt of the information or the end of the 48-hour time period. Written notice will follow within three calendar days of the decision.

Postservice claim determinations
The purpose of postservice claim review is to review initial requests for certification received after discharge or after the provision of services, retrospectively analyze potential quality and utilization issues, initiate appropriate follow-up action based on quality or utilization issues and review all appeals of inpatient concurrent review decisions for coverage of health care services.

If we have all information necessary to make a determination regarding a postservice claim, we will make a determination and notify you (or your designee) within 30 calendar days of the receipt of the claim. If we need additional information, we will request it within 30 calendar days. You will then have 45 calendar days to provide the information. We will make a determination and provide notice to you (or your designee) in writing within 15 calendar days of the earlier of our receipt of the information or the end of the 45-day period.

Whether a utilization review determination is made before, during or after services are provided, any adverse determination, including a claim denial, will be made by a clinical peer reviewer, and all notices of adverse determinations will include the specific reasons for the denial as well as information about your rights to appeal, including your right to appeal a final adverse determination to the New York State External Review Program. Utilization review will be conducted by a health care professional who is appropriately trained in the principles, procedures and standards of such utilization review agent; provided however, that a health care professional who is not a clinical peer reviewer may not render an adverse determination. All final adverse determinations will be made by a clinical peer reviewer other than the clinical peer reviewer who made the initial adverse determination.

The notice of adverse determination will include:

- A written detailed explanation and the reasons for the adverse determination, including reference to specific plan provisions upon which the determination is based and the clinical rationale, if any
- Instructions on how to start the appeals, expedited appeals and external appeals process and, if applicable, forms for the filing of such an appeal and what additional information, if any, must be obtained by the utilization agent on appeal
- A written statement that insufficient information was presented or available to reach a determination
- The claim amount (if applicable), and a statement of the availability, upon request, of the diagnosis and treatment codes and their meaning
- Notice of the availability, upon request, of the clinical review criteria used to make the adverse determination. This notice will also specify what necessary additional information, if any, must be provided to or obtained by us in order to render a decision on the appeal.

Timeframes for home care services

After receiving a request for coverage of home care services following an inpatient hospital admission, we will make our decision and notify you (or your designee) and/or your provider, by telephone and in writing, within one business day of our receipt of the necessary information. If the day after the request falls on a weekend or holiday, we'll notify you within 72 hours of receipt of the necessary information. We will not deny coverage for home care services while our decision is pending.

Grievances

A grievance is a complaint you communicate to us that does not involve a utilization review determination. Our grievance procedure applies to any issue not relating to a medical necessity or experimental or investigational determination by us. For example, it applies to contractual benefit denials or issues or concerns you have regarding our administrative policies or access to providers.

Filing a grievance: You can contact us by phone by calling Member Services at **1-866-565-1236**, in person or in writing to file a grievance. You may submit an oral grievance in connection with a denial of a referral or a covered benefit determination. You or your designee has up to 180 calendar days from when you received the decision you are asking us to review to file the grievance.

When we receive your grievance, we will mail an acknowledgment letter within 15 business days. The acknowledgment letter will include the name, address and telephone number of the person handling your grievance, and indicate what additional information, if any, must be provided.

We keep all requests and discussions confidential and will take no discriminatory action because of your issue. We have a process for both standard and expedited grievances, depending on the nature of your inquiry.

Grievance determination: Qualified personnel will review your grievance. Or if it is a clinical matter, a licensed, certified or registered health care professional will look into it. We will decide the grievance and notify you within the following timeframes:

Expedited/urgent grievances: By phone within the earlier of 36 hours of the necessary information or 72 hours of receipt of your grievance. Written notice will be provided within 72 hours of receipt of your grievance.

Preservice grievances: (A request for a service or treatment that has not yet been provided) In writing, within 15 calendar days of receipt of your grievance

Postservice grievances: (A claim for a service or a treatment that has already been provided) In writing, within 30 calendar days of receipt of your grievance

All other grievances: (That are not in relation to a claim) In writing, within 30 calendar days of receipt of your grievance

Grievance appeals

If you are not satisfied with the resolution of your grievance, you or your designee may file an appeal by phone, in person or in writing. However, urgent appeals may be filed by phone. You will have 180 days after receipt of notice of grievance determination to file a written appeal. When we receive your appeal, we will mail an acknowledgment letter within 15 business days. The acknowledgement letter will include the name, address and telephone number of the person handling your appeal and indicate what additional information, if any, must be provided.

One or more qualified personnel at a higher level than the personnel who rendered the grievance determination will review it, or if it is a clinical matter, a clinical peer reviewer will look into it. We will decide the appeal and notify you in writing within the following timeframes:

Expedited/urgent grievances: The earlier of 2 business days of receipt of all necessary information or 72 hours of receipt of your appeal

Preservice grievances: (A request for a service or treatment that has not yet been provided) 15 calendar days of receipt of your appeal

Postservice grievances: (A claim for a service or a treatment that has already been provided) 30 calendar days of receipt of your appeal

All other grievances: (That are not in relation to a claim) 30 calendar days of receipt of all information neccessary to make a determination

The appeal determination will include:

- The detailed reasons for the determination
- In cases where the determination has a clinical basis, the clinical rationale for the determination
- Further appeal rights, if any

If you remain dissatisfied with our appeal determination or at any other time you are dissatisfied, you may:

Call the New York State Department of Health at **1-800-206-8125** or write them at:

New York State Department of Health
Office of Health Insurance Programs
Division of Health Plan Contracting and Oversight
Bureau of Managed Care Certification and Surveillance
Corning Tower, OCP, Room 1609
Albany, NY 12237
www.health.ny.gov

If you need assistance filing a grievance or appeal, you may also contact the state independent consumer assistance program at:

Community Health Advocates
105 East 22nd Street
New York, NY 10010
Toll-free: **1-888-614-5400**
E-mail **cha@cssny.org**

Grievances for out-of-network referral denials

You may have a grievance for a referral to an out-of-network provider treated as a medical denial (utilization review appeal) and subject to an independent external review if:

- You requested a referral to an out-of-network provider because we did not have an in-network provider with the training and experience to meet your health care needs, and who is able to provide the requested health care service.
- Your doctor submits a written statement to us that the in-network providers recommended by your health plan do not have the training and experience to meet your health care needs.
- Your doctor recommends an out-of-network provider with the appropriate training and experience to meet your health care needs who is able to provide the requested service.

Out-of-network service denial

You also have the right to appeal the denial of a precertification request for an out-of-network health service when we determine the out-of-network health service is not materially different from an available in-network health service. A denial of an out-of-network health service is a service provided by a nonparticipating provider, but only when the service is not available from a participating provider. You are not eligible for a utilization review appeal if the service you request is available from a participating provider, even if the nonparticipating provider has more experience in diagnosing or treating your condition. (Such an appeal will be treated as a grievance.) For a utilization review appeal of denial of an out-of-network health service, you or your designee must submit:

- A written statement from your attending physician, who must be a licensed, board-certified or board-eligible physician qualified to practice in the specialty area of practice appropriate to treat your condition, that the requested out-of-network health service is materially different from the alternate health service available from a participating provider we approved to treat your condition
- Two documents from the available medical and scientific evidence that the out-of-network service is likely to be more clinically beneficial to you than the alternate in-network service, and that the adverse risk of the out-of-network service would likely not be substantially increased over the in-network health service

Your right to appeal an out-of-network referral denial to a nonparticipating provider.
If we have denied coverage of a request for a referral to a nonparticipating provider because we determine we have a participating provider with the appropriate training and experience to meet your particular health care needs who is able to provide the requested health care service, you may appeal to an external appeal agent if you meet the two requirements for an external appeal as stated above.

In addition, your attending physician must: certify that the participating provider recommended by us does not have the appropriate training and experience to meet your particular health care needs; and recommend a nonparticipating provider with the appropriate training and experience to meet your particular health care needs who is able to provide the requested health care service.

For purposes of this section, your attending physician must be a licensed, board-certified or board-eligible physician qualified to practice in the specialty area appropriate to treat you for the health service.

Utilization reviews

This is a review to determine whether services are or were medically necessary or experimental or investigational, including treatment for a rare disease or a clinical trial.

We review health services to determine whether the services are or were medically necessary or experimental or investigational (medically necessary). This process is called utilization review (UR). Utilization review includes all review activities, whether they take place before the service is performed (preauthorization); when the service is being performed (concurrent); or after the service is performed (retrospective). If you have any questions about the utilization review process, please call the number on your ID card.

All determinations that services are not medically necessary will be made by licensed physicians or by licensed, certified, registered or credentialed health care professionals who are in the same profession and same or similar specialty as the health care provider who typically manages your medical condition or disease or provides the health care service under review. We do not compensate or provide financial incentives to employees or reviewers for determining services are not or were not medically necessary. We have developed guidelines and protocols to assist in this process. Specific guidelines and protocols are available for your review upon request. For more information, you can call Member Services at the toll-free number on your ID card or visit our website at **www.aetna.com**.

To contact the utilization review agent, call Member Services at the toll-free number on your ID card or call **1-866-565-1236**. Doctors or health care professionals who have questions about your coverage can write or call our patient management department. The address and phone number are on your ID card. The utilization review agent is available during regular business hours (8 a.m. - 4 p.m. ET) Monday through Friday. For calls made after business hours or during the weekend, you can leave a message.

Preauthorization reviews

This review takes place before you receive a covered service, procedure, treatment plan, device or prescription drug to determine whether the covered service, treatment plan, device or prescription drug is medically necessary. We will indicate which of the covered services requires preauthorization.

If we have all the information necessary to make a determination regarding a preauthorization review, we will make a determination and provide notice to you (or your designee) and your provider by telephone and in writing within three business days of receipt of the necessary information.

If we need additional information, we will request it within 15 calendar days. You or your provider will then have 45 calendar days to submit the information. If we receive the requested information within 45 days, we will make a determination and provide notice to you (or your designee) and your provider by telephone and in writing within three business days of our receipt of the information. If all necessary information is not received within 45 days, we will make a determination within 15 calendar days of the end of the 45-day period.

Urgent preauthorization reviews
With respect to urgent preauthorization requests, if we have all information necessary to make a determination, we will make a determination and provide notice to you (or your designee) and your provider by telephone and in writing within 72 hours of receipt of the request. If we need additional information, we will request it within 24 hours. You or your provider will then have 48 hours to submit the information. We will make a determination and provide notice to you and your provider by telephone and in writing within 48 hours of the earlier of our receipt of the information or the end of the 48-hour time period.

After receiving a request for coverage of home care services following an inpatient hospital admission, we will make a determination and provide notice to you (or your designee) and your provider by telephone and in writing within one business day of receipt of the necessary information. If the day following the request falls on a weekend or holiday, we will make a determination and provide notice to you (or your designee) and your provider within 72 hours of receipt of the necessary information. When we receive a request for home care services and all necessary information prior to your discharge from an inpatient hospital admission, we will not deny coverage for home care services while our decision on the request is pending.

Concurrent reviews

Utilization review decisions for services during the course of care (concurrent reviews) will be made, and we will notify you (or your designee) and your provider by telephone and in writing within one business day of receipt of all necessary information. If we need additional information, we will request it within 24 hours. You or your provider will then have at least 48 hours to submit the information. We will make a determination and provide notice to you (or your designee) and your provider by telephone and in writing within the earlier of one business day of the receipt of necessary information, or the end of the time period allotted to provide the clinical information.

Discharge planning

Discharge planning may be initiated at any stage of the patient management process and begins immediately upon identification of post-discharge needs during precertification or concurrent review. The discharge plan may include initiation of a variety of services/benefits for the member after he or she is released from the inpatient facility.

Retrospective reviews

If we have all information necessary to make a determination regarding a retrospective claim, we will make a determination and notify you and your provider within 60 calendar days of the receipt of the request. If we need additional information, we will request it within 30 calendar days. You or your provider will then have 45 calendar days to provide the information.

We will make a determination and notify you and your provider in writing within 15 calendar days of the earlier of our receipt of the information or the end of the 45-day period.

Once we have all the information to make a decision, our failure to make a utilization review determination within the applicable time frames set forth above will be deemed an adverse determination subject to an internal appeal.

Retrospective review of preauthorized services

We may only reverse a preauthorized treatment, service or procedure on retrospective review when:

- The relevant medical information presented to us upon retrospective review is materially different from the information presented during the preauthorization review;
- The relevant medical information presented to us upon retrospective review existed at the time of the preauthorization but was withheld or not made available to us;
- We were not aware of the existence of such information at the time of the preauthorization review; and
- Had we been aware of such information, the treatment, service or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria or procedures as used during the preauthorization review.

Reconsideration

If we did not attempt to consult with your provider before making an adverse determination, your provider may request reconsideration by the same clinical peer reviewer who made the adverse determination. For preauthorization and concurrent reviews, the reconsideration will take place within one business day of the request for reconsideration. If the adverse determination is upheld, you and your provider will receive written notice of the adverse determination.

Utilization review internal appeals

You, your designee, and, in retrospective review cases, your provider, may request an internal appeal of an adverse determination, either by phone, in person or in writing.

You also have the right to appeal the denial of a preauthorization request for an out-of-network health service when we determine the out-of-network health service is not materially different from an available in-network health service. A denial of an out-of-network health service is a service provided by a nonparticipating provider, but only when the service is not available from a participating provider. You are not eligible for a utilization review appeal if the service you request is available from a participating provider, even if the nonparticipating provider has more experience in diagnosing or treating your condition. Such an appeal will be treated as a grievance.

For a utilization review appeal of denial of an out-of-network health service, you or your designee must submit:

- A statement from your attending physician (who must be a licensed, board-certified or board-eligible physician qualified to practice in the specialty area of practice appropriate to treat your condition) that the requested out-of-network health service is materially different from the alternate health service available from a participating provider that we approved to treat your condition
- Two documents from the available medical and scientific evidence stating that the out-of-network service:
  - Is likely to be more clinically beneficial to you than the alternate in-network service
  - That the adverse risk of the out-of-network service would likely not be substantially increased over the in-network health service

You have up to 180 calendar days after you receive notice of the adverse determination to file an appeal. We will acknowledge your request for an internal appeal within 15 calendar days of receipt. This acknowledgment will include the name, address and phone number of the person handling your appeal. A clinical peer reviewer who is a physician or a health care professional in the same or similar specialty as the provider who typically manages the disease or condition at issue and who is not subordinate to the clinical peer reviewer who made the initial adverse determination will perform the appeal.

Appeals

If your appeal relates to a preauthorization request, we will decide the appeal within 30 calendar days of receipt of the appeal request. Written notice of the determination will be provided to you (or your designee) and, where appropriate, your provider within two business days after the determination is made but no later than 30 calendar days after receipt of the appeal request.

If your appeal relates to a retrospective claim, we will decide the appeal within 30 calendar days of receipt of the appeal request. Written notice of the determination will be provided to you (or your designee) and, where appropriate, your provider within two business days after the determination is made but no later than 30 calendar days after receipt of the appeal request.

You have a right to appeal utilization review decisions through the expedited and standard appeal process.

Expedited appeals

Appeals of reviews of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient hospital admission, services in which a provider requests an immediate review or any other urgent matter will be handled on an expedited basis. Expedited appeals are not available for retrospective reviews. For expedited appeals, your provider will have reasonable access to the clinical peer reviewer assigned to the appeal within one business day of receipt of the request for an appeal. Your provider and a clinical peer reviewer may exchange information by telephone or fax.

Expedited appeals will be determined within the lesser of 72 hours from receipt of the appeal or two business days of receipt of the information necessary to conduct the appeal.

If you are not satisfied with the resolution of your expedited appeal, you may file a standard internal appeal or an external appeal.

Our failure to render a determination of your appeal within the applicable time frame will be deemed a reversal of the initial adverse determination.

Call the New York State Department of Health at **1-800-206-8125** or write them at:

New York State Department of Health
Office of Health Insurance Programs
Division of Health Plan Contracting and Oversight
Bureau of Managed Care Certification and Surveillance
Corning Tower, OCP, Room 1609
Albany, NY 12237
www.health.ny.gov

Call the New York State Department of Financial Services at **1-800-342-3736** or write them at:

New York State Department of Financial Services
Consumer Assistance Unit
1 Commerce Plaza
Albany, NY 12257
www.dfs.ny.gov

If you need assistance filing a grievance or appeal you may also contact the state independent consumer assistance program at:

Community Health Advocates
105 East 22nd Street
New York, NY 10010
Or call toll-free: **1-888-614-5400**
Or e-mail: **cha@cssny.org**

External appeal

I. Your right to an external appeal

In some cases, you have a right to an external appeal of a denial of coverage. Specifically, if we have denied coverage on the basis that a service does not meet our requirements for medical necessity (including appropriateness, health care setting, level of care or effectiveness of a covered benefit) or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), or is an out-of-network treatment, you or your representative may appeal that decision to an external appeal agent, which is an independent third party certified by the state to conduct these appeals. An external appeal application may be obtained from Member Services by calling **1-866-565-1236**.

In order for you to be eligible for an external appeal you must meet the following two requirements:

- The service, procedure or treatment must otherwise be a covered service under the plan.
- In general, you must have received a final adverse determination through the first level of our internal appeal process.

But, you can file an external appeal even though you have not received a final adverse determination through the first level of our internal appeal process if:

- We agree in writing to waive the internal appeal. We are not required to agree to your request to waive the internal appeal.
- You may file an expedited external appeal at the same time as you apply for an expedited internal appeal.
- We fail to adhere to utilization review claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to you, and we demonstrate the violation was for good cause or due to matters beyond our control and the violation occurred during an ongoing, good faith exchange of information between you and Aetna).

II. Your right to a determination that a service is not medically necessary
If we have denied coverage on the basis that the service does not meet its requirements for medical necessity, you may appeal to an external appeal agent if you meet the requirements for an external appeal in I above.

III. Your right to appeal a determination that a service is experimental or investigational
If we have denied coverage on the basis that the service is an experimental or investigational treatment, you must satisfy the two requirements for an external appeal in I above and your attending physician must certify that:

1. Your condition or disease is one for which standard health services are ineffective or medically inappropriate.
2. One for which there does not exist a more beneficial standard service or procedure covered by Aetna.
3. One for which there exists a clinical trial or rare disease treatment (as defined by law).

In addition, your attending physician must have recommended one of the following:

- A service, procedure or treatment that two documents from available medical and scientific evidence indicate is likely to be more beneficial to you than any standard covered service (only certain documents will be considered in support of this recommendation – your attending physician should contact the state for current information as to what documents will be considered or acceptable)
- A clinical trial for which you are eligible (only certain clinical trials can be considered
- A rare disease treatment for which your attending physician certifies that there is no standard treatment that is likely to be more clinically beneficial to you than the requested service, the requested service is likely to benefit you in the treatment of your rare disease and such benefit outweighs the risk of the service. In addition, your attending physician must certify your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network or that it affects fewer than 200,000 U.S. residents per year.

For purposes of this section, your attending physician must be a licensed, board-certified or board eligible physician qualified to practice in the area appropriate to treat your condition or disease. In addition, for a rare disease treatment, the attending physician may not be your treating physician.

IV. Your right to appeal a determination that a service is out of network
If we have denied coverage of an out-of-network treatment because it is not materially different than the health service available in network, you may appeal to an external appeal agent if you meet the two requirements for an external appeal in I above, and you have requested preauthorization for the out-of-network treatment.

In addition, your attending physician must certify the out-of-network service is materially different from the alternate recommended in-network health service, and based on two documents from available medical and scientific evidence, is likely to be more clinically beneficial than the alternate in-network treatment and that the adverse risk of the requested health service would likely not be substantially increased over the alternate in-network health service.

For purposes of this section, your attending physician must be a licensed, board-certified or board-eligible physician qualified to practice in the specialty area appropriate to treat you for the health service.

You do not have a right to an external appeal for a denial of a referral to an out-of-network provider on the basis that a health care provider is available in network to provide the particular health service requested by you.

V. The external appeal process
We will provide you with a copy of the standard description of the external appeal process. Requests for an external appeal shall be submitted to the Department of Financial Services, Consumer Assistance Unit, 1 Commerce Plaza, Albany, New York 12257.

Upon receipt of such request, the Department of Financial Services will screen the request for eligibility. You and/or your provider must release all pertinent medical information concerning your medical condition and request for services. All external appeals will be conducted by clinical peer reviewers. All requests, after they have been determined they are eligible, shall be randomly assigned to an external appeals agent.

You have four months from receipt of a final adverse determination or from receipt of a waiver of the internal appeal process to file a written request for an external appeal. If you are filing an external appeal based on our failure to adhere to claim processing requirements, you have four months from such failure to file a written request for an external appeal.

We will provide an external appeal application with the final adverse determination issued through the first level of our internal appeal process or our written waiver of an internal appeal. You may also request an external appeal application from the New York State Department of Financial Services at **1-800-400-8882**. Submit the completed application to the Department of Financial Services at the address indicated on the application. If you meet the criteria for an external appeal, the state will forward the request to a certified external appeal agent.

You can submit additional documentation with your external appeal request. If the external appeal agent determines that the information you submit represents a material change from the information on which we based our denial, the external appeal agent will share this information with us in order for us to exercise our right to reconsider our decision. If we choose to exercise this right, we will have three business days to amend or confirm our decision. Please note that in the case of an expedited appeal (described below), we do not have a right to reconsider our decision.

In general, the external appeal agent must make a decision within 30 days of receipt of your completed application. The external appeal agent may request additional information from you, your physician or Aetna. If the external appeal agent requests additional information, it will have five additional business days to make its decision. The external appeal agent must notify you in writing of its decision within two business days.

If your attending physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to your health; or if your attending physician certifies that the standard external appeal time frame would seriously jeopardize your life, health or ability to regain maximum function; or if you received emergency services and have not been discharged from a facility and the denial concerns an admission, availability of care or continued stay, you may request an expedited external appeal. In that case, the external appeal agent must make a decision within seventy-two hours of receipt of your completed application. Immediately after reaching a decision, the external appeal agent must try to notify you and Aetna by telephone or facsimile of that decision. The external appeal agent must also notify you in writing of its decision.

If the external appeal agent overturns our decision that a service is not medically necessary or approves coverage of an experimental or investigational treatment or an out-of-network treatment, we will provide coverage subject to the other terms and conditions of the plan.

Please note that if the external appeal agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, we will only cover the costs of services required to provide treatment to you according to the design of the trial. We will not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research or costs that would not be covered under this plan for nonexperimental or noninvestigational treatments provided in the clinical trial. The external appeal agent's decision is binding on both you and Aetna. The external appeal agent's decision is admissible in any court proceeding.

A physician requesting an external appeal of an adverse determination involving a concurrent care claim, including when such physician requests the external appeal as the member's designee, shall not pursue reimbursement from any member for services determined not medically necessary by the external appeal agent except to collect a copayment.

We will charge you a fee of $25 for each external appeal, not to exceed $75 in a single plan year. The external appeal application will explain how to submit the fee. We will waive the fee if we determine that paying the fee would be a hardship to you. If the external appeal agent overturns the denial of coverage, the fee will be refunded to you.

VI. Your responsibilities

It is your responsibility to start the external appeal process. You may start the external appeal process by filing a completed application with the New York State Department of Financial Services. You may appoint a representative to assist you with your application; however, the Department of Financial Services may contact you and request that you confirm in writing that you have appointed the representative.

Under New York State law, your completed request for external appeal must be filed within four months of either the date upon which you receive a final adverse determination, the date upon which you receive a written waiver of any internal appeal, or our failure to adhere to claim processing requirements. We have no authority to extend this deadline.

Member rights and responsibilities

Information

- Know the names and qualifications of the health care professionals involved in your medical treatment.
- Obtain complete and current information concerning a diagnosis, treatment and prognosis from a physician or other provider in terms you can be reasonably expected to understand. When it is not advisable for such information to be given to the member, it shall be made available to an appropriate person on the member's behalf.
- Get up-to-date information about the services covered or not covered by your plan and any applicable limitations or exclusions.
- Know how your plan decides what services are covered.
- Get information about copayments and fees that you must pay.
- Get up-to-date information about the health care professionals, hospitals and other providers that participate in the plan.
- Be advised how to file a complaint, grievance or appeal with the plan.
- Know how the plan pays network health care professionals for providing services to you.
- Receive information from health care professionals about your medications, including what the medications are, how to take them and possible side effects.
- Receive from health care professionals as much information about any proposed treatment or procedure as you may need in order to give informed consent or refuse a course of treatment. Except in an emergency, this information should include a description of the proposed procedure or treatment, the potential risks and benefits involved, any alternate course of treatment (even if not covered) or nontreatment and the risks involved in each, and the name of the health care professionals who will carry out the procedure or treatment. When it is not advisable to give such information to you, your doctor may give such information to a person acting on your behalf.
- Be informed by participating providers about continuing health care requirements following discharge from inpatient or outpatient facilities.
- Be advised if a health care professional proposes to use an experimental treatment or procedure in your care. You have the right to refuse to participate in research projects.
- Receive an explanation regarding noncovered services.
- Receive a prompt reply when you ask questions about the plan or request information.
- Receive a copy of the plan's Member Rights and Responsibilities statement.

Access to care

- Obtain primary and preventive care from the PCP you chose from the plan's network.
- Change your PCP to another available PCP who participates in the plan.
- Obtain necessary care from participating network specialists, hospitals and other providers.
- Be referred to participating network specialists who are experienced in treating your chronic illness.
- Be advised by your health care professionals how to schedule appointments and get health care during and after office hours, including continuity of care.
- Be advised how to get in touch with your PCP or a backup physician 24 hours a day, every day.
- Call 911 (or the local emergency hotline) or go to the nearest emergency facility when you have an emergency medical condition as defined in your plan documents.
- Receive urgently needed medically necessary care.

Freedom to make decisions

- Exercise these rights regardless of your race, physical or mental disability, ethnicity, gender, sexual orientation, creed, age, religion, national origin, cultural or educational background, economic or health status, English proficiency, reading skills or source of payment for your care.
- Have any person who has legal responsibility to make medical care decisions for you exercise these rights on your behalf.
- Refuse treatment to the extent permitted by law and to be informed of the medical consequences of that action.
- Complete an advance directive, living will or other directive and give it to your health care professionals.
- Know that you or your health care professionals cannot be penalized for filing a complaint or appeal.

Personal rights

- Be treated with respect for your privacy and dignity.
- Have your medical records kept private except when permitted by law or with your approval.
- Help your health care professionals make decisions about your health care.

Input

- Have your health care professionals help you to make decisions about the need for services and with the complaint process.
- Suggest changes in the plan's policies and services. To submit suggestions on the plan's policies, please write to us at the below address:

  Aetna Life Insurance Company
  980 Jolly Road
  U12N, Blue Bell, PA 19422

Exercise your rights

- Choose a PCP from the plan's network, and form an ongoing patient-physician relationship.
- Help your health care professionals make decisions about your health care.

Follow instructions

- Read and understand your plan and benefits. Know the copayments and what services are covered and what services are not covered.
- Follow the directions and advice on which you and your health care professionals have agreed.
- See the specialists your PCP refers you to.
- Make sure you have the appropriate authorization for certain services including referrals and precertification for inpatient hospitalization and out-of-network treatment.
- Show your membership card to health care professionals before getting care from them.
- Pay the copayments required by your plan.
- Promptly follow your plan's complaint processes if you believe you need to submit a complaint.
- Treat all providers, their staff members and the staff of the plan with respect.
- Not be involved in dishonest activity directed at the plan or at any provider.

Communicate

- Tell your health care professionals if you do not understand the treatment you receive and ask if you do not.
- Understand how to care for your illness.
- Tell your health care professionals promptly when you have unexpected problems or symptoms.
- Consult with your PCP for referrals to nonemergency covered specialists or hospital care.
- Understand that network physicians and other health care professionals who care for you are not employees of Aetna, and that Aetna does not control them.
- Contact Member Services if you do not understand how to use your benefits.
- Give correct and complete information to physicians and other health care professionals who care for you.
- Advise Aetna about other medical insurance coverage you or plan members in your family may have.
- Ask your treating physician about all treatment options.
- Ask about the physician's compensation arrangement with Aetna.

You may have additional rights and responsibilities depending on state laws applicable to your plan.

Advance directives

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

There are three types of advance directives:

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

You can create an advance directive in several ways:

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

Annual privacy notice

We protect your privacy

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

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

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

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

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

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

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

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

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

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

Health Insurance Portability and Accountability Act

The following information is provided to inform you of certain provisions contained in the group health plan and related procedures that may be utilized by you in accordance with federal law.

Special enrollment rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption or placement for adoption. To request special enrollment or obtain more information, contact your benefits administrator.

Special enrollment periods for groups with 1 to 50 employees
Outside of the annual open enrollment period, you, the subscriber, your spouse or child can enroll for coverage within 60 days prior to or after the occurrence of one of the following events:

1. You, your spouse or child involuntarily loses minimum essential coverage including COBRA or state continuation coverage;
2. You, your spouse or child are determined newly eligible for advance payments of the premium tax credit because the coverage you are enrolled in will no longer be employer-sponsored minimum essential coverage including as a result of your employer discontinuing or changing available coverage within the next 60 days provided that you are allowed to terminate existing coverage; or
3. You, your spouse or child loses eligibility for Medicaid coverage including Medicaid coverage for pregnancy-related services and Medicaid coverage for the medically needy but not including other Medicaid programs that do not provide coverage for primary and specialty care.

Outside of the annual open enrollment period, you, the subscriber, your spouse or child can enroll for coverage within 60 days after the occurrence of one of the following events:

1. You, your spouse or child's enrollment or non-enrollment in another health plan was unintentional, inadvertent or erroneous and was the result of the error, misrepresentation or inaction of an officer, employee or agent of a health plan or the NYSDOH.
2. You, your spouse or child adequately demonstrates to us that another health plan in which you were enrolled substantially violated a material provision of its contract;
3. You, your spouse or child move and become eligible for new health plans.
4. You gain a dependent or become a dependent through marriage, birth, adoption or placement for adoption or foster care.
5. You, your spouse or child are determined newly eligible or newly ineligible for advance payments of the premium tax credit or have a change in eligibility for cost-sharing reductions.

We must receive notice and any premium payment within 60 days of one of these events.

Additional information available upon request

In accordance with New York law, the following information is available to a member or prospective member upon request by contacting Member Services:

1. List of the names, business addresses and official positions of the membership of the board of directors, officers, controlling persons, owners or partners of the plan
2. The most recent certified financial statements of the plan, including a balance sheet and summary of receipts and disbursements prepared by a certified public accountant
3. Copy of the most recent individual, direct-pay subscriber contracts
4. Information relating to consumer complaints compiled pursuant to Section 210 of the New York insurance law
5. Procedures for protecting the confidentiality of medical records and other enrollee information
6. Drug formularies, if any, used by the plan and the inclusion/exclusion of individual drugs
7. Written description of the organizational arrangements and ongoing procedures of the plan's quality assurance program
8. Description of the procedures followed in making decisions about experimental or investigational nature of individual drugs, medical devices or treatments in clinical trials
9. Individual health practitioner affiliations with participating hospitals, if any
10. Upon written request, specific written clinical review criteria relating to a particular condition or disease and, where appropriate, other clinical information that the plan might consider in its patient management program and the plan may include with the information a description of how it will be used in the patient management process, provided, however, that to the extent such information is proprietary to the plan, the enrollee or prospective enrollee shall only use the information for the purposes of assisting the enrollee or prospective enrollee in evaluating the covered services provided by the plan
11. Written application procedures and minimum qualification requirements for health care providers considered by the plan
12. Such other information as required by the Commissioner of Health provided that such requirements are promulgated pursuant to the state administrative procedure act
13. Whether a health care provider scheduled to provide a health care service is a participating provider
14. With respect to out-of-network coverage approved by the plan, receive the approximate dollar amount that Aetna will pay for a specific out-of-network health care service. This information is nonbinding, and the approximate dollar amount for a specific out-of-network service may change.

Protection from surprise bills

1. A surprise bill is a bill you receive for covered services in the following circumstances:

   - For services performed by a nonparticipating physician at a participating hospital or ambulatory surgical center, when:
     - A participating physician is unavailable at the time the health care services are performed;
     - A nonparticipating physician performs services without your knowledge; or
     - Unforeseen medical issues or services arise at the time the health care services are performed.

   A surprise bill does not include a bill for health care services when a participating physician is available and you elected to receive services from a nonparticipating physician.

   - You were referred by a participating physician to a nonparticipating provider without your explicit written consent acknowledging that the referral is to a nonparticipating provider and it may result in costs not covered by us. For a surprise bill, a referral to a nonparticipating provider means:
     - Covered services are performed by a nonparticipating provider in the participating physician's office or practice during the same visit;
     - The participating physician sends a specimen taken from you in the participating physician's office to a nonparticipating laboratory or pathologist; or
     - For any other covered services performed by a nonparticipating provider at the participating physician's request, when referrals are required under your certificate.

   You will be held harmless for any nonparticipating provider charges for the surprise bill that exceed your in-network copayment, deductible or coinsurance if you assign benefits to the nonparticipating provider in writing. In such cases, the nonparticipating provider may only bill you for your in-network copayment, deductible or coinsurance.

2. The assignment of benefits form for surprise bills is available on the next page, at **www.dfs.ny.gov**, or you can visit our website at **www.aetna.com** for a copy of the form. You need to mail a copy of the assignment of benefits form to us at the address on your ID card and to your provider. You may also use the mailing or e-mail address noted below.

   You can call Member Services if you need help completing the form and to send the form to Aetna. The phone number is on your Aetna ID card. You may mail the form to us at:

   Member Correspondence
   Aetna
   PO Box 981106
   El Paso, Texas 79998-1106

   Or send the form electronically:

   1. Log in to your secure member website at **www.aetna.com**.
   2. Click "Contact us" in upper right corner.
   3. You can submit the form as an attachment.

3. **Independent Dispute Resolution Process.** Either we or a provider may submit a dispute involving a surprise bill to an independent dispute resolution entity ("IDRE") assigned by the state. Disputes are submitted by completing the IDRE application form, which can be found at **www.dfs.ny.gov**. The IDRE will determine whether our payment or the provider's charge is reasonable within 30 days of receiving the dispute. You may also submit a dispute if you do not assign benefits, or are uninsured.

New York State Out-of-Network Surprise Medical Bill Assignment of Benefits Form

Use this form if you receive a surprise bill for health care services and want the services to be treated as in network. To use this form, you must: (1) fill it out and sign it; (2) send a copy to your health care provider (include a copy of the bill or bills); and (3) send a copy to your insurer (include a copy of the bill or bills). If you don't know if it is a surprise bill, contact the Department of Financial Services at **1-800-342-3736**.

A surprise bill is when:

1. You received services from a nonparticipating physician at a participating hospital or ambulatory surgical center, where a participating physician was not available; or a nonparticipating physician provided services without your knowledge; or unforeseen medical circumstances arose at the time the services were provided. You did not choose to receive services from a nonparticipating physician instead of from an available participating physician; OR
2. You were referred by a participating physician to a nonparticipating provider, but you did not sign a written consent that you knew the services would be out-of-network and would result in costs not covered by your insurer. A referral occurs: (1) during a visit with your participating physician, a nonparticipating provider treats you; or (2) your participating physician takes a specimen from you in the office and sends it to a nonparticipating laboratory or pathologist; or (3) for any other health care services when referrals are required under your plan.

I assign my rights to payment to my provider and I certify to the best of my knowledge that:

I (or my dependent) received a surprise bill from a health care provider. I want the provider to seek payment for this bill from my insurance company (this is an "assignment"). I want my health insurer to pay the provider for any health care services I or my dependent received that are covered under my health insurance. With my assignment, the provider cannot seek payment from me, except for any copayment, coinsurance or deductible that would be owed if I or my dependent used a participating provider. If my insurer paid me for the services, I agree to send the payment to the provider.

Patient Name: _____

Patient Address: _____

Insurer Name: _____

Patient Insurance ID No.: _____

Provider Name: _____ Provider Telephone Number: _____

Provider Address: _____

Date of Service: _____

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

_____ _____

(Signature of patient) (Date of signature)

NYS FORM OON-AOB (5/26/15)

We are 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 **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 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.

See "Other Reports on Health Care Quality" in the drop-down 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 1-866-565-1236.
Si usted necesita este material en otro lenguaje, por favor llame a Servicios al Miembro al 1-866-565-1236.

www.aetna.com

63.28.303.1-NY C (9/15)

aetna®